CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Partnership Plan Medicaid Section 1115 Demonstration**

AWARDEE: **New York State Department of Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New York's Partnership Plan section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the New York State Department of Health (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the Demonstration and the state's obligations to CMS during the life of the Demonstration. The STCs are effective August 1, 2011, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration extension is approved through December 31, 2014; however, some components of the Demonstration will expire earlier, as described below in these STCs and associated waiver and expenditure authority documents, and in the table in Attachment F.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Demonstration Eligibility; Demonstration Benefits and Enrollment; Delivery Systems; Quality Demonstration Programs and Clinic Uncompensated Care Funding; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

The state's goal in implementing the Partnership Plan section 1115(a) Demonstration is to improve access to health services and outcomes for low-income New Yorkers by:

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

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. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As

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

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. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. During this extension period, the state will expand Family Health Plus eligibility for low-income adults with children.

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program).

In 2010, the Home and Community-Based Services Expansion Program (HCBS expansion program) was added to the Demonstration. It provides cost-effective home and community-based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs, and strives to provide quality services for individuals in the community, ensure the well-being and safety of the participants, and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the state is authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, will provide funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity, and quality of care for individuals receiving primary care in outpatient hospital settings. By the end of the demonstration extension period, the hospital teaching programs which receive grants under the H-MH project will have received certification by the National Committee for Quality Assurance as patient-centered medical homes and implemented additional improvements in patient safety and quality outcomes.

The second initiative is intended to reduce 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. Under the Potentially Preventable Readmissions (PPR) project, the state will provide funding, on a competitive basis, to hospitals and/or collaborations of hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of PPRs for the Medicaid population. Projects will target readmissions related to both medical and behavioral health conditions.

Finally, CMS will provide funding for the state's program to address clinic uncompensated care through its Indigent Care Pool. Prior to this extension period, the state has funded (with state dollars only) this program which provides formula-based grants to voluntary, non-profit, and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state.

In 2012, New York added to the Demonstration an initiative to improve service delivery and

coordination of long-term care services and supports for individuals through a managed care model. Under the Managed Long-Term Care (MLTC) program, eligible individuals in need of more than 120 days of community-based long-term care are enrolled with managed care providers to receive long-term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not exercised its option to include the individual in the Mainstream Medicaid Managed Care Program **(**MMMC). Enrollment in MLTC may be phased in geographically and by group.

The state's goals specific to managed long-term care (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;
- Reduce preventable inpatient and nursing home admissions; and
- Improve satisfaction, safety and quality of life.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this Demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

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

6. **Changes Subject to the Amendment Process.** Changes related to program design, eligibility, enrollment, expansion program benefits, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive, and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process outlined in STC 7 below.

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

    a) An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group/EG) the impact of the amendment;

    c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Demonstration Phase-Out.** The state may suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

    a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 4 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each

public comment received, the state's response to the comment, and the way the state incorporated the received comment into a revised phase-out plan.

CMS must approve the phase-out plan prior to the implementation of the phase-out activities. There must be a 14-day period between CMS approval of the phase-out plan and implementation of phase-out activities.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan its process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213. In addition, the state must ensure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR 431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine whether they qualify for Medicaid eligibility under a different eligibility category as discussed in the October 1, 2011, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, subject to adequate public notice, (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

10. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX of the Act. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS's determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; monitoring

and oversight of managed care plans providing long-term services and supports including quality and enrollment processes; and reporting on financial and other Demonstration components.

13. **Quality Review of Eligibility.** The state will continue to submit to the CMS Regional Office by December 31 of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by federal regulations at 42 CFR 431.812(c).

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when the state proposes any program changes to the Demonstration, including (but not limited to) those referenced in STC 6.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter, or the consultation process in the state's approved Medicaid state plan, if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, and/or renewal of this Demonstration (42 CFR 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **FFP.** No federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. DEMONSTRATION ELIGIBILITY

16. **Demonstration Components**. The Partnership Plan includes five distinct components, each of which has its own specific eligibility criteria.

    a) **Mainstream Medicaid Managed Care Program (MMMC)**. This component provides Medicaid state plan benefits through a managed care delivery system comprised of managed care organizations (MCOs), and primary care case management (PCCM) arrangements to most recipients eligible under the state plan. All state plan eligibility determination rules apply to this program, except those otherwise noted in this section.

    The state has authority to expand mandatory enrollment in mainstream managed care to all individuals identified in Table 2 (except those otherwise excluded or exempted as outlined in STC 26) and who reside in any county other than Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties. When the state intends to expand mandatory managed care enrollment to additional counties (other than those identified in this subparagraph), it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the demonstration's budget neutrality agreement, which reflects the projected impact of the

expansion for the remainder of the Demonstration approval period.

Note: The authority to require mandatory managed care enrollment for any of the individuals who are identified in Table 2 and who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties has been provided under the Federal-State Health Reform Partnership Demonstration (11-W-00234/2).

b) **Managed Long Term Care (MLTC)**. This component provides a limited set of Medicaid state plan benefits including long-term services and supports through a managed care delivery system to individuals eligible through the state plan who require more than 120 days of community-based long-term care services.

Services not provided through the MLTC program are provided on a fee-for-service basis. The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3 (except those otherwise excluded or exempted as outlined in STC 27) with initial mandatory enrollment starting in any county in New York City and then expanding statewide based on the Enrollment plan as outlined in Attachment G. When the state intends to expand into a new county outside of New York City, it must notify CMS 90 days prior to the effective date of the expansion and submit a revised assessment of the Demonstration's budget neutrality agreement along with all other required materials as outlined in STC 32.

c) **Family Health Plus (FHPlus)**. This component provides a more limited benefit package, with cost-sharing imposed, to enrolled adults with and without dependent children who meet specific income eligibility requirements through MCOs. FHPlus-eligible individuals that have access to cost-effective employer-sponsored health insurance are required to enroll in the Family Health Plus Premium Assistance Program (FHP-PAP). Under FHP-PAP, enrollees will not be responsible for any portion of the premium payments for that coverage. Adults in this program will use employer-sponsored health insurance as their primary insurance policy, with all premiums, deductibles, and coinsurance (if any) paid by the state.

d) **Family Planning Expansion Program (FP Expansion)**. This component provides only family planning and family planning-related services to men and women of childbearing age with net incomes at or below 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, as well as to women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum.

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

The state will also ensure that redeterminations of eligibility for this component of the demonstration are conducted, at a minimum, once every 12 months. Administrative (or ex parte) redeterminations are acceptable.

e) **Home and Community-Based Services Expansion Program (HCBS Expansion).** This component provides home and community-based services identical to those provided under

three of the state's section 1915(c) HCBS waivers (Long-Term Home Health Care Program/LTHHCP, Nursing Home Transition and Diversion Program/NHTD, and Traumatic Brain Injury Program/TBI) to certain medically needy individuals. These services enable these individuals to live at home with appropriate supports rather than in a nursing facility.

17. **Individuals Eligible under the Medicaid State Plan (State Plan Eligibles).** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as further described in these STCs. State plan eligibles are included in the MMMC component of the Demonstration to ensure access to cost-effective high quality care.

18. **Individuals Not Otherwise Eligible under the Medicaid State Plan**. Individuals made eligible under this Demonstration by virtue of the expenditure authorities expressly granted include those in the FHPlus, FP Expansion, and HCBS Expansion components of the Demonstration and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as specified as not applicable in the expenditure authorities for this Demonstration.

19. **Continuous Eligibility Period**.

i. **Duration.** The state is authorized to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits. Once the state begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with Medicaid state plan or FHPlus rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under Medicaid state plan or FHPlus rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

Table 1: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory Reference (Social Security Act)
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV); and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children up to age 19	1931 and 1925
Medically needy pregnant women, children, and parents/caretaker relatives	Without spend-down under 1902(a)(10)(C)(i)(III)
Demonstration Eligible Group	**Qualifying Criteria**
Safety Net Adults	Income based on statewide standard of need (determined annually)
Family Health Plus Adults with children	Income above the applicable statutory level but gross family income at or below 160% FPL.
Family Health Plus Adults without children	Income above the statewide standard of need but gross household income at or below 100% FPL.

Note: Children under 19 who are eligible at the applicable FPL already receive 12 months continuous eligibility under the Medicaid state plan.

ii. **Exceptions.** Notwithstanding subparagraph i, if any of the following circumstances occur during an individual's 12-month continuous eligibility period, the individual's Medicaid or FHPlus eligibility shall be terminated:

i. The individual cannot be located;

ii. The individual is no longer a New York State resident;

iii. The individual requests termination of eligibility;

iv. The individual dies;

v. The individual fails to provide, or cooperate in obtaining, a Social Security number if otherwise required;

vi. The individual provided an incorrect or fraudulent Social Security number;

vii. The individual was determined eligible for Medicaid in error;

viii. The individual is receiving treatment in a setting where Medicaid eligibility is not available (e.g., institution for mental disease);

ix. The individual is in receipt of long-term care services;

x. The individual is receiving care, services, or supplies under a section 1915 waiver program;

xi. The individual was previously otherwise qualified for emergency medical assistance benefits only, based on immigration status, but is no longer qualified because the emergency has been resolved;

xii. The individual fails to provide the documentation of citizenship or immigration status required under federal law; or

xiii. The individual is incarcerated.

20. **Individuals enrolled in MMMC.** Table 2 below lists the groups of individuals who receive Medicaid benefits through the Medicaid managed care component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 2: Mainstream Medicaid Managed Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Pregnant Women	Income up to 200%	Demonstration Population 2/ Temporary Assistance to Needy Families (TANF) Adult
Children under age 1	Income up to 200%	Demonstration Population 1/ TANF Child
Children 1 through 5	Income up to 133%	Demonstration Population 1/ TANF Child
Children 6 through 18	Income up to 133%	Demonstration Population 1/ TANF Child
Children 19-20	Income at or below the monthly income standard (determined annually)	Demonstration Population 1/ TANF Child

Parents and Caretaker Relatives	Income at or below the monthly income standard (determined annually)	Demonstration Population 2/ TANF Adult
Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditure and Eligibility Group Reporting**
Safety Net Adults	Income based on statewide standard of need (determined annually)	Demonstration Population 5/ Safety Net Adults

21. **Individuals enrolled in MLTC**. Table 3 below lists the groups of individuals who may be enrolled in the Managed Long-Term Care component of the Demonstration as well as the relevant expenditure reporting category (demonstration population) for each. To be eligible, all individuals in this program must need more than 120 days of community-based long-term care services and for MAP and PACE have a nursing home level of care.

Table 3: Managed Long-Term Care Program

State Plan Mandatory and Optional Groups	FPL and/or Other Qualifying Criteria	Expenditure and Eligibility Group Reporting
Adults aged 65 and older	Income at or below SSI level	MLTC Adults 65 and above
Adults/children aged 18 - 64	Income at or below SSI level	MLTC Adults 18 – 64
Adults aged 65 and older	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 65 and above
Adults/children aged 18-64 blind and disabled	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 18 – 64
Aged 16 – 64 Medicaid Buy In for Working People with Disabilities	Income up to 250%	MLTC Adults 18 – 64
Parents and Caretaker Relatives 21-64	Income at or below the monthly income standard, or with spenddown to monthly income standard	MLTC Adults 18 – 64
Children aged 18 – 20	Income at or below the monthly income standard or with spenddown	MLTC Adults 18 – 64

Pregnant Women	Income up to 200%	MLTC Adults 18 – 64
Poverty Level Children Aged 18 to 20	Income up to 133%	MLTC Adults 18 – 64
Foster Children Aged 18 – 20	In foster care on the date of 18th birthday	MLTC Adults 18 – 64

Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditure and Eligibility Group Reporting**
Safety Net Adults	Income based on statewide Standard of Need (determined annually)	Safety Net Adults
Individuals Moved from Institutional Settings to Community Settings for Long Term Care Services	Income based on higher income standard to community settings for long term services and supports pursuant to STC 25	MLTC Adults 18 – 64 MLTC Adults 65 and above

22. **Individuals enrolled in FHPlus.** Table 4 below lists the groups of individuals who may be enrolled in the Family Health Plus component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population) for each.

Table 4: Family Health Plus

Demonstration Eligible Groups	**FPL and/or Other Qualifying Criteria**	**Expenditure and Eligibility Group Reporting**
Parents and caretaker relatives of a child under the age of 21 (who could otherwise be eligible under section 1931 of the Medicaid state plan)	Income above the Medicaid monthly income standard but gross family income at or below 160% FPL.	Demonstration Population 6/ FHP Adults w/Children
Non-pregnant, non-disabled ("childless") adults (19-64)	Income above the statewide standard of need but gross household income at or below 100% FPL.	Demonstration Population 7/ FHP Childless Adults

23. **Individuals enrolled in Family Planning Expansion Program.** Table 5 lists the groups of individuals who may be enrolled in the family planning expansion component of the Demonstration, as well as the relevant expenditure reporting category (demonstration population).

Table 5: Family Planning Expansion Program

Demonstration Eligible Groups	Expenditure and Eligibility Group Reporting
Women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum	Demonstration Population 8/ FP Expansion
Men and women of childbearing age with net incomes at or below 200% FPL who are not otherwise eligible for Medicaid	Demonstration Population 8/ FP Expansion

24. **Individuals enrolled in HCBS Expansion Program**. This group, identified as Demonstration Population 9/HCBS Expansion, includes married medically needy individuals:

    a) Who meet a nursing home level of care;

    b) Whose spouse lives in the community; and

    c) Who could receive services in the community but for the application of the spousal impoverishment eligibility and post-eligibility rules of section 1924 of the Act.

25. **Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports.** Individuals discharged from a nursing facility who enroll into the MLTC program in order to receive community-based long-term services and supports are eligible based on a special income standard. Spousal impoverishment rules shall not apply to this population. The special income standard will be determined by utilizing the average Housing and Urban Development (HUD) Fair Market Rent (FMR) dollar amounts for each of the seven regions in the state, and, subtracting from that average**,** 30 percent of the Medicaid income level (as calculated for a household of one) that is considered available for housing. The seven regions of the state include: Central Region; Northeastern; Western; Northern Metropolitan; New York City; Long Island; and Rochester.

    The state shall work with Nursing Home Administrators, nursing home discharge planning staff, family members, and the MLTC health plans to identify individuals who may qualify for the housing disregard as they are able to be discharged from a nursing facility back into the community and enrolled into the MLTC program.

    In addition, the state will ensure that the MLTC Managed Care Organizations (MCOs) work with individuals, their families, nursing home administrators, and discharge planners to help plan for the individual's move back into the community, as well as to help plan for the individual's medical care once he/she has successfully moved into his/her home.

26. **Exclusions and Exemptions from MMMC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MMMC program (i.e., excluded), while others may request an exemption from receiving benefits through the MMMC program (i.e., exempted). Tables 6 and 7 list those individuals either excluded or exempted from MMMC.

Table 6: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state-certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Foster care children in direct care [at the option of the local Department of Social Services (LDSS)]
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid-eligible for less than 6 months (except for pregnant women)
Individuals receiving long-term care services through long-term home health care programs
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Individuals who are eligible for Medicaid buy-in for the working disabled and who must pay a premium
Individuals who are eligible for Emergency Medicaid

Table 7: Individuals who may be exempted from MMMC

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
Individuals with a developmental or physical disability receiving services through a Medicaid home- and community-based services (HCBS) waiver authorized under section 1915(c) of the Act
Residents of alcohol/substance abuse long-term residential treatment programs
Native Americans
Individuals who are eligible for Medicaid buy-in for the working disabled and who do not pay a premium
Individuals with a “county of fiscal responsibility code of 98” (OPWDD in Medicaid Management Information System/MMIS) in counties where program features are approved by the state and operational

at the local district level to permit these individuals to voluntarily enroll

27. **Exclusions and Exemptions from MLTC.** Notwithstanding the eligibility criteria in STC 16, certain individuals cannot receive benefits through the MLTC program (i.e., excluded), while others may request an exemption from receiving benefits through the MLTC program (i.e., exempted). Tables 8 and 9 list those individuals either excluded or exempted from MLTC.

Table 8: Individuals excluded from MLTC

Residents of psychiatric facilities
Residents of residential health care facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a "county of fiscal responsibility" code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 (Individuals in an OPWDD facility or treatment center)
Individuals eligible for the family planning expansion program
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal, and/or prostate early detection program and need treatment for breast, cervical, colorectal, or prostate cancer, and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse long-term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home- and Community-Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 9: Individuals who may be exempted from MLTC.

Individuals aged 18 – 21 who are nursing home certifiable and require more than 120 days of community-based long-term care services
Native Americans

Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

28. **Population-Specific Program Requirements.**

a) **MMMC Enrollment of Individuals Living with HIV.** The state is authorized to require individuals living with HIV to receive benefits through MMMC. Once the state begins implementing MMMC enrollment in a particular district, individuals living with HIV will have thirty days in which to select a health plan. If no selection is made, the individual will be auto-assigned to a MCO. Individuals living with HIV who are enrolled in a MCO (voluntarily or by default) may request transfer to an HIV Special Needs Plans (SNP) at any time if one or more HIV SNPs are in operation in the individual's district. Further, transfers between HIV SNPs will be permitted at any time.

b) **Restricted Recipient Programs.** The state may require individuals participating in a restricted recipient program administered under 42 CFR 431.54(e) to enroll in MMMC. Furthermore, MCOs may establish and administer restricted recipient programs, through which they identify individuals that have utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the state, and restrict them for a reasonable period of time to obtain Medicaid services from designated providers only. The state must adhere to the following terms and conditions in this regard.

i. Restricted recipient programs operated by MCOs must adhere to the requirements in 42 CFR 431.54(e)(1) through (3), including the right to a hearing conducted by the state.

ii. The state must require MCOs to report to the state whenever they want to place a new person in a restricted recipient program. The state must maintain summary statistics on the numbers of individuals placed in restricted recipient programs, and the reasons for those placements, and must provide the information to CMS upon request.

c) **Managed care enrollment of individuals using long-term services and supports for both MMMC and MLTC.** The state is authorized to require certain individuals using long-term services and supports to enroll in either mainstream managed care or managed long-term care as identified in STC 16. In addition, the populations that are exempted from mandatory enrollment, based on the exemption lists in STCs 26 and 27 may also elect to enroll in managed care plans. Once these individuals begin to enroll in managed care, the state will be required to provide the following protections for the population:

i. **Person Centered Service planning** – The state, through its contracts with its MCOs and/or Prepaid Inpatient Health Plans (PIHPs), will require that all individuals utilizing long-term services and supports will have a person-centered individual service plan maintained at the MCO or PIHP. Person-Centered Planning includes consideration of the current and unique psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

(A) The state must establish minimum guidelines regarding the Person-Centered Plan (PCP) that will be reflected in MCO/PIHP contracts. These must include at a minimum, a description of:
   a. The qualification for individuals who will develop the PCP;
   b. Types of assessments;
   c. How enrollees are informed of the services available to them; and
   d. The MCOs' responsibilities for implementing and monitoring the PCP.

(B) The MCO/PIHP contract shall require the use of a person centered and directed planning process intended to identify the strengths, capacities, and preferences of the enrollee, as well as to identify an enrollee's long term care needs and the resources available to meet those needs, and to provide access to additional care options as specified by the contract. The person-centered plan is developed by the participant with the assistance of the MCO/PIHP, provider, and those individuals the participant chooses to include. The plan includes the services and supports that the participant needs.

(C) The MCO/PIHP contract shall require that service plans must address all enrollees' assessed needs (including health and safety risk factors) and personal goals, taking into account an emphasis on services being delivered in home- and community-based settings.

(D) The MCO/PIHP contract shall require that a process is in place that permits the participants to request a change to the person-centered plan if the participant's circumstances necessitate a change. The MCO contract shall require that all service plans are updated and/or revised at least annually or when warranted by changes in the enrollee's needs.

(E) The MCO/PIHP shall ensure that meetings related to the enrollee's Person Centered Plan will be held at a location, date, and time convenient to the enrollee and his/her invited participants.

(F) The MCO/PIHP contract shall require development of a back-up plan to ensure that needed assistance will be provided in the event that the regular services and supports identified in the individual service plan are temporarily unavailable. The back-up plan may include other individual assistants or services.

(G) The MCO/PIHP contract shall require that services be delivered in accordance with the service plan, including the type, scope, amount, and frequency.

(H) The MCO/PIHP contract shall require that enrollees receiving long-term services and supports have a choice of provider, where available, which has the capacity to serve that individual within the network. The MCO/PIHP must contract with at least two providers in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified, or available in that county.

(I) The MCO/PIHP contract shall require policies and procedures for the MCO/PIHP

to monitor appropriate implementation of the individual service plans.

ii. **Health and Welfare of Enrollees** – The State through its contracts with its MCOs/PIHPs shall ensure a system is in place to identify, address, and seek to prevent instances of abuse, neglect, and exploitation of its enrollees on a continuous basis. This should include provisions such as critical incident monitoring and reporting to the state, investigations of any incident including, but not limited to, wrongful death, restraints, or medication errors that resulted in an injury

iii. **Network of qualified providers** – The provider credentialing criteria described at 42 CFR 438.214 must apply to providers of long-term services and supports. If the MCO's/PIHP's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO/PIHP shall create alternative mechanisms to ensure the health and safety of its enrollees. To the extent possible, the MCO/PIHP shall incorporate criminal background checks, reviewing abuse registries as well as any other mechanism the state includes within the MCO/PIHP contract.

d. **MLTC enrollment**. Including the protections afforded individuals in subparagraph (c) of this STC, the following requirements apply to MLTC plan enrollment.

i. **Transition of care period**. Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the MCO/PIHP, whichever is later. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404 which clearly articulates the enrollee's right to file an appeal (either expedited, if warranted, or standard), the right to have authorized service continue pending the appeal, and the right to a fair hearing if the plan renders an adverse determination (either in whole or in part) on the appeal. For initial implementation of the auto-assigned population, the plans must submit data for state review on a monthly basis reporting instances when the plan has issued a notice of action that involves a reduction of split shift or live-in services or when the plan is reducing hours by 25 percent or more. The plan will also report the number of appeals and fair hearings requested regarding these reductions. The state shall ensure through its contracts that if an enrollee is to change from one MCO/PIHP to another, the MCO/PIHPs will communicate with one another to ensure a smooth transition and provide the new MCO/PIHP with the individual's current service plan.

ii. **MLTC Eligibility**. MLTC plans conduct the initial programmatic eligibility determination for plan enrollment using a standardized assessment tool designated by the state. The following requirements apply to the activities that must be undertaken by a MLTC plan as it assesses applicants for enrollment in the plan.

1. The state shall ensure all individuals requesting long-term services and supports are assessed for MLTC eligibility.
    a. The MCO/PIHP will use the Semi-Annual Assessment of Members (SAAM) tool (or successor tool designated by the state) to determine if the individual meets the eligibility criteria to be enrolled in an MLTC.
    b. In addition to the SAAM tool, the MCO/PIHP may use other assessment tools as appropriate. The state must review and approve all other assessment tools used by the MCO/PIHP.
    c. The state must ensure through its contracts that each MCO/PIHP must complete the initial assessment in the individual's home of all individuals referred to or requesting enrollment in an MLTC plan within 30 days of that referral or initial contact. MCO/PIHP compliance with this standard shall be reported to CMS in the quarterly reports as required in STC 62.
2. The MCO/PIHP shall complete a re-assessment at least annually, or at another timeframe as specified in the MCO/PIHP contract.
3. The state shall require each MCO/PIHP, through its contract, to report to the enrollment broker the names of all individuals for whom an assessment is completed. If the individual has not been referred by the enrollment broker, the MCO/PIHP shall report the date of initial contact by the individual and the date of the assessment to determine compliance with the 30-day requirement.
    a. The state shall use this information to determine if individuals have been wrongfully determined ineligible.
    b. The state shall review a sample of those assessments at least annually, either through the External Quality Review Organization (EQRO) or by the state, to verify the correct determination was made.

iii. **Marketing Oversight**.

1. The state shall require each MCO/PIHPs through its contract to meet 42 CFR 438.104 and state marketing guidelines which prohibit cold calls, use of government logos and other standards.
2. All materials used to market the MCO/PIHP shall be prior approved by the state.
3. The state shall require through its contract that each MCO/PIHP provide all individuals who were not referred to the plan by the enrollment broker with information (in a format determined by the state) describing Managed Long Term Care, a list of available plans, and contact information to reach the enrollment broker for questions or other assistance. The plan shall report the number of individuals receiving these materials to the state on a quarterly basis pursuant to STC 62.

e. **Demonstration Participant Protections.** The state will ensure that adults in LTSS in

MLTC programs are afforded linkages to adult protective services through all service entities, including the MCO's/PIHP's. The state will ensure that these linkages are in place before, during, and after the transition to MLTC as applicable.

f. **Non-duplication of Payment.** MLTC Programs will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

V. DEMONSTRATION BENEFITS AND ENROLLMENT

29. **Demonstration Benefits and Cost-Sharing.** The following benefits are provided to individuals eligible for the Medicaid managed care, FHPlus, and family planning expansion components of the Demonstration:

a) **Mainstream Medicaid Managed Care (MMMC).** State plan benefits delivered through MCOs or, in certain districts, primary care case management arrangements, with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients, are listed in Attachment A.

b) **Managed Long Term Care.** State plan benefits delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the state on a fee-for-service basis. All MLTC benefits are listed in Attachment B.

c) **Family Health Plus (FHPlus).**

i. FHPlus direct coverage benefits must be delivered by an MCO, with the exception of certain services carved out of the FHPlus contract and delivered directly by the state on a fee-for-service basis. In districts where no MCO is available, these benefits may be provided by a commercial insurer contracted with the state.

ii. FHPlus benefits, as well as the applicable co-payments charged to FHPlus recipients, are listed in Attachment C.
   (1) FHPlus enrollees under 21 years of age or who are pregnant are exempt from any cost-sharing otherwise applicable.
   (2) Emergency services, family planning services and supplies, and psychotropic and tuberculosis drugs are exempt from cost-sharing requirements in all settings which otherwise require cost-sharing.

iii. The 'benchmark" FHP-PAP Employer-Sponsored Health Insurance (ESHI) plan will include, at a minimum, the following services: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, and emergency services. Maximum out-of-pocket charges for FHP-Premium Assistance Program (PAP) enrollees are limited to the co-payment amounts specified in Attachment C. Any out-of-pocket charges exceeding those amounts will be reimbursed by the state.

d) **Family Planning Expansion Program.**

i. The Family Planning expansion program provides family planning services and supplies described in section 1905(a)(4)(c) of the Act directly on a fee-for-service basis. Such services and supplies are limited to those whose primary purpose is family planning and which are provided in a family planning setting. Family planning services and supplies are reimbursable at the 90 percent matching rate, including:
   (1) Approved methods of contraception;
   (2) Sexually transmitted infection (STI) testing, Pap smears, and pelvic exams (NOTE: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs, blood count, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.);
   (3) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements (subject to the national drug rebate program requirements); and
   (4) Contraceptive management, patient education, and counseling.

ii. Family planning-related services and supplies are defined as those services provided as part of, or as follow-up to, a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family-planning related services include:
   (1) Colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
   (2) Drugs for the treatment of STIs/Sexually Transmitted Diseases (STD), except for HIV/AIDS and hepatitis, when the STIs/STDs are identified/ diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs and subsequent follow-up visits to rescreen for STIs/STDs based on Centers for Disease Control and Prevention guidelines may also be covered.
   (3) An annual exam for men, such an annual family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.
   (4) Drugs/treatment for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may also be covered.
   (5) Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting. An example of a preventive service could be a vaccination to prevent cervical cancer.
   (6) Treatment of major complications arising from a family planning procedure, such as:
      a. Treatment of a perforated uterus due to an intrauterine device insertion;
      b. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
      c. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

iii. Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are not covered for enrollees of this Demonstration. The state must facilitate access to primary care services for enrollees in the family planning expansion program, and must assure CMS that written materials concerning access to primary care services are distributed to enrollees. The written materials must explain to the participants how they can access primary care services.

30. **Option for Consumer Directed Personal Assistance Program**. Until such time as the consumer directed personal assistance program (CDPAP) is incorporated into the mainstream and MLTC plans, enrollees shall have the option to elect self direction on a fee-for-service basis under the state plan. Once incorporated into the plan benefit packages, the state shall ensure through its contracts with the MCOs/PIHPs that enrollees are afforded the option to select self direction and enrollees are informed of CDPAP as a voluntary option to its members. Individuals who select self direction must have the opportunity to have choice and control over how services are provided and who provides the service.
    a) **Information and Assistance in Support of Participant Direction.** The state/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option.
    b) **Participant Direction by Representative.** The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Services may be directed by a legal representative of the participant. Consumer-directed services may be directed by a non-legal representative freely chosen by the participant. A person who serves as a representative of a participant for the purpose of directing services cannot serve as a provider of personal attendant services for that participant.
    c) **Participant Employer Authority.** The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
    i. **Participant.** The participant (or the participant's representative) provides training, supervision and oversight to the worker who provides services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law.
    ii. **Decision-Making Authorities.** The participants exercise the following decision making authorities: Recruit staff, hire staff , verify staff's ability to perform identified tasks, schedule staff, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.
    d) **Disenrollment from Self-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system through the MMMC or MLTC program. To the extent possible, the member shall provide his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the consumer-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed

to self-direct services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant-directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO/PIHP must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

e) **Appeals.** The following actions shall be considered adverse action under both 42 CFR 431 subpart E and 42 CFR 438 subpart F:

i. A reduction, suspension, or termination of authorized CDPAP services;

ii. A denial of a request to change Consumer Directed Personal Assistance Program services.

31. **Adding Services to the MMMC and/or MLTC plan benefit package**. At any point in time the state intends to add to either the MMMC or MLTC plan benefit package currently authorized state plan or Demonstration services that have been provided on a fee-for-service basis, the state must provide CMS the following information, with at least 30 days notice prior to the inclusion of the benefit, either in writing or as identified on the agenda for the monthly calls referenced in STC 61:

    a) A description of the benefit being added to the MCO/PIHPs benefit package;
    b) A detailed description of the state's oversight of the MCO/PIHP's readiness to administer the benefit including: readiness and implementation activities, which may include on-site reviews, phone meetings, and desk audits reviewing policies and procedures for the new services, data sharing to allow plans to create service plans as appropriate, process to communicate the change to enrollees, MCO/PIHP network development to include providers of that service, and any other activity performed by the state to ensure plan readiness.
    c) Information concerning the changes being made to MMMC and/or MLTC contract provisions and capitation payment rates in accordance with STC 36.

    CMS reserves the right to delay implementation of the benefit transition until such time as appropriate documentation is provided showing evidence of MCO/PIHP readiness. In addition, new services that are not currently authorized under the state plan or demonstration may be added only through approved amendments to the state plan or demonstration.

    CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled benefit transition.

32. **Expanding MLTC enrollment into a new geographic area**. Any time the state is ready to expand mandatory MLTC plan enrollment into a new geographic area, the state must provide CMS notification at least 90 days prior to the expansion. Such notification will include:

    a) A list of the counties that will be moving to mandatory enrollment;
    b) A list of MCO/PIHPs with an approved state certificate of authority to operate in those counties demonstrating that enrollees will be afforded choice of plan within the new geographic area;
    c) Confirmation that the MCO/PIHPs in the new geographic area have met the network requirements in STCs 42 and 43 for each MCO/PIHP.

CMS reserves the right to delay implementation of the geographic expansion until such time as notification documentation is provided.

CMS will notify the state of concerns within 15 days. If no comments are received, the state may proceed with the scheduled geographic expansion.

33. **Enrollment into the Family Health Plus Premium Assistance Program (FHP-PAP).**

a) At the time of initial application or recertification, individuals will be asked if they have access to ESHI. If so, the individual will be asked to provide information about the available ESHI insurance coverage. In the interim, individuals determined eligible for FHPlus will be enrolled, or continue to be enrolled, in a FHPlus plan.

b) For those individuals with access to qualified and cost effective ESHI, including state or local government employees, enrollment into the ESHI is required in order for the individual to maintain access to FHPlus eligibility and benefits. However, individuals will not be forced to disenroll from their FHPlus plan until they can enroll in their ESHI Program (during an ESHI open enrollment period or after a required "waiting period").

c) The state will subsidize the premiums for this coverage and reimburse any deductibles and co-pays, to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

d) The state will pay for any FHPlus benefits not covered by the enrollee's ESHI for enrollees of the FHP-PAP when they obtain services from a Medicaid provider.

34. **Operation of the HCBS Expansion Program.** The individuals eligible for this component of the Demonstration will receive the same home and community-based services (HCBS) as those individuals determined eligible for and enrolled in the state's Long Term Home Health Care Program (LTHHCP), Nursing Home Transition and Diversion Program (NHTDP) and Traumatic Brain Injury Program (TBIP) authorized under section 1915(c) of the Act. The specific benefits provided to participants in this program are listed in Attachment C.

The state will operate the HCBS Expansion program in a manner consistent with its approved LTHHCP, NHTDP and TBIP 1915(c) waiver programs and must comply with all administrative, operational, quality improvement and reporting requirements contained therein. The state shall provide enrollment and financial information about the individuals enrolled in the HCBS Expansion program as requested by CMS.

35. **Facilitated Enrollment.** Facilitated enrollers, which may include MCOs, health care providers, community-based organizations, and other entities under state contract, will engage in those activities described in 42 CFR 435.904(d)(2), as permitted by 42 CFR 435.904(e)(3)(ii), within the following parameters:

a) Facilitated enrollers will provide program information to applicants and interested individuals as described in 42 CFR 435.905(a).

b) Facilitated enrollers must afford any interested individual the opportunity to apply for Medicaid without delay as required by 42 CFR 435.906.

c) If an interested individual applies for Medicaid by completing the information required under 42 CFR 435.907(a) and (b) and 42 CFR 435.910(a) and signing a Medicaid application, that application must be transmitted to the LDSS for determination of eligibility.

d) The protocols for facilitated enrollment practices between the LDSS and the facilitated enrollers must:
   i. Ensure that choice counseling activities are closely monitored to minimize adverse risk selection; and
   ii. Specify that determinations of Medicaid eligibility are made solely by the LDSS.

VI. DELIVERY SYSTEMS

36. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation.

    Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

37. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of model contract language. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 45 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the Demonstration, until the contract compliance requirement is met.

38. **Managed Care Benefit Package.** Individuals enrolled in either MMMC or MLTC must receive from the managed care program the benefits as identified in Attachments A or B, as appropriate. As noted in plan readiness and contract requirements, the state must require that, for enrollees in receipt of LTSS, each MCO/PIHP coordinate, as appropriate, needed state plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and must also assure coordination with services not included in the established benefit package.

39. **Revision of the State Quality Strategy.** The state must update its Quality Strategy to reflect all managed care plans operating under MMMC and MLTC programs proposed through this Demonstration and submit to CMS for approval within 90 days of approval of the August 2012 amendment. The state must obtain the input of recipients and other stakeholders in the development of its
    revised comprehensive Quality Strategy and make the Strategy available for public comment. The state must revise the strategy whenever significant changes are made, including changes through this Demonstration. Pursuant to STC 63, the state must also provide CMS with annual reporting on the implementation and effectiveness of the updated comprehensive Quality strategy, as it impacts

the Demonstration.

40. **Required Components of the State Quality Strategy.** The revised Quality Strategy shall meet all the requirements of 42 CFR 438 Subpart D. The quality strategy must include components relating to managed long term services and supports. The Quality strategy must address the following regarding the population utilizing long term services and supports: level of care assessments, service planning, and health and welfare of enrollees.

41. **Required Monitoring Activities by State and/or EQRO.** The state's EQR process for the mainstream managed care and MLTC plans shall meet all the requirements of 42 CFR 438 Subpart E. In addition, the state, or its EQRO shall monitor and annually evaluate the MCO/PIHPs performance on specific new requirements under mandatory enrollment of individuals utilizing long term services and supports. The state shall provide an update of the processes used to monitor the following activities as well as the outcomes of the monitoring activities within the annual report in STC 63. The new requirements include, but are not limited to the following:
    a) MLTC Plan Eligibility Assessments – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with LTSS meet the MLTC plan eligibility requirements for plan enrollment . The state will also monitor assessments conducted by the plan where individuals are deemed ineligible for enrollment in an MLTC plan.
    b) Service plans – to ensure that MCOs/PIHPs are appropriately creating and implementing service plans based on enrollee's identified needs.
    c) MCO/PIHP credentialing and/or verification policies – to ensure that LTSS services are provided by qualified providers.
    d) Health and welfare of enrollees – to ensure that the MCO/PIHP, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

42. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS).** The state shall set specific requirements for MCO/PIHPs to follow regarding providers of LTSS, consistent with 42 CFR 438 Part D. These requirements shall be outlined within each MCO/PIHP contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MLTC or mainstream managed care plan is not permitted to set these standards.

43. **Demonstrating Network Adequacy**. Annually, each MCO/PIHP must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate coverage of benefits as described in Attachment A and B for the anticipated number of enrollees in the service area.

    a) The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the Demonstration as well as:
        i. The number and types of providers available to provide covered services to the Demonstration population;

ii. The number of network providers accepting the new Demonstration population; and

iii. The geographic location of providers and Demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

b) The state must submit the documentation required in subparagraphs i – iii above to CMS with each annual report.

44. **Advisory Committee as required in 42 CFR 438**. The state must maintain for the duration of the Demonstration a managed care advisory group comprised of individuals and interested parties appointed pursuant to state law by the Legislature and Governor. To the extent possible, the state will attempt to appoint individuals qualified to speak on behalf of seniors and persons with disabilities who are impacted by the Demonstration's use of managed care, regarding the impact and effective implementation of these changes on individuals receiving LTSS.

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

VII. QUALITY DEMONSTRATION PROGRAMS AND CLINIC UNCOMPENSATED CARE FUNDING

46. **Hospital-Medical Home (H-MH) Demonstration**. The purpose of this demonstration is to improve the coordination, continuity, and quality of care for individuals receiving primary care in hospital outpatient departments operated by teaching hospitals, as well as other primary care settings used by teaching hospitals to train resident physicians. The demonstration will be instrumental in influencing the next generation of practitioners in the important concepts of patient-centered medical homes. Training sites, in particular, due to the structural discontinuity imposed by rotating residents and attending physicians' schedules, present a significant opportunity to improve patient experience and care through residency redesign.

During this extension period, entities that serve as clinical training sites for primary care residents will work toward 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™ program (PPC®-PCMH™) and the 'Joint Principles' for medical home development articulated by primary care professional associations.

In addition, hospitals which receive funding under this demonstration shall be required to implement a number of patient safety and systemic quality improvement projects.

47. **H-MH Demonstration Eligibility and Selection.** All teaching institutions in New York State will be eligible to participate in the H-MH demonstration. However, because the state does not intend to use a public competitive process to select awardees, the selection criteria for the H-MH demonstration will include for each:

a) The extent to which the hospital has existing arrangements with training sites in the community (such as federally qualified health centers) to provide clinical experience to its primary care residents;
b) An attestation as to their willingness and commitment to accomplish all milestones outlined in STC 48, including achieving NCQA PPC®-PCMH™ Level 2 recognition or above (in accordance with the standards applicable at the time that recognition is awarded) by the end of the second year of the demonstration;
c) An agreement to track and report the clinical performance metrics required in STC 49; and
d) An agreement to implement both the system improvement and patient safety initiatives consistent with STCs 50 and 51.

To ensure that a mix of both academic medical centers and community teaching hospitals receive awards under the H-MH demonstration, the Department must submit its recommendations (along with proposed award amounts) to CMS for review before making final awards. An institution that already has achieved at least PPC®-PCMH™ Level 2 recognition under an earlier set of NCQA standards may participate if its goal is to renew or upgrade its recognition under later, more stringent NCQA standards.

48. **H-MH Milestones related to achievement of National Committee for Quality Assurance (NCQA) PPC®-PCMH™ for all awardees**. The key milestone for receiving demonstration funding will be the achievement of NCQA PPC®-PCMH™ Level 2 or Level 3 recognition within two (2) years from the start date of the program. The state will receive from NCQA a monthly 'roster' of practices, which have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition. In the interim, programs must demonstrate the achievement of the following milestones throughout the duration of the project:

a) **A detailed work plan after award.** Each awardee must submit a redesign strategy and detailed work plan to the state that documents how funds will be used for the following approved purposes: consultation services for practice re-design; staff development activities to support 'team' design to assuring continuity of care for patients; activities associated with curriculum changes; workforce retraining and retooling, and NCQA certification costs. The work plan must also

   i. indicate the clinical performance metrics that will be used (as discussed in STC 49 below), and provide baseline rates for each measure,

   ii. describe how the awardee will implement the H-MH System Improvement Initiatives described in STC 50, and

   iii. indicate which H-MH Quality and Safety Improvement Projects that the awardee will undertake, along with associated milestones (see STC 51).

b) **Baseline assessment within six months.** Each awardee must submit a formal baseline assessment to the state (using the NCQA tool or one developed by a primary care professional organization) that compares current practice with NCQA standards, along with a revised work plan and timeline.

c) **Interim report at the end of year 1.** Each awardee must submit to the state a report of interim progress in meeting the first year milestones and goals identified through the baseline assessment tool with revised plan as appropriate.

d) **MH recognition.** Each awardee must achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by the end of year 2.

49. **H-MH clinical performance metrics for years 2 and 3.** Each awardee must develop at least five clinical performance metrics which shall be consistent with the standardized measures used by the New York State Department of Health in its Quality Assurance Reporting Requirements (QARR) system and/or meaningful use measures and relevant to the population being served, for internal practice measurement and improvement. Baseline and yearly rates for each measure must be submitted in the annual progress reports.

50. **H-MH System Improvement Initiatives**. Each awardee's project work plan and subsequent progress reports must incorporate the awardee's strategy for accomplishing the implemented initiatives as well as the milestones to measure success.

a) Each awardee must implement an initiative to restructure operations to enhance patients' continuity of care experience in conjunction with developing a patient centered medical home.

Awardees shall extend the ambulatory, continuity training experience of residents within the limits of residency requirements from the Residency Review Committee of the Accreditation Council for Graduate Medical Education. This could be accomplished by increasing the number of continuity training sites, expanding sites beyond the hospital environment (if the program is based in a hospital), increasing resident time in ambulatory settings, or other activities or combinations of approaches. These sites would also be required to provide care consistent with medical home requirements and achieve formal recognition within two years of program start date. The project work plan must include:

i. A method for objective measurement of progress which may include number of new continuity sites, percent increase in ambulatory training experience for residents;
ii. How these activities will support core activities of medical home transformation; and
iii. How these restructuring changes will be sustained following the termination of the demonstration.

b) Further, each awardee must select at least one of the following four initiatives to implement during the grant award period:

1. Care Transitions/Medication Reconciliation Programs. Hospital awardees may be ideally suited to coordinate care between inpatient and outpatient settings given that they are frequently the same providers of care. This initiative would allow programs to develop a better 'bridge' for this transition, particularly with respect to medication reconciliation and management but also for outpatient primary and specialty care follow up. While the methods and staffing used to improve coordination could vary, all proposals must incorporate the evidence-based components of effective medication reconciliation. Programs would be required to:
   - Develop a registry of patients who have participated (directly through contact/outreach or indirectly through shared electronic information or medication lists) in medication reconciliation. The registry must contain sufficient unique identifiers to enable linkage to Medicaid claims data and be completed by the end of Year 1.
   - Participate as needed (sharing lists), with the Department, in periodic evaluation of readmissions and other utilization and quality metrics for patients receiving care

transition/medication reconciliation services including the tracking of quarterly progress either on pilot unit or hospital wide.

- Develop standardized clinical protocols for communication with patients/families during and post-discharge and care transition processes focused on most common causes of avoidable readmissions.
- Develop integrated information systems between hospital inpatient and outpatient sites to enable improved continuity and follow up care.
- Create system to identify patients at highest risk of subsequent avoidable hospitalization and create a patient stratification approach to allocation of resources to facilitate community linkages including primary and specialty care services.

2. Integration of Physical-Behavioral Health Care. Medicaid has a large number of members with co-existing physical and mental health/substance abuse co-morbidities. Optimal care requires integration of services and providers so that care is coordinated and appropriate for the well-being of the entire person, not just for a single condition. There are many barriers between behavioral and physical health care including different providers, varying locations, multiple agencies, confidentiality rules and regulations, historic lack of communication between providers, and more. This initiative will require training programs to find ways to integrate care for their patients with behavioral health conditions within the medical home. The project work plan must include details on:
   - A strategy for integration which includes a means of improving referrals to behavioral health providers, enhanced communication with mental health/substance abuse providers, processes for obtaining appropriate consents for sharing personal health information, and procedures for coordinated case management (particularly for cases in which patients may have more than one provider).
   - Developing a linkage to the Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYKES) project, which provides data and recommendations for potential problems of polypharmacy and metabolic syndrome exacerbation for Medicaid members using Medicaid databases within the first year of the program start date. The linkage will require creating systems to receive, and act on, reports generated by PSYKES. The linkage must be completed by the end of Year 1.
   - Developing training for primary care clinicians in behavioral health care with particular focus on integrating depression screening and pain management with appropriate treatment modalities and referral.
   - Assessing demand and capacity to provide co-located services or other approaches to decrease wait times and improve access to behavioral health services.
3. Improved Access and Coordination between Primary and Specialty Care. There is a tremendous opportunity to promote access and coordination between primary and specialty providers who are both providing care within the same delivery system, often in close physical proximity. Despite that opportunity, there are many examples in which the level of coordination is suboptimal, having the greatest adverse impact on those patients with more advanced, chronic diseases.
   - Programs will be required to put into place systems that would facilitate the ready access to specialty care when appropriate, with improved bilateral communication between primary and specialty care providers/clinics through transparent, standardized, referral processes. Specific goals include improving timely access to specialists, completed referral forms with required clinical information and reason(s) for referral,

timely response of findings/recommendations from the specialist and higher rates of satisfaction on the part of providers and patients with respect to specialty care services.

- Programs will be required to generate measures of access and coordination. These measures should be incorporated into a baseline assessment and annual evaluations and include patient and provider experiences related to wait times, follow up with primary care provider after specialty visit (as appropriate), delayed or rejected referrals, patient/provider satisfaction.
- Identify gaps in care and coordination for specialty services including collection of baseline data on wait times and appointment backlogs; survey primary care providers and specialists regarding the referral process and access and develop improvement plan based on findings with at least quarterly data collection, which will consider expansion of selected specialists, training of primary care providers in provision of select low level specialty care, inclusion of specialists in team care, protocols for primary-specialty care co-management.

4. Enhance Interpretation Services and Culturally Competent Care.
   - Programs will conduct an analysis to determine gaps in access to language services, and implement language access policies and procedures
   - Programs may expand workforce within interpreter services by hiring, training, and/or certifying interpreters, or determining other methods for increasing patients' access to appropriate language services.
   - Programs may include use of remote video and voice technology for instantaneous qualified health care interpretations
   - Develop programs to improve staff cultural competence and awareness through evidence based training.
   - Develop capacity to generate prescription labels in patient's primary language with easy to understand instructions.

51. **H-MH Quality and Safety Improvement Projects (QSIP).** In addition, each awardee shall implement at least two of the six Quality and Safety Improvement Projects outlined in this STC.

    These QSIPs will include interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals; have a strong evidence base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and are meaningful to hospital patients.

    An awardee is precluded from choosing any QSIP for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, where "top performance" is defined as being in the Top Quartile. Each QSIP below has specific measures that an awardee must include; however, awardees may include additional milestones to enable the implementation of the measures specified for the intervention.

    Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. Awardees must include for each year a milestone for reporting the data on each QSIP to the Department. Improvement Targets will be determined based on the progress an awardee has already made on the improvement project pursuant to baseline data collected as of January 1, 2012.

The 3-year end goals for each measure will be to move from one performance band to the next, except in the case of hospitals that are in the Top Band where the goal will be to move into the Top Quartile. Hospitals will be placed in one of 3 bands based on baseline performance as compared to state or national data on hospital performance, including safety net hospital performance, as follows:

- "Lower band" performers, as defined as the bottom one-third (1-33 percentile) of hospitals, will target moving into the middle-third performance band;
- "Middle band" performers, as defined as the middle third (34-65 percentile) of hospitals, will target moving into the top performance band; and
- "Top band" performers, as defined as the top third (66-100 percentile) of hospitals, will target moving into the top quartile.

Hospitals that have achieved performance in the top quartile will be expected to maintain or exceed top performance.

a) Severe Sepsis Detection and Management
   i. *Elements*
      (1) Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl).
      (2) Implement the Sepsis Management Bundle: to be completed within 24 hours for patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).
      (3) Make the elements of the Sepsis Bundles more reliable.

   ii. *Key Measures*
      (1) Percent compliance with four elements of the Sepsis Resuscitation Bundle, as measured by percent of hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction where targeted elements of the Sepsis Resuscitation Bundle were completed.
      (2) Sepsis mortality

b) Central Line-Associated Bloodstream Infection (CLABSI) Infection Prevention
   i. *Elements*
      (1) Implement the central line bundle
      (2) Make the process for delivering all bundle elements more reliable

   ii. *Key Measures*
      (1) Compliance with Central Line Bundle
      (2) Central Line Bloodstream Infections

c) Surgical Complications Core Processes (SCIP)
   i. *Elements*
      (1) Surgical site infection prevention
      (2) Beta blockers continuation
      (3) Venous Thromboembolism (VTE) prophylaxis

   ii. *Key Measures*
      (1) SCIP Composite Process Measure:

- SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients
- SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time/48 hours for cardiac patients
- SCIP-Inf-4: Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
- SCIP-Inf-6: Surgery patients with appropriate hair removal
- SCIP-Inf-9 : Urinary catheter removed on postoperative day 1 (POD 1) or postoperative day 2 (POD 2) with day of surgery being day zero
- SCIP-Card- 2: Surgery patients on a beta-blocker prior to arrival who received a beta-blocker during the perioperative period
- SCIP-VTE-1: Surgery patients with recommended venous thromboembolism prophylaxis orderedSCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery

(2) Rate of surgical site infection for Class 1 and 2 wounds within 30 days of surgery

d) Venous Thromboembolism (VTE) Prevention and Treatment

i. *Elements*

(1) Provide appropriate VTE Prophylaxis, including pharmaceutical and mechanical approaches based on national guidelines

ii. *Key Measures*

(1) VTE Discharge Instructions
(2) VTE Prophylaxis

e) Neonatal Intensive Care Unit (NICU) Safety and Quality

i. *Elements*

(1) Participation in Vermont Oxford Network (VON) quality/safety measurement and improvement activities or New York State Obstetric and Neonatal Quality Collaborative (NYSONQC) sponsored Neonatal Enteral Nutrition Project and Statewide Collaborative to decrease NICU central line associated bloodstream infections.
(2) Assess current areas of need for performance improvement based on relative performance of hospital NICU to VON benchmarks and/or state level performance.
(3) Develop improvement projects (at least 2 which may include, but is not limited to, enteral nutrition or central line projects above) focusing on areas of greatest need making use of VON network quality improvement strategies and/or other evidence based care bundles.

ii. *Key Measures*

(1) Use of appropriate metrics for quality, safety, morbidity, complications, and risk adjusted mortality based on improvement project, including but not limited to:
   A. Nosocomial sepsis rates (per 1000 patient days) from NYS NICU Module;
   B. Central line associated bloodstream infection rates per 1000 central line days using the NYS hospital acquired infection data reporting system;
   C. Maintenance checklist use per total number of days of central line use; and

D. Percent infants discharged from NICU at less than 10th percentile weight born <31 weeks gestation.

f) Avoidable Preterm Births: Reducing Elective Delivery Prior to 39 Weeks Gestation

i. *Elements*

(1) Use of evidence based interventions for evaluation, measurement, and improvement of preventable preterm births using findings from NICHQ/CMS Neonatal Outcomes Improvement Project and/or California Toolkit to Transform Maternity Care
   A. Identification and treatment of chronic medical conditions and high risk behaviors
   B. Early identification of mothers at high risk for preterm delivery
   C. Use of antenatal steroids in appropriate patients
   D. Reducing elective inductions/cesarean sections without appropriate medical or obstetric indication

ii. *Key Measures*

(1) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(2) Percent of scheduled inductions at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled inductions
(3) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(4) Percent of scheduled C-sections at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled C-sections
(5) Percent of all scheduled deliveries at 36(0/7) to 38(6/7) weeks without medical or obstetrical indication documented of all scheduled deliveries
(6) Percent of infants born at 36(0/7) to 38(6/7) weeks gestation by scheduled delivery who went to neonatal intensive care unit
(7) Percent of mothers informed about risks and benefits of scheduled deliveries 36(0/7) to 38(6/7) weeks gestation documented in the medical record
(8) Percent scheduled deliveries at 36(0/7) to 38(6/7) weeks that have documentation in the medical record of meeting optimal criteria of gestational age assessment
(9) IHI Elective Induction Bundle Elements: Percentage of times that all four of the following elements are in place:
   A. gestational age >/= 39 weeks
   B. monitor fetal heart rate for reassurance of fetal status
   C. pelvic exam: assess to determine dilation, effacement, station, cervical position and consistency, and fetal presentation
   D. monitor and manage hyperstimulation (tachysystole).

52. **H-MH Funding Distribution**. Awardees will receive demonstration funds based on the number of Medicaid recipients served and the number of primary care residents trained. Eighty percent of an awardee's funds will be based on Medicaid patient volume and twenty percent will be based on primary care residents trained in that facility. The formula will be proportionally allocated using these criteria. Facilities will not be included if they do not satisfy the requirements for one of the supplemental program initiatives. Full or partial funding is contingent on achieving each year's goals. *In no instance will an awardee receive funding beyond year 2 unless the awardee has achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition.*

a) Year 1 Funds. Each awardee will receive one-fourth of the first year's funding amount upon award. The remaining first year payment will be issued once the awardee has documented that the applicable first-year program milestones (as stipulated in STC 48 (a), (b), and (c) above) have been met. If the first year milestones are not met by the end of year 1, the awardee will forfeit the remaining funding for that year but would be allowed to continue to work toward meeting the milestones and eligible for subsequent year funding.

b) Year 2 Funds. Each awardee will receive one-fourth of the second year's funding amount upon completion of the applicable year one milestones. Upon achieving NCQA PPC®-PCMH™ Level 2 or Level 3 accreditation, the remainder of the second year's funds will be made available, provided all other requirements for Quality Service Improvement Programs (QSIP) projects are up to date. If an awardee does not achieve accreditation by the end of year two or, for a hospital awardee, make progress on the additional initiatives that are required as a condition of funding, the remainder of year two funding will be forfeited.

c) Year 3 Funds. Third year funding will be provided only to awardees that have achieved NCQA PPC®-PCMH™ Level 2 or Level 3 recognition and, for hospital awardees, meet the applicable milestones for the additional initiatives as stipulated in the hospital's approved work plan. Awardees will receive one-fourth of the funding amount at the start of the year and the remainder after submission of the third year milestones.

53. **H-MH Reporting**.

a) The state shall include updates on activities related to the H-MH demonstration in the quarterly operational reports required under STC 62 including updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

b) The state shall provide an assessment of the H-MH demonstration by summarizing each awardee's activities during the demonstration year in each annual report required under STC 63.

c) The state shall include an assessment of the success of the H-MH demonstration in the evaluation required by STC 88 including the milestones in STC 48(c), the hospital improvement projects in STC 47(d) as well as the outcome measures for each supplemental program initiative implemented by the awardees.

54. **Potentially Preventable Readmissions (PPR) Demonstration.** The purpose of this demonstration is to test strategies for reducing the rate of preventable readmission 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. It is intended to assist hospitals with reducing the rate of PPRs in advance of the implementation of the Hospital Readmissions Reduction Program (authorized by section 3025 of the Patient Protection and Affordable Care Act) on October 1, 2012. Beginning with FFY 2012, hospitals will face reductions in Medicare payments if they have readmission rates higher than what would be expected for specific conditions.

Hospitals will be asked to devise unique strategies that target each hospital's particular experiences, strengths, weaknesses and patient profile. Projects will focus on improved quality and

cost savings and will include reporting and evaluation components to ensure that the projects are replicable and sustainable. Activities will include a review of policies and operational procedures that may be contributing to high rates of avoidable readmissions; reengineering the discharge planning process; and appropriate management of post-hospital/transition care; coordination with outpatient and post-discharge providers, including institutions and community providers, to address transitional care needs.

a) Eligibility. All hospitals in the state will be eligible to participate in the PPR demonstration.

b) Selection. The state will develop and issue a Request for Grant Application (RGA). Awards will be made based on the published criteria in the RGA, and funding will be made available over the demonstration extension period as specified in the RGA. The RGA shall also include requirements for evaluating the success of the implemented strategies.

c) Reporting.

i. Once grantees are in place, the state shall include in the quarterly operational report required under STC 62, the following information:
(1) A summary of the interventional strategies each grantee intends to implement;
(2) Baseline assessment of each grantee's readmission rate;
(3) Interim assessments (as data is available) of each grantee's success in reducing PPRs; and
(4) Updated expenditure projections reflecting the expected pace of disbursements under the demonstration.

ii. The state shall provide a progress report in the implementation of the PPR demonstration in each annual report required under STC 63.

55. **Clinic Uncompensated Care Funding.** The state currently provides grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state through the Indigent Care Pool (ICP). In 2008, there were 64 voluntary and 13 public D&TCs eligible for Indigent Care pool funding located in 21 counties of the state. Of the 64 voluntary D&TCs, 54 facilities are Federally Qualified Health Centers (FQHCs). Beginning in demonstration year 13, 176 mental health clinic providers are now eligible for ICP grants. This program will allow the state to double the amount of grants provided through the ICP.

a) Eligibility. In order to receive ICP funds, each facility must provide a comprehensive range of primary health care or mental health care services; have at least 5 percent of their visits providing services to uninsured individuals; and have a process to collect payments from third-party payers.

b) Reporting.

i. The state shall include updates on activities related to ICP grants in each quarterly operational report required under STC 62, including the extent to which actual expenditures for the grants are consistent with projections.

ii. The state shall also include the following information on each facility which received a grant in each demonstration year in annual report required under STC 63:
(1) The total amount of ICP funds awarded;
(2) The total amount of funding that each clinic received from other federal agencies, including but not limited to, the Health Resources and Services Administration and the Substance Abuse and Mental Health Services Administration;
(3) The extent to which the clinic participates in any medical home initiative, including a summary of the initiative;
(4) The extent to which the clinic has implemented certified electronic health records (EHRs) for its patients; and
(5) The number of providers practicing predominantly within a Federally Qualified Health Centers (FQHC) grantee who are "meaningful users" of certified EHRs consistent with 42 CFR 495.6.

56. **Funding for Quality Demonstrations and Clinic Uncompensated Care**. Federal funds will be used to pay the full cost of these programs. Accordingly, Federal Financial Participation (FFP) will be available for state funds for the Indigent Care Pool (beginning August 1, 2011 and ending December 31, 2013) and the Designated State Health Programs (DSHP) described in STC 56 (beginning August 1, 2011 and ending December 31, 2014), as certified on each quarterly CMS Form 64 expenditure reports.

a) Limitations on FFP.

i. FFP is limited to no more than $477.2million over the demonstration extension period as follows:
(1) $325 million for the H-MH demonstration;
(2) $20 million for the PPR demonstration; and
(3) $132.2 million for the ICP, but only to the extent that the state appropriates and expends at least $132.2 million over the extension period. Otherwise, FFP for the ICP may be no more than one-half of total ICP spending (both federal and state funds).

ii. The state shall be eligible to receive FFP over the demonstration period for its own expenditures for:
(1) The Indigent Care Pool (for ICP expenditures made between August 1, 2011 and December 31, 2013); and
(2) DSHP (for DSHP expenditures made between August 1, 2011 and December 31, 2014).

b) Reporting.

i. Updated expenditure projections shall be provided by the state in each quarterly operational report required under STC 62.

ii. Expenditure Reporting for the H-MH demonstration. DSHP expenditures used to draw down federal funds for the H-MH demonstration shall be reported on the CMS-64 under waiver name MH Demo – DSHP.

iii. Expenditure Reporting for the PPR demonstration. DSHP expenditures used to draw down federal funds for the PPR demonstration shall be reported on the CMS-64 under waiver name PPR Demo – DSHP.

iv. Expenditure Reporting for Clinic Uncompensated Care.
(1) The state's own expenditures for ICP grants shall be reported on the CMS-64 under waiver name ICP – Direct.
(2) DSHP expenditures used to draw down federal funds for Clinic Uncompensated Care shall be reported on the CMS-64 under waiver name ICP – DSHP.

c) Reconciliation and Recoupment. By the end of the demonstration extension period, if the amount of DSHP claimed over the demonstration period results in the state receiving FFP in an amount greater than what the state actually expended for quality demonstrations and clinic uncompensated care, the state must return to CMS federal funds in an amount that equals the difference between claimed DSHP and actual state expenditures made for these initiatives.

i. As part of the annual report required under STC 63, the state will report both DSHP claims and expenditures to date for the quality demonstrations and clinic uncompensated care.

ii. The reported claims and expenditures will be reconciled at the end of the Demonstration with the state's CMS-64 submissions.

iii. Any repayment required under this subparagraph will be accomplished by the state making an adjustment for its excessive claim for FFP on the CMS-64 by entering an amount in line 10(b) of the Summary sheet equal to the amount that equals the difference between claimed DSHP and actual expenditures made for these initiatives during the extension period.

57. **Designated State Health Programs**. Subject to the conditions outlined in STC 55, FFP may be claimed for expenditures made for the following designated state health programs beginning August 1, 2011 through December 31,2014:

a) Homeless Health Services

b) HIV-Related Risk Reduction

c) Childhood Lead Poisoning Primary Prevention

d) Healthy Neighborhoods Program

e) Local Health Department Lead Poisoning Prevention Programs

f) Cancer Services Programs

g) Obesity and Diabetes Programs

h) TB Treatment, Detection and Prevention

i) TB Directly Observed Therapy

j) Tobacco Control

k) General Public Health Work

l) Newborn Screening Programs

58. **Designated State Health Programs (DSHP) Claiming Process.**

a) Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS.

b) Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs in STC 57. Claims may not be submitted for state expenditures disbursed after December 31, 2014.

c) Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. To the extent that federal funds from any federal programs are received for the DSHP listed in STC 57, they shall not be used as a source of non-federal share.

d) The administrative costs associated with DSHPs in STC 57 and any others subsequently added by amendment to the Demonstration shall not be included in any way as Demonstration and/or other Medicaid expenditures.

e) Any changes to the DSHPs listed in STC 57 shall be considered an amendment to the Demonstration and processed in accordance with STC 7.

VIII. GENERAL REPORTING REQUIREMENTS

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

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

61. **Monthly Calls.** CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), transition and implementation activities, health care delivery, the FHP-PAP program, enrollment, cost sharing, quality of care, access, family planning issues, benefits, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, state legislative developments, services being added to the MMMC and/or MLTC plan benefit package pursuant to STC 30, and any Demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The state and CMS shall jointly develop the agenda for the calls.

62. **Quarterly Operational Reports.** The state must submit progress reports in accordance with the guidelines in Attachment E taking into consideration the requirements in STC 65 and STC 66, no later than 60 days following the end of each quarter (December, March, and June of each demonstration year). The state may combine the quarterly report due for the quarter ending September with the annual report in STC 63. The intent of these reports is to present the state's

analysis and the status of the various operational areas.

63. **Annual Report.** The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The state must submit this report no later than 90 days following the end of each Demonstration year. Additionally, the annual report must include:
    a) A summary of the elements included within each quarterly report;
    b) An update on the progress related to the quality strategy as required in STC 39;
    c) An aggregated enrollment report showing the total number of individuals enrolled in each plan
    d) A summary of the use of self-directed service delivery options in the state at the time when those benefits are included in the demonstration;
    e) A listing of the new geographic areas the state has expanded MLTC to;
    f) A list of the benefits added to the managed care benefit package;
    g) An updated transition plan which shows the intended transition and timeline for any new benefits and/or populations into the demonstration;
    h) Network adequacy reporting as required in STC 43;
    i) Any other topics of mutual interest between CMS and the state related to the demonstration; and
    j) Any other information the state believes pertinent to the demonstration.

64. **Transition Plan.** On or before July 1, 2012, and consistent with guidance provided by CMS, the state is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the Demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The plan must include the required elements and milestones described in paragraphs (a)-(e) outline below. In addition, the Plan will include a schedule of implementation activities that the state will use to operationalize the Transition Plan. For any elements and milestones that remain under development as of July 1, 2012, the state will include in the Transition Plan a description of the status and anticipated completion date.

    a) **Seamless Transitions.** Consistent with the provisions of the ACA, the Transition Plan will include details on how the state plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. Specifically, the state must:

    i. Determine eligibility under all January 1, 2014, eligibility groups for which the state is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL;
    ii. Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the ACA and the authorities the state identifies that may be necessary to continue coverage for these individuals; and

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

b) **Access to Care and Provider Payments.**

i. Provider Participation. The state must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

ii. Adequate Provider Supply. The state must provide the process that will be used to assure adequate provider supply for the state plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of the of service delivery. The report must separately address each of the following provider types:

(A) Primary care providers,
(B) Mental health services,
(C) Substance use services, and
(D) Dental.

iii. Provider Payments. The state will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive rate (e.g., certain Indian Health providers).

c) **System Development or Remediation.** The Transition Plan for the Demonstration is expected to expedite the state's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:

i. Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries.

d) **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the state must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e) **Implementation.**

i. By October 1, 2013, the state must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the state plan, the state will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the state must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

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

a) In each annual report required by STC 63, the state shall report:
   i. The average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.);
   ii. The number of actual births that occur to FP Expansion participants (participants include all individuals who obtain one or more covered medical family planning services through the Demonstration) each year;
   iii. Yearly enrollment reports for Demonstration enrollees for each Demonstration Year (DY) (eligibles include all individuals enrolled in the Demonstration); and
   iv. Total number of participants for each DY (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

66. **Reporting Requirements Related to Individuals using long term services and supports**.
   a) In each quarterly report required by STC 62, the state shall report:
   i. Any critical incidents reported within the quarter and the resulting investigations as appropriate;
   ii. The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter;
   iii. The total number of assessments for enrollment performed by the plans, with the number of individuals who did not qualify to enroll in an MLTC plan;
   iv. The number of individuals referred to an MLTC plan that received an assessment within 30 days;
   v. The number of people who were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials;
   vi. Rebalancing efforts performed by the MLTC Plans and mainstream plans once the benefit is added. ;
      (A) Rebalancing reporting should include, but is not limited to the total number of individuals transitioning in and out of a nursing facility within the quarter.
   vii. Total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event.

67. **Final Evaluation Report**. The state shall submit a Final Evaluation Report pursuant to the requirements of section 1115 of the Act.

IX. GENERAL FINANCIAL REQUIREMENTS

68. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using

Form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X.

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

a) In order to track expenditures under this Demonstration, New York must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

b) DY reporting shall be consistent with the following time periods:

Demonstration Year	Time Period
1	10/1/1997 - 9/30/1998
2	10/1/1998 - 9/30/1999
3	10/1/1999 - 9/30/2000
4	10/1/2000 - 9/30/2001
5	10/1/2001 - 3/30/2003
6	04/1/2003 - 9/30/2004
7	10/1/2004 - 9/30/2005
8	10/1/2005 - 9/30/2006
9	10/1/2006 - 09/30/2007
10	10/1/2007 - 09/30/2008
11	10/1/2008 - 09/30/2009
12	10/1/2009 - 09/30/2010
13	10/1/2010 - 09/30/2011
14	10/1/2011 - 09/30/2012
15	10/1/2012 - 09/30/2013
16	10/1/2013 – 12/31/2013
17	1/1/2014 – 3/31/2014
18	4/1/2014 – 12/31/2014

c) Demonstration expenditures will be correctly reported on Forms CMS-64.9 Waiver. Quarterly cost settlements and pharmaceutical rebates relevant to the Demonstration will be allocated to the Demonstration populations specified in subparagraph (g) and offset against current quarter waiver expenditures. Demonstration expenditures net of these cost settlement offsets will be

reported on Form CMS-64.9 Waiver. Amounts offset will be identifiable in the state's supporting work papers and made available to CMS.

i. Allocation of cost settlements. The state will calculate the percentage of Medicaid expenditures for each demonstration eligibility group to expenditures for all Medicaid population groups from a DataMart file produced for the latest completed federal fiscal year. Quarterly recoveries will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

ii. Allocation of pharmacy rebates. The state will calculate the percentage of pharmacy expenditures for each demonstration eligibility group to pharmacy expenditures for all population groups from a DataMart file produced for the latest completed federal fiscal year. Rebates will be allocated to the eligibility groups based on those percentages. These percentages will be updated annually to reflect the most recent completed federal fiscal year.

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

i. Allowable family planning-related expenditures eligible for reimbursement at the state's federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.

ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

e) For the HCBS Expansion component of the Demonstration, the state shall report only the home and community-based services expenditures for Demonstration Population 9 on line 19A on Forms CMS-64.9 Waiver and/or 64.9P.

f) Premiums paid for ESHI under FHP-PAP will be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver on Line 18.E. in order to ensure that the Demonstration is properly credited with these premium payments. Additionally, both the total computable and federal share amounts that are paid under FHP-PAP must be separately reported on the CMS-64Narr.

g) For each DY, thirteen separate waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below in brackets, to report expenditures for the following Demonstration populations and/or services.

i. **Demonstration Population 1:** Temporary Assistance to Needy Families (TANF) child under age 1 through age 20 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Child].

ii.	**Demonstration Population 2:**	TANF Adults aged 21-64 required to enroll in managed care in any county **other than** Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates, for expenditures associated with dates of service on or before March 31, 2014 [TANF Adult].
iii.	**Demonstration Population 3:**	Disabled Adults and Children 0-64, for expenditures associated with dates of service on or before March 31, 2014 [SSI 0-64]
iv.	**Demonstration Population 4:**	Aged or Disabled Adults, for expenditures associated with dates of service on or before March 31, 2014 [SSI 65+]
v.	**Demonstration Population 5:**	Safety Net Adults, for expenditures associated with dates of service on or before December 31, 2013 [Safety Net Adults]
vi.	**Demonstration Population 6:**	Family Health Plus Adults with children up to 150% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Adults w/Children]
vii.	**Demonstration Population 7**:	Family Health Plus Adults without children up to 100% FPL, for expenditures associated with dates of service on or before December 31, 2013 [FHP Childless Adults]
viii.	**Demonstration Population 8:**	Family Planning Expansion Adults, for expenditures associated with dates of service on or before December 31, 2013 [FP Expansion]
ix.	**Demonstration Population 9:**	Home and Community-Based Services Expansion participants, for expenditures associated with dates of service on or before March 31, 2014 [HCBS Expansion]
x.	**Demonstration Population 10:**	MLTC Adults age 18 – 64 [MLTC Adults 18 -64]
xi.	**Demonstration Population 11:**	MLTC Adults age 65 and above [MLTC Adults 65+]
xii.	**Demonstration Services 1:**	State Indigent Care Pool (ICP) Direct Expenditures, for expenditures made on or before December 31, 2013 [ICP-Direct]
xiii.	**Demonstration Services 2:**	Designated State Health Programs to Support

Clinic Uncompensated Care Funding, for expenditures made on or before December 31, 2013 [ICP - DSHP]

xiv. **Demonstration Services 3:** Designated State Health Programs to Support Medical Home Demonstration, for expenditures made on or before December 31, 2014 [DSHP - HMH Demo]

xv. **Demonstration Services 4:** Designated State Health Programs to Support Potentially Preventable Readmission Demonstration, for expenditures made on or before December 31, 2014 [DSHP - PPR Demo]

Note: Waiver forms for Demonstration Populations 3 and 4 are no longer required under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership (F-SHRP). However, they remain defined Demonstration Populations for future use if needed.

70. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures in STC 69(g) for individuals who are enrolled in this Demonstration (with the exception of the populations identified in subparagraphs iii, iv, and ix), as well as the demonstration services described in subparagraphs x through xiii, subject to limitations enumerated in this paragraph. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

a) Beginning in DY 9, all expenditures for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration and may not be reported on Forms CMS-64.9 Waiver and/or 64.9P for this Demonstration. These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2).

b) Beginning in DY 9, expenditures for Demonstration Populations 3 and 4 defined in STC 69 (g) will no longer be reported under this Demonstration. However, these eligibility groups remain as a placeholder in the event these populations are transferred from the F-SHRP Demonstration (11-W-00234/2) back to this Demonstration. The state shall follow the amendment process outlined in STC 7 to effectuate this transfer.

c) Beginning in DY 9, Demonstration Populations 3 and 4, as defined in STC 69 (g), are no longer considered expenditures subject to the budget neutrality agreement for this Demonstration. These expenditures may not be reported on Forms CMS-64.9 Waiver and/or 64.9P under this Demonstration, except if permitted under the provisions of subparagraph (b). These expenditures will be reported under the F-SHRP Demonstration (11-W-00234/2), subject to the provisions of subparagraph (b) of this STC.

d) Only the home and community-based services expenditures for Demonstration Population 9 shall be subject to the budget neutrality agreement.

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

72. **Premium Collection Adjustment.** The state must include any Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis and shall be reported in accordance with STC 69 (f).

73. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

74. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

    a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 62, the actual number of eligible member months for the Demonstration Populations defined in STC 69 (g), for months prior to or including the ending date indicated in STC 69 (g) for each Demonstration Population. The state must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

    Beginning in DY 9, the actual number of member months for Demonstration Populations 3 and 4, as defined in STC 69 (g), will not be used for the purpose of calculating the budget neutrality expenditure agreement, except as defined in STC 70(b).

    Additionally, Beginning in DY 9, the actual number of member months for Demonstration Populations 1 and 2 who reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties will not be used for the purpose of calculating the budget neutrality expenditure agreement, subject to the limitations in STC 69.

    To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively for up to 2 years as needed.

    b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months, for a total of 4 eligible member months.

    c) For the purposes of this Demonstration, the term "Demonstration eligibles" excludes

unqualified aliens and refers to the Demonstration Populations described in STC 69 (g). Beginning in DY 9, "Demonstration eligibles" excludes Demonstration Populations 3 and 4, subject to STC 70(b), as well as portions of Demonstration Populations 1 and 2, as specified in STC 70(a - b).

75. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. New York must estimate matchable Demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

76. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in section X:

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

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

    c) Net expenditures and prior period adjustments, made under approved expenditure authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration.

    d) FFP will be provided for the Family Planning Expansion Program as described in STC77.

77. **Extent of FFP for Family Planning Expansion Program.** FFP will be provided for the Family Planning Expansion Program in accordance with family planning and family planning-related services (including prescriptions) at the applicable federal matching rates described in STC 29(d), subject to the limits described below:
    a) For procedures or services clearly provided or performed for the primary purpose of family planning and which are provided in a family planning setting, reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service.
    b) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, (e.g., those provided at a public STI clinic), no FFP will be available.

c) Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the Demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

78. **Sources of Non-Federal Share.** The state certifies that the non-federal share of funds for the Demonstration is state/local monies. The state further certifies that such funds shall not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS may review the sources of the non-federal share of funding for the Demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

79. **State Certification of Funding Conditions.** The state must certify that the following conditions for the non-federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the Demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the

understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

X. MONITORING BUDGET NEUTRALITY

81. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and, if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

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

83. **Demonstration Populations Used to Calculate Budget Neutrality Expenditure Limit.** The following Demonstration populations are used to calculate the budget neutrality expenditure limit subject to the limitations outlined in STC 69 and are incorporated into the following eligibility groups (EGs):

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

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

    c) **Eligibility Group 3:** FHPlus Adults with children (Demonstration Population 6)

    d) **Eligibility Group 4:** Individuals of childbearing age receiving a limited family planning benefit through the Family Planning Expansion Program (Demonstration Population 8)

    e) **Eligibility Group 5:** MLTC Adults age 18 – 64

f) **Eligibility Group 6**: MLTC Adults age 65 and above

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure cap under this demonstration, but under demonstration 11-W-000234/2, The Federal-State Health Reform Partnership.

84. **Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in STC 83 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state in accordance with the requirements outlined in STC 74, for each EG, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below. Should EGs 3 and 4 be incorporated into the budget neutrality expenditure limit, as outlined in STC 70, the PMPM costs may be revised.

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

iii. The PMPM costs for the calculation of the annual budget neutrality expenditure limit for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below.

(1) To reflect the additional demonstration year that was authorized through temporary extensions (DY 12), the PMPM cost for each EG in Demonstration year 11 has been increased by the appropriate growth rate from the prior extension period. These figures are displayed below.

Eligibility Group	DY 11 (10/1/08 – 9/30/09)	Trend Rate	DY 12 (10/1/09 – 9/30/10)
TANF Children under age 1 through 20	$549.19	6.7%	$585.99
TANF Adults 21-64	$751.73	6.6%	$801.34
FHPlus Adults with Children	$586.82	6.6%	$625.55

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

(2) For the current extension period, the PMPM cost for each EG in Demonstration year 12 has been increased by the appropriate growth rate included in the President's federal fiscal year 2011 budget for DYs 13 through 16, as outlined below. In addition, because the Family Planning Expansion Adults are going to be treated as a "hypothetical state plan population" beginning in DY 13, a PMPM cost was constructed based on state expenditures in DY 10, and increased by the rate of growth in the medical care component of the Consumer Price Index between 2004 and 2008. Because DYs 16 and 17 combined are less than 12 months in duration, they are assigned the PMPM costs equal to what would have been calculated for the

full year starting October 1, 2013 and ending September 30, 2014. The FHPlus Adults with Children and Family Planning Expansion Adults groups will end on December 31, 2013, so no PMPM is defined for those groups for DY 17. The budget neutrality expenditure limit will end March 31, 2014; expenditures made after that date for DSHP must be offset by accumulated savings from DYs 1 through 17.

Eligibility Group	DY 12 (10/1/09 – 9/30/10)	Trend Rate	DY 13 (10/1/10 – 9/30/11)	DY 14 (10/1/11 – 9/30/12)	DY 15 (10/1/12 – 9/30//13)	DY 16 (10/1/13– 12/31/13)	DY 17 (1/1/2014 – 3/31/2014)
TANF Children under age 1 through 20	$585.99	6.6%	$624.67	$665.90	$709.85	$756.70	$756.70
TANF Adults 21-64	$801.34	6.4%	$852.63	$907.20	$965.26	$1,027.04	$1,027.04
FHPlus Adults with Children	$625.55	6.4%	$665.59	$708.19	$753.51	$801.73	N/A
Family Planning Expansion Adults	[redacted]	4.1%	$20.23	$21.06	$21.92	$22.81	N/A
MLTC Adults age 18 - 64	[redacted]	1.19%	[redacted]	$4009.38	$4,057.09	$4,105.37	$4,105.37
MLTC Adults 65 and above	[redacted]	3.23%	[redacted]	$4,742.15	$4,895.32	$5,053.44	$5,053.44

Note: Demonstration Populations 3 and 4 are no longer part of the calculation of the budget neutrality expenditure limit under this demonstration, but under demonstration 11-W-00234/2, The Federal-State Health Reform Partnership.

iv. The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of the projected annual expenditure limits for each EG calculated in subparagraph (i) above.

b) The overall budget neutrality expenditure limit for the demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iv) above for each year. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of Demonstration populations and expenditures described in STC 68 (g) during the Demonstration period.

85. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Partnership Plan.

86. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. DY 18 expenditures, which will consist only of DSHP expenditures in support of the H-MH and PPR demonstrations, will be included in the

budget neutrality test for the demonstration. The state may receive FFP for these expenditures to the extent that sufficient accumulated budget neutrality savings are available from prior DYs.

87. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. EVALUATION OF THE DEMONSTRATION

88. The evaluation design must include a discussion of the goals and objectives set forth in Section II of these STCs, and develop evaluation questions specific to the changes implemented in the Demonstration during this extension period.

a) The evaluation questions should include, but are not limited to:

i. To what extent has the provision of continuous eligibility affected the stability and continuity of coverage and care to adults? How has the implementation of the Statewide Enrollment Center impacted "churning" by Demonstration participants?

ii. A quantitative and qualitative assessment of the effectiveness of the provider and enrollee education and outreach efforts, as well as plan oversight and compliance monitoring, in minimizing the impact of the transition of individuals living with HIV into mandatory Medicaid managed care.

iii. To what extent has the mandatory enrollment of individuals living with HIV into MMC impacted their perceptions of care (fee-for-service v. Safety Net Population/SNP v. mainstream)?

iv. Has the required enrollment of individuals living with HIV into Medicaid managed care (either mainstream plans or HIV SNPs) impacted quality outcomes, which in earlier studies showed that these individuals enrolled in managed care on a voluntary basis received better quality care than in fee-for-service?

v. An assessment of the successes and failures, along with recommendations for improvement, of the HIV SNP program.

vi. Has the state's H-MH Demonstration resulted in demonstrable improvements in the quality of care received by Demonstration participants?

vii. To what extent has the H-MH demonstration produced replicable residency program design features that enhance training in medical home concepts?

viii. How has the H-MH demonstration helped the selected facilities improve both their systemic and quality performance under each initiative implemented by the selected facilities?

ix. How have the results of the PPR demonstration program informed changes in reimbursement policies that provide incentives to help people stay out of the hospital?

x. How has the PPR demonstration program improved quality and cost savings at selected facilities? To what extent are the interventions tested both replicable and sustainable?

xi. How has the additional funding provided under the Clinic Uncompensated Care program increased the use of patient-centered medical homes and electronic medical records?

xii. How have the results of the family planning expansion program expanded access to family planning services among the target population?

b) The evaluation questions for MLTC goals should include, but are not limited to:
   i. How has enrollment in MLTC plans increased over the length of the demonstration?
   ii. What are the demographic characteristics of the MLTC population? Are they changing over time?
   iii. What are the functional and cognitive deficits of the MLTC population? Are they changing over time?
   iv. Are the statewide and plan-specific overall functional indices decreasing or staying the same over time?
   v. Are the average cognitive and plan-specific attributes decreasing or staying the same over time?
   vi. Are the individual care plans consistent with the functional and cognitive abilities of the enrollees? This evaluation question will be included as there is sufficient data available in 2014 to provide accurate measures. NYS will address this question in the Final Evaluation Plan.
   vii. Access to Care: To what extent are enrollees able to receive timely access to personal, home care and other services such as dental care, optometry and audiology?
   viii. Quality of Care: Are enrollees accessing necessary services such as flu shots and dental care?
   ix. Patient Safety: Are enrollees managing their medications? What are the fall rates and how are they changing over time?
   x. Satisfaction: What are the levels of satisfaction with access to, and perceived timeliness and quality of network providers?
   xi. Costs: What are the PMPM costs of the population?

   The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the state.

c) The state must submit to CMS for approval a draft evaluation design no later than October 1, 2012.

89. **Evaluation Implementation**. The state shall implement the final evaluation design and submit its progress in each of the quarterly and annual progress reports.

90. **Interim Evaluation Report**. The state must submit an interim evaluation report as part of the state's request for any future renewal of the Demonstration.

91. **Final Evaluation Report.** The state must submit draft final evaluation reports according to the following schedule.
   a) By July 31, 2014, the state must submit to CMS a draft final evaluation report,

presenting findings from all evaluation activities. Findings from the evaluations of the H-MH and PPR demonstrations may be preliminary findings. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

b) By April 30, 2015, the state must submit to CMS a draft final evaluation report on the evaluations of the H-MH and PPR demonstrations. CMS shall provide comments within 60 days after receipt of the report. The state shall submit the final evaluation report within 60 days after receipt of CMS comments.

92. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration, the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	Reference
11/1/2011	Submit Draft Evaluation Plan	Section XI, STC 88

	Deliverable	Reference
Annual	By January 1st - Annual Report	Section VIII, STC 63
	By December 31st – Annual MEQC Program Report	Section III, STC 13
Quarterly		
	Quarterly Operational Reports	Section VIII, STC 62
	Quarterly Expenditure Reports	Section IX, STC 68
	Eligible Member Months	Section IX, STC 74

ATTACHMENT A

Mainstream Medicaid Managed Care Benefits

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services
Early Periodic Screening, Diagnosis, and Treatment services (for individuals under age 21 only)
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services
Physical and occupational therapy
Speech, hearing, and language therapy
Prescription drugs, over-the-counter drugs, and medical supplies
Durable Medical Equipment (DME), including prosthetic and orthotic devices, hearing aids, and prescription shoes
Vision care services, including eyeglasses
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
Nursing facility services
Personal care services
Case management services
Hospice care services
TB-related services
Inpatient and outpatient behavioral health services (mental health and chemical dependence services)
Emergency medical services, including emergency transportation
Adult day care
Personal Emergency Response Services (PERS)
Renal dialysis
Home and Community Based Services waivers (HCBS)
Care at Home Program (OPWDD)
Non–emergency transportation
Experimental or investigational treatment (covered on a case-by-case basis)

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

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

ATTACHMENT B

Managed Long Term Care Benefits

Home Health Care*
Medical Social Services
Adult Day Health Care
Personal Care
Durable Medical Equipment**
Non-emergent Transportation
Podiatry
Dental
Optometry/Eyeglasses
Outpatient Rehabilitation PT, OT, SP
Audiology/Hearing Aids
Respiratory Therapy
Private Duty Nursing
Nutrition
Skilled Nursing Facilities
Social Day Care
Home Delivered/Congregate Meals
Social and Environmental Supports
PERS (Personal Emergency Response Service)

*Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)

**DME including Medical/Surgical, Hearing Aid Batteries, Prosthetic, Orthotics, and Orthopedic Footwear

ATTACHMENT C

Family Health Plus Benefits and Cost-Sharing

Inpatient and outpatient hospital services
Clinic services including Rural Health Clinic and Federally Qualified Health Center services
Laboratory and X-ray services
Home health services (covered for 40 visits in lieu of hospitalization, plus 2 post-partum visits for high-risk women)
Early Periodic Screening, Diagnosis, and Treatment services (for individuals ages 19 and 20 only) to the extent available under otherwise covered services
Family planning services and supplies
Physicians services including nurse practitioners and nurse midwife services
Dental services (optional)
Physical and occupational therapy (20 visits for each therapy annually)
Speech therapy (for conditions amenable to clinical improvement within a 2–month period)
Prescription drugs, diabetic supplies, and smoking cessation products
Durable medical equipment, including prosthetic and orthotic devices and hearing aids
Vision care services including eyeglasses
Nursing facility services (inpatient rehab)
Hospice care services
TB-related services, except Directly Observed Therapy
Behavioral health services (mental health and chemical dependence services), limited to 60 outpatient visits combined and 30 inpatient days combined
Emergency medical services including emergency transportation
Renal dialysis
Experimental or investigational treatment (covered on a case by case basis)

Service	Co-payment
Clinic services *	$5 per visit
Physician services	$5 per visit
Prescription Drugs • Brand name • Generic	 $6 $3
Over-the-counter medications for smoking cessation and diabetes	$.50
Dental services	$5 per visit ($25 maximum annual cap)
Medical supplies (e.g. for treatment of diabetes and enteral formula)	$1.00 per supply
Laboratory services	$.50
Radiology services (ordered in an ambulatory setting)	$1
Inpatient Hospital services	$25 per stay
Non-emergent Emergency Room services	$3

***** except those provided by mental health and chemical dependence clinics

ATTACHMENT D

Home and Community-Based Services Expansion Program Benefits

All HCBS Expansion program participants may not receive all benefits listed below; an individual participant's access to the benefits below may vary based on the individual's similarity to an individual determined eligible for and enrolled in the LTHHC, NHTD, or TBI 1915(c) waiver program.

Assistive Technology (including personal emergency response system)
Community Integration Counseling and Services
Community Transition Services
Congregate/Home Delivered Meals
Environmental Modifications
Home and Community Support Services
Home Maintenance
Home Visits by Medical Personnel
Independent Living Skills Training
Intensive Behavioral Programs
Medical Social Services
Moving Assistance
Nutritional Counseling/Education
Peer Mentoring
Positive Behavioral Interventions
Respiratory Therapy
Respite Care/Services
Service Coordination
Social Day Care (including transportation)
Structured Day Program
Substance Abuse Programs
Transportation
Wellness Counseling Services

ATTACHMENT E

Quarterly Operational Report Format

Under STC 62, the state is required to submit quarterly reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter (except for the report due for the quarter ending on September 30 of each demonstration year, which can be incorporated into the annual report required under STC 63).

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Partnership Plan

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 14 (10/1/11 - 9/30/12)
Federal Fiscal Quarter: 1/2012 (10/11 - 12/11)

Introduction:

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

Enrollment Information:

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Please note any changes in enrollment that fluctuate 10 percent or more over the previous quarter as well as the same quarter in the prior Demonstration year.

Enrollment Counts

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

Demonstration Populations (as hard coded in the CMS-64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – TANF Child under age 1 through age 20 in mandatory MC counties as of 10/1/06			
Population 2 - TANF Adults aged 21-64 in mandatory MC counties as of 10/1/06			
Population 5 – Safety Net Adults			
Population 6 - Family Health Plus Adults with children			
Population 7 - Family Health Plus Adults w/o children			
Population 8 - Family Planning Expansion Adults			

ATTACHMENT E

Quarterly Operational Report Format

Population 9 – HCBS Expansion participants			

Voluntary Disenrollments:

- Cumulative Number of Voluntary Disenrollments within Current Demonstration Year
- Reasons for Voluntary Disenrollments

Involuntary Disenrollments:

- Cumulative Number of Involuntary Disenrollments within Current Demonstration Year
- Reasons for Involuntary Disenrollments

Enrollment Information for Specific Sub-populations:

- FHPlus enrollees served under PAP
- Enrollees in the HCBS Expansion program
- For the Family Planning Expansion Program please provide the following:
    - Quarterly enrollment reports for Demonstration eligibles (eligibles include all individuals enrolled in the Demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement; and
    - Total number of participants served during the quarter (participants include all individuals who obtain one or more covered family planning services through the Demonstration).

Program Operations

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

Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity. Also include any anticipated activities or program changes related to health care delivery, benefits, enrollment, grievances, quality of care, access, and other operational issues.

Update on Progress and Activities related to Quality Demonstrations and Clinic Uncompensated Care Funding: Identify all activities relating to the implementation of these programs, including but not limited to:

- Release of solicitations and selection of awardees for the quality demonstrations;
- An explanation of grants, contracts or other financial arrangements entered into for purposes of implementing the quality demonstrations of this Demonstration; and
- Progress of grantees in meeting the milestones identified in these STCs and any award documents.

Consumer Issues: A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences, this should be

broken out to show the number of LTSS complaints vs. all other categories identified. Also discuss feedback, issues or concerns received from the Medicaid Managed Care Advisory Review Panel (MMCARP), advocates and county officials.

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

Managed Long Term Care Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, all requirements as outlined in STC 65 should be included.

Family Planning Expansion Program: Identify all significant program developments, issues, or problems that have occurred in the current quarter. Additionally, note any changes in enrollment that fluctuate 10 percent or more over the previous quarter of the same Demonstration year and the same quarter in the previous Demonstration year.

Home and Community-Based Services Expansion Program: For the quarter ending March 31 each year, attach a copy of the CMS-372 report completed in accordance with Appendix A of the approved Long-Term Home Health Care, the Nursing Home Transition and Diversion, and the Traumatic Brain Injury 1915(c) waivers.

Demonstration Evaluation: Discuss progress of evaluation implementation.

Financial/Budget Neutrality Developments/Issues: Provide information on:

- Quality demonstration and clinic uncompensated care expenditures – to whom and when
- Designated State Health Programs – amount of FFP claimed for the quarter

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

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

Date Submitted to CMS:

ATTACHMENT F

Expiration Dates for Demonstration Components

The following table shows the expiration dates for the various components of the Demonstration.

Demonstration Components	Expiration Date
• Family Health Plus (parents and caretaker relatives to 160 percent of FPL; non-pregnant, non-disabled adults age 19-64 up to 100 percent of FPL) • Family Planning Expansion Program (to 200 percent of FPL) • Safety Net Adults (state determined income standard – in 2011, approximately 78 percent of FPL for single adult households and 72 percent for couples) • Indigent Care Pool	December 31, 2013
• Medicaid Managed Care Program • Medicaid Eligibility Quality Control waivers • Facilitated Enrollment Services • Twelve-Month Continuous Eligibility Period • Home and Community-Based Services Expansion Program	March 31, 2014
• Hospital-Medicaid Home Demonstration • Potentially Preventable Re-Hospitalization Demonstration • Designated State Health Programs	December 31, 2014

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

Mandatory Managed Long Term Care/Care Coordination Model (CCM)

Mandatory Population: Dual eligible, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- **Long Term Home Health Care Program;**
- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants; and**
- **Dual eligible that do not require community based long term care services.**

Voluntary Population: Dual eligible, age 18-21, in need of community based long term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I: New York City

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community based long term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

ATTACHMENT G

Mandatory Managed Long Term Care Enrollment Plan

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Initiate enrollments citywide of Long Term Home Health Care Program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity upon CMS approval of 1915(c) waiver amendment.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties

*Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2014 **Phase II: Nassau, Suffolk and Westchester Counties**

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated January 2013

Phase III: Rockland and Orange Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated December 2013

Phase V: Other Counties with capacity

Dually eligible community based long term care service recipients in these additional counties as capacity is established. Anticipated June 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate programs:

- **Nursing Home Transition and Diversion waiver participants;**
- **Traumatic Brain Injury waiver participants;**
- **Nursing home residents;**
- **Assisted Living Program participants;**
- **Dual eligible that do not require community based long term care services.**