Partnership Plan
Section 1115 Quarterly
Demonstration Year: 16 (10/1/2013 – 9/30/2014)
Federal Fiscal Quarter: 3 (04/01/2014 – 06/30/2014)

I. Introduction

In July 1997, New York State received approval from the Centers for Medicare and Medicaid Services (CMS), for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times, most recently through December 31, 2014. The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care. There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997.

CMS approved an extension on September 29, 2006 of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from the recommendations of Governor Cuomo's Medicaid Redesign Team.

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section 1115 Demonstration expired on March 31, 2014. In accordance with Special Terms and Conditions (STC) Number 50, a final report for the F-SHRP demonstration is required and was submitted to CMS on June 30, 2014. The populations that were included in the F-SHRP consist of Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) recipients. With the expiration of F-SHRP, these populations have transitioned into the New York State's Partnership Plan Medicaid Section 1115 Demonstration.

On May 28, 2014, New York State submitted an application requesting an extension of the Partnership Plan 1115 Demonstration for five years. On May 30, 2014, CMS accepted New York's application as completed and posted the application for a 30 day public comment period. This application will extend the Demonstration until December 31, 2019, thus allowing the State to reinvest federal savings generated by the Medicaid Redesign Team reform initiatives, and to reinvest in the state's health care system currently authorized by the Partnership Plan.

II. Enrollment : Third Quarter

Partnership Plan- Enrollment as of June 2014

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 - TANF Child 1 - 20 years in Mandatory Counties as of 10/1/06	1,601,168	26,036	76,679
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06Population 2 - TANF Adults 21 - 64 years in Mandatory Counties as of 10/1/06	429,036	10,492	22,273
Population 3 - TANF Child 1 - 20 ('new' MC Enrollment)	90,236	1,561	4,151
Population 4 - TANF Adults 21 - 64 ('new' MC Enrollment)	27,298	665	1,743
Population 5 - Safety Net Adults	936,399	18,158	31,959
Population 6 - Family Health Plus Adults with Children	258,258	6,614	25,285
Population 7 - Family Health Plus Adults without Children	227	125	842
Population 8 - Disabled Adults and Children 0 - 64 (SSI 0-64 Current MC)	56,621	1,291	337
Population 9 - Disabled Adults and Children 0 - 64 (SSI 0-64 New MC)	248,902	9,316	2,087
Population 10 - Aged or Disabled Elderly (SSI 65+ Current MC)	3,471	243	43
Population 11 - Aged or Disabled Elderly (SSI 65+ New MC)	48,405	2,166	520

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Total # Voluntary Disenrollments in Current Demonstration Year[1]	**76,7667**

Reasons for voluntary disenrollments include: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year[1]	**165,919**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility; eligibility transfers between Family Health Plus (FHPlus) and Medicaid; inappropriate enrollment and death.

III. Outreach/Innovative Activities

The New York State Department of Health (the Department), Maximus and the local departments of social services (LDSS) continue to provide education and outreach in the areas of enrollment and health plan selection to Medicaid eligible individuals that are not enrolled in managed care.

A. Progress of Mandatory Managed Care Expansion

As of November 2012, the expansion of mandatory Medicaid managed care is complete, with programs operating in all counties of the state, including New York City. During this quarter, staff continued to provide technical support to both county staff and providers in all counties. The counties opting to utilize the assistance of the enrollment broker also received support from Maximus staff.

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.2 million. Currently, 2.1 million are enrolled in a managed care plan, including eligible SSI recipients.

The Medicaid Redesign Team (MRT) changes implemented during the reporting period had a significant impact on the work of New York Medicaid Choice (NYMC).

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 12 Medicaid offices and 17 Job Centers.

The Education and Enrollment Driven Referral (EED) process was responsible for 94 % of the total consumers engaged by NYMC in the last quarter.

[1] Demonstration year to date: 10/01/2013– 09/30/2014

The overall activities at Medicaid offices remained constant averaging five consumers per work session. A work session covers a half day of work activities.

A total of 2,551 presentations were scheduled by NYMC. Of these, 588 or 23% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

C. New York State (outside of NYC) Outreach Activities

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on MRT #1458, including expansion of the Medicaid managed care benefit package to include: Adult Day Health Care, AIDS Adult Day Health Care, and Directly Observed Therapy for Tuberculosis.

IV. Operational/Policy Developments/Issues

A. Partnership Plan Waiver Amendments

CMS granted approval of several amendments to the Waiver effective January 1, 2014. These changes coincided with continued implementation of the Affordable Care Act.

FHPlus expired on December 31, 2013 and has become a state-only program, but federal matching funding for state expenditures for FHPlus will continue to be available as a designated state health program (DSHP) through December 31, 2014.

CMS approved expenditure authority to allow the state to claim federal matching dollars for the DSHP, which provides premium subsidies to parents and caretaker relatives with incomes between 138%-150% FPL, who enroll in a Qualified Health Plan using Advanced Premium Tax Credits. Eligibility for this premium assistance is determined by New York's Marketplace, and the majority of enrollees were determined during the open enrollment period that concluded April 15, 2014. There continues to be some enrollment due to special enrollment period provisions.

An additional DSHP was approved that allows federal matching dollars to provide FHPlus benefits to parents and caretaker relatives up to 150% FPL, for continued funding through the full phase-out of the program. The transition is ongoing and all recipients will be out of the program by December 31, 2014.

B. Health Plans

1. Changes to Certificates of Authority (COA)

- Excellus-COA updated 04/01/2014- removal of Medicaid and FHPlus products from Cayuga, Clinton, Essex, Franklin, Madison, Onondaga, and Tompkins Counties.

- Fidelis-COA updated 4/01/2014 – approval of Medicaid Advantage expansion into Allegany, Broome, Cattaraugus, Chenango, Cortland, Delaware, Erie, Hamilton, Niagara, Putnam, Sullivan and Wyoming Counties.

- Fidelis-COA updated 04/22/2014- approval Medicaid, FHPlus, CHPlus expansion into Seneca and Yates Counties.

- Total Care, a Today's Options of New York Health Plan- COA updated 04/16/2014 – approval of Medicaid Advantage product for the counties of: Broome, Cayuga, Chenango, Cortland, Jefferson, Madison, Onondaga, Oneida, Oswego, and Tompkins.

- WellCare of New York, Inc. –COA Updated 01/01/2014 - Medicaid Advantage removed completely from COA per Managed LTC.

- WellCare of New York, Inc. –COA Updated 01/04/14 - The following counties were removed from Medicaid Advantage –Bronx, Kings, Nassau, New York, Richmond, Suffolk, Queens, and Westchester.

- WellCare of New York, Inc. –COA Updated 04/25/14 - Medicaid, FHPlus, CHPlus added to Erie County

- Humana Health Company of New York, Inc. -COA updated 05/08/2014 - Medicare expansion into the counties of Allegany, Broome, Cattaraugus, Chautauqua, Chemung, New York.

Surveillance Activities

Surveillance activity for 3rd Quarter FFY 2013-2014 (4/1/14 to 6/30/14) included the following:

- HealthFirst PHSP, Inc.: A Comprehensive Operational Survey was conducted April 7-10, 2014. A Statement of Deficiency was issued and an acceptable Plan of Corrections has been received.

- Amida Care, Inc.: A Target Operational Survey conducted May 20, 2014. Plan was found to be in compliance.

- MetroPlus and MetroPlus HIV SNP: A joint Target Operational Survey was conducted May 23, 2014. The Plans were found to be in compliance.

- HealthNow New York, Inc.: An acceptable Plan of Correction was received June 9, 2014 for the Statement of Deficiency issued as the result of the Comprehensive Operational Survey conducted in October 2013.

- Capital District Physicians' Health Plan, Inc: On April 15, 2014 the Department approved the Plan of Correction submitted in response to the Statement of Deficiency issued for the Targeted Operational Survey conducted May 13-July 16, 2013.

- Independent Health Association, Inc.: On May 22, 2014 the Department approved the Plan of Correction submitted in response to the Statement of Deficiency issued for the Comprehensive Operational Survey conducted November 18-22, 2013.

Focus Surveys to determine plan compliance with Fraud and Abuse/Medicaid Program Integrity requirements were conducted of all 19 Medicaid Managed Care Plans during the period March 4 -27, 2014. Results were issued during the 3rd quarter (FFY 2013-2014). Statements of Findings were issued to the following plans:

- Affinity Health Plan, Inc., AMERIGROUP New York, LLC, , Amida Care, Inc., Capital District Physicians Health Plan Inc., Excellus Health Plan, Inc., HealthNow New York, Inc., EmblemHealth Plan ("HIP"), Hudson Health Plan, Inc., Independent Health Association, Inc., MVP Health Plan, Inc., Today's Options of New York, Inc., United Health Care of New York, Inc., Univera Community Health, Inc. and VNS Choice SNP

- Acceptable Plans of Correction have been received from all plans.

- In the last phase of a series of withdrawals from Medicaid Managed Care and FHPlus Health Plus, effective April 1, 2014, Excellus Health Plan, Inc. withdrew from the following seven counties: Cayuga, Clinton, Essex, Franklin, Madison, Onondaga, and Tompkins.

- Effective June 1, 2014, New York State Catholic Health Plan, Inc. expanded its Medicaid Managed Care and FHPlus service area to include Seneca and Yates Counties.

C. Fiscal Year (FY) 2013 State Budget Changes to Medicaid

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

Waiver Deliverables

Medicaid Eligibility Quality Control Plan (MEQC)

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Re-Determinations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance

With CMS approval, the Pacific Health Policy Group (PHPG), the contractor hired to assist the New York State Department of Health with multiple MEQC reviews, began implementing an alternate approach for generating the necessary universes of cases. A revised approach was necessary because availability of DOH system staff continued to be limited due to other system priorities (i.e., system work related to ACA and the NY State of Health Marketplace).

Implementation of the revised approach began in September 2013. However, the alternate universe identification process is labor intensive and very time consuming. During the quarter, the final two universes were finalized and samples were pulled. A letter requesting copies of the corresponding case records were issued to the appropriate district. It is anticipated that the initial peer and supervisory reviews for a majority of the cases will be completed during the next quarter.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability

A summary report was issued to the regional CMS office on January 31, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

A summary report was issued to the regional CMS office on June 28, 2013.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

A summary report was issued to the regional CMS office on July 25, 2013.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding

A summary report was issued to the regional CMS office on August 1, 2014.

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

See Attachment 3 – DD Transformation Evaluation

Benefit Changes/Other Program Changes

D. As part of Medicaid Redesign Team proposal #1458, effective April 1, 2014, Medicaid Managed Care Plans began covering the following HIV resistance laboratory tests as prescribed by a physician: genotypic testing; phenotypic testing; and HIV tropism assay.

These laboratory tests may be used in any combination to identify specific HIV strains and drug resistance in order to determine the most effective treatment.

E. Twelve Month Continuous Coverage

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide continuous coverage for certain Medicaid beneficiaries for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. The intent of the policy is to provide stability and continuity of coverage and care to certain adults in the same way it has for children on Medicaid. Twelve months continuous coverage was effective January 1, 2014, for New York's Marketplace for most Medicaid beneficiaries in Modified Adjusted Gross Income (MAGI) categories, including pregnant women, parents/caretaker relatives, children and other adults under age 65.

F. Federally Qualified Health Services (FQHC) Lawsuit

CHCANYS, et al vs NYS Dept. of Health -- The CHACNYs case commenced oral arguments in mid-June with Attorney General's Jim Herschler and, Andrew Amend. At this point, the appeal is still pending and we are simply waiting on the Court to deliver its opinion.

G. Managed Long Term Care Program

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

The mandatory enrollment process began in New York County in June 2012 with announcement letters notifying recipients of fee for service (FFS) personal care services (of at least 120 days and 120 days of Medicaid eligibility) that the Medicaid program was changing. The recipients then received a mandatory notice and materials to start the choice period. Recipients eligible were given sixty (60) days to choose a plan. The enrollment process has followed the enrollment plan submitted with the Partnership Plan amendment, by New York City borough (Bronx, Brooklyn, Queens and Staten Island) through December 2012. The population seeking services is now directed by Health Resources Administration (HRA) case workers to New York Medicaid Choice (NYMC), the New York State enrollment broker, which provides information and counseling to consumers, facilitates enrollment, educates plans and supports the state with data gathering.

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

1. Accomplishments

- Mandatory enrollment process initiated and continuing in all five boroughs. Due to the length of the prior authorization and Medicaid eligibility periods, additional cohorts from all NYC counties will continue to be identified for the enrollment process; the anticipated time frame to transition all personal care cases in the five boroughs is June 2013. The mandatory transition process for Personal Care Services in NYC counties was essentially completed as of September 2013.

- Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Care Program can now receive that benefit through a MLTCP and are included in the mandatory enrollment population. This was made effective in November of 2012. (See separate section below).

- Completed systemic process to identify recipients receiving Private Duty Nursing (PDN) and/or Adult Day Health Care services and include these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population can be identified and will be transitioned when CMS approval is received.

- Continued to develop reporting mechanisms with Enrollment Broker and Computer Sciences Corporation to assure information is gathered as required as transition moves forward.

- Expanded MLTCP availability by approving 13 service area expansions, two new lines of business for operational MLTCPs, and 12 new certificates of authority since September 2012. During the period October 2013 through December 2013, MLTCP availability was expanded by approving two service area expansions. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions. During the period April 2014 through June 2014 MLTC availability was expanded by approving one Service Area Expansion.

- Developed, in consultation with local officials and NYMC, processes for Nassau, Suffolk and Westchester local social services districts to commence notification to participants in January 2013.

- Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued to plans, Care Management Administrative Services Contract Statement and Certification, Standard Clauses for Care Management Administrative Services Contract, and Care Management Administrative Services Contract Guidelines for MLTC Plans, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the managed long term care process.

- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and

found that 86% of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant. For the period from October 2013 to December 2013 post enrollment surveys were completed for 193 enrollees and 88% of the respondents are receiving services from the same home attendant. For the period from January 2014 to March 2014 post enrollment surveys were completed for 897 enrollees and 86% of respondents are receiving services from the same home attendant. For the period from April 2014 to June 2014 post enrollment surveys were completed for 639 enrollees and 81% of respondents are receiving services from the same home attendant.

- Expanded the scope of the transition of community based services to include Certified Home Health Agency care, Private Duty Nursing and Adult Day Health Care services in mandatory counties beginning in February 2013.

- Expanded the geographic transition region to include Nassau, Suffolk and Westchester counties in February 2013 with CMS approval. The transition expanded to Rockland and Orange counties as of September 2013.

- Expanded Department's complaint hotline staffing and developed and implemented a new standardized database for tracking complaints and resolution.

- Additional education was developed and shared with MLTC Plans addressing Consumer Directed Personal Assistance Services and its use.

- Entered into discussion to initiate a Member Services survey of all MLTC Plans on a semi-annual basis by the State's contractor to assure information shared with potential enrollees is accurate and helpful.

- Developed, with the Enrollment Broker, training for Local Social Services staff in the transition process, identifying the districts ongoing role during the transition, establish clear communication mechanisms with MLTC plans, SDOH and stakeholders to ease transitions, addressing potential systemic issues and ensure informed choice by stakeholders and enrollees.

- Initiated activities for expansion of transition to Albany, Erie, Onondaga, and Monroe counties in December 2013.

- Developed strategies to achieve the 2014 transition plan; expanding mandatory enrollment to additional counties incrementally each month. Preparation activities have commenced with April Districts (Columbia, Putnam, Sullivan, and Ulster). Initial outreach underway with the May Districts (Rensselaer, Cayuga, Herkimer, and Oneida).

- With CMS approval, successfully expanded the mandatory transition region to include Columbia, Putnam, Sullivan, and Ulster during April 2014; Rensselaer, Cayuga, Herkimer, and Oneida during May 2014; and Schenectady, Saratoga, Greene, and Washington during June 2014. Preparation activities have commenced with July Districts (Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, and Oswego). Preliminary information sessions have been conducted with Local District

Commissioners for the remaining counties, aligning with strategies for the 2014 transition plan.

2. Significant Program Developments

- Initial mandatory enrollment process completed in NYC.
- Mandatory enrollment initiative moving into Nassau, Suffolk and Westchester counties.
- Continued incorporation of community based LTSS into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
- Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
- Continuity of care assured through transition period.
- Monitoring of network capacity, delivery systems and coordination of care.
- Development of data gathering systems to meet terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915 c LTHHCP.
- Created study protocol with External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirement related to transition of care.
- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.
- Established mechanism for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.
- Improvement to network reporting guidelines for all MLTCs.
- Initiated training for use of the mandatory Uniform Assessment System for New York State which will replace the Semi Annual Assessment of Members tool previously utilized by MLTC assessors.
- Developed Guidelines for MLTC plans and the State's Enrollment Broker on Involuntary Disenrollment to assure appropriate notice and ongoing care as needed to support health and safety of enrollees in the community.
- Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.
- Enhanced monitoring of MLTC Provider Networks where deficiencies are identified and action taken.

- Enhanced oversight of Social Day Care utilization and plan contract monitoring continues.

- Submitted preliminary proposal to develop independent clinical assessment process for MLTC enrollment. Formulating process guidelines to inform development of strategic goals and objectives. During the second quarter completed steps to finalized the infrastructure, including roles and responsibilities, with goal to operationalize the process by October, 2014 in the New York City region. Refining workplan to finalize an implementation schedule that will lead to statewide operations.

- Conducting outreach and education in preparation to enroll permanent Nursing Home residents into MLTC plans in NYC, Westchester, Nassau, and Suffolk; pending CMS approval. Enhanced monitoring of MLTC NH networks to ensure increased capacity is established. Continued on going monitoring of NH network enhancements and began analysis of nursing home to plan contracting patterns.

- Conducted analysis of complaints received by Technical Assistance Center and identified plan specific trends and problem area. Formulated process to commence an in depth focus audit of plan during third quarter. Developing strategies to further expand the focus audit activities.

- During June, 2014 issued survey to MLTC plans to gather data on membership residing in New York State Licensed Adult Care Facilities. Survey developed to inform strategies to address STC 30, Home and Community Settings Characteristics.

- Completed development of a Request for Application to address the requirement for an Independent Consumer Support Program. Review and selection process has commenced and remains ongoing.

3. Issues and Problems

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

- It was necessary to pause the implementation and processing of auto-assignments in New York City during November due to disruptions caused by Hurricane Sandy. This resulted in delays in issuing announcement and mandatory enrollment notices to targeted consumers during November; however schedules were back on track by December of 2013.

- NYMC, the Department enrollment broker, had to redeploy systems and resources due to storm damage at their main facility.

- The Department's ability to systemically identify certain transition populations was delayed.

- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, SDOH, the Attorney General's Office and the Office of the Medicaid Inspector General are cooperating in ongoing audits and investigations. Focused activities are being expanded on an ongoing basis as issues are identified.

4. Summary of Self Directed Options

To minimize disruption and promote continuity for members receiving Consumer Directed Personal Assistance Service (CDPAS) a policy for the transition of CDPAS into MLTC and the MCO benefit package was created. Self-direction gives individuals and families greater control over the services they receive, how they receive them and who provides them and a clear direction to both the MLTC plans and MCOs supports its success.

This policy document was created in conjunction with a CDPAS Workgroup reflective of numerous stakeholders that met a number of times to discuss issues and develop policies for this new benefit:

- **Contracting During the Transition Period:** For the period October 1 2012-September 30, 2013 (Transition Period), Health Plans are required to contract with FIs that currently have a contract or MOU with a LDSS and currently provide fiscal intermediary services to the health plan's member(s). The rate of payment must be at least the FFS rate of payment provided for in the contract or MOU between the FI and the LDSS. The MLTC/MCO is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the MLTC/MCO maintains two (2) FIs for each county. To adequately meet the needs of members who are newly assessed and considered eligible to receive CDPAS, the MLTC/MCO may also include in the MLTC/MCO's network FIs that do not have a contract or MOU with the LDSS.

- **Consumer Continuity of Care and Choice during the Transition Period:** The Department provided a list of FIs currently providing FI services to FFS and MCO's enrolled members. To promote and maintain consumer choice, members may, during the Transition Period, change to any FI in the county that has a contract with the MCO.

  If, at the time of transition, an FI serves less than five (5) members in a county, MLTC/MCOs may encourage the members to use an alternative FI to minimize the number of FIs an MLTC/ MCO must have under contract. However, during the transition period, the expectation is that a member is not required to transition to a different consumer directed personal assistant due to the lack of an MLTC/MCO/FI contract. MLTC/ MCOs are prohibited from coercing or threatening the member or the worker to change FIs.

- **Network Adequacy during the Transition Period**: An MLTC/ MCO that does not have members participating in CDPAS in a particular LDSS must have at least two (2) FI contracts. This will ensure that members will have the option to participate in CDPAS.

- **FI Contracting and Network Adequacy after the Transition Period**: Beginning October 1, 2013, MLTC/MCOs may contract with two (2) FIs to cover members in multiple counties.

- **Model FI Contract and Department of Health Review**: The Department supports the use of the MLTC/MCO/FI model contract developed by the parties. However, each MLTC/MCO/FI may negotiate the terms of the model contract, except that no agreement may contain provisions that would be considered management functions under 10 NYCRR 98-1.11 or a provider agreement per 10 NYCRR 98-1 and the Provider Contract Guidelines without the express written approval of the Department. The MCO were required to submit to the Department the name(s) of the contracted FIs for each county prior to October 1, 2012 and the fourth quarter of each year thereafter, or upon request of the Department.

- **Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative:** Each member prior to receiving CDPAS must sign a consumer acknowledgement of the roles and responsibilities of the MLTC/MCO and the member. The Department has provided a sample acknowledgment form with the minimum requirements for its use by the MLTC/MCO.

- Transition of Consumer Direct Services continues throughout the mandatory counties.

- Department is preparing guidelines to share with all MLTCs regarding Consumer Direct Services to supplement existing educational materials shared previously.

- Posting of Consumer Direct Services guidelines to the Department of Health website for clarification.

5. Required Quarterly Reporting

- **Critical incidents:** The most significant critical incident thus far during this demonstration period was Hurricane Sandy. In order to assure ongoing connection to members the Department required Plans: to provide working phone numbers available 24/7 and alternate working email addresses; to make member service representatives available beyond office hours; to perform outreach to members to assess their safety and location; and to authorize out of network coverage for services to assure that members could continue services in alternative locations due to evacuations. In addition NYMC had to make adjustments due to being evacuated from their workplace such as shifting consumer representative phone lines, delaying mandatory mailings, and creating alternate access to systems. During recovery, Plans, the Department, the HRA and NYMC have continued to identify issues (i.e. mailing addresses; out of service area members) to assure ongoing continuity.

- The electronic reporting system has been implemented and will continue to be refined as needed. There were 215 critical incidents reported to the Department for the first quarter

utilizing the enhanced system. There were 122 critical incidents reported to the Department for the second quarter utilizing the enhanced system.

- **Grievance and appeals:** The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter:

Period: 4/01/14 – 6/30/14			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	7496	7496	100%
# Standard/Expedited	1082	999	92%
Total for this period:	8578	8495	99%

Period: 4/01/14 – 6/30/14	
Grievance Appeals	
Total appeals filed for this period:	
Total for this period:	10

Period: 04/01/14 – 6/30/14	
Grievances	
Reason for Grievances	**Total**
Dissatisfaction with quality of home care (other than lateness or absences)	**931**
# Same Day	620
# Standard	306
# Expedited	5
Home care aides late/absent on scheduled day of service	**451**
# Same Day	368
# Standard	81
# Expedited	2

Period: 4/01/14 – 6//30/14	
Dissatisfaction with quality of day care	**11**
# Same Day	9
# Standard	2
# Expedited	0
Dissatisfaction with quality of other covered services	**376**
# Same Day	252
# Standard	123
# Expedited	1
Dissatisfaction with transportation	**5877**
# Same Day	5616

# Standard	259
# Expedited	2
Travel time to services too long	**9**
# Same Day	7
# Standard	2
# Expedited	0
Wait too long to get appointment or service	**84**
# Same Day	45
# Standard	38
# Expedited	1
Waiting time too long in provider's office	**3**
# Same Day	3
# Standard	0
# Expedited	0
Dissatisfaction with care management	**172**
# Same Day	113
# Standard	59
# Expedited	0
Dissatisfaction with member services and plan operations	**186**
# Same Day	152
# Standard	34
# Expedited	0
Dissatisfied with choice of providers in network	**32**
# Same Day	25
# Standard	7
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**13**
# Same Day	10
# Standard	3
# Expedited	0
Language translation services not available	**2**
# Same Day	2
# Standard	0
# Expedited	0
Hearing/vision needs not accommodated	**0**
# Same Day	0
# Standard	0
# Expedited	0
Disenrollment issues	**14**
# Same Day	9
# Standard	5
# Expedited	0
Enrollment issues	**5**

# Same Day	3
# Standard	2
# Expedited	0
Plan staff rude or abusive	**33**
# Same Day	12
# Standard	21
# Expedited	0
Provider staff rude or abusive	**62**
# Same Day	45
# Standard	17
# Expedited	0
Violation of other enrollee rights	**9**
# Same Day	9
# Standard	0
# Expedited	0
Denial of expedited appeal	**1**
# Same Day	0
# Standard	1
# Expedited	0
Other:	**308**
# Same Day	194
# Standard	113
# Expedited	1
Total for this period:	**8578**
# Same Day	7496
# Standard	1070
# Expedited	12

Period: 4/01/14 – 6/30/14	
Reason for Appeal	**Total**
Denial or limited authorization of service including amount, type or level of service	**314**
# of Standard Filed	294
# of Expedited Filed	20
Reduction, suspension or termination of previously authorized service	160
# of Standard Filed	157
# of Expedited Filed	3
Denial in whole or part of payment for service	**1245**
# of Standard Filed	1245
# of Expedited Filed	0
Failure to provide services in a timely manner	**0**
# of Standard Filed	0

# of Expedited Filed	0
Failure of plan to act upon grievance or appeal of grievance in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon appeal of plan action in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Other	**1**
# of Standard Filed	1
# of Expedited Filed	0
Total appeals filed for this period:	**1720**
# of Standard Filed	1697
# of Expedited Filed	23

Period: **4/01/14 – 6/30/14**	
Fraud and Abuse Complaints Reported during Quarter	70

Period: 4/01/14 – 6/30/14	
Reason for Complaints	**Total**
Home Health Care - Dissatisfaction	80
Billing- provider questions on coverage/payer	16
Billing- claims denied in error	25
Billing – spendown problems	11

- **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 15,382, with 721 individuals who did not qualify to enroll in an MLTC plan. For the first quarter of 2014 the total number of assessments for enrollment performed by the plans is 19,128, with 2036 individuals who did not qualify to enroll in an MLTC plan. For the second quarter of 2014 the total number of assessments for enrollment performed by the plans is 15,633, with 1492 individuals who did not qualify to enroll in an MLTC plan.

- **Referrals and 30 days assessment:** This was the first quarter for Plans to report to the enrollment broker (New York Medicaid Choice) the number of individuals they received referral on from outside NYMC and the time frame in which assessments were completed. The establishment of the reporting system and training of Plans to assure data completeness and quality is an ongoing effort. This quarter there were 1,604 reported referrals with 1,362 dates of assessment within the 30 day time frame. This represents an

85% rate of assessment completion based on data elements submitted. The remaining 242 reported referrals had errors in the data that resulted in an inability to calculate a date for assessment. NYMC is reaching out to plans to improve the data reporting. The State will review the finalized data to determine if actions need to be taken. For the quarter from July to September, the Department continues to track the data provided by NYMC and will continue to identify areas that need improvement. For the fourth quarter of 2013, total assessments conducted by MLTC plans during the period are 2579. 50% were conducted within the 30 day time frame. Noncompliance is specific to 5 plans. Quality of data will be verified then remedial action pursued. Data reporting has improved. For the first quarter of 2014, total assessments conducted by MLTC plans during the period is 5,995. 83% were conducted within the 30 day time frame. For the second quarter of 2014, total assessments conducted by MLTC plans during the period is 7,318. 87.7% were conducted within the 30 day time frame.

- **Referrals outside enrollment broker:** During the fourth quarter of 2013, 7,763 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials. During the first quarter of 2014, 9,594 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials. During the second quarter of 2014, 9,003 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Fraud and Abuse**: Increase in reporting of incidents from first quarter of 21 to 70 in the second quarter was reviewed. Half of those incidents reported for second quarter related to one plan's identification of outcomes from a Federal HEAT (Health Care Prevention and Enforcement Action Team) arrest regarding physicians.

- **Rebalancing efforts:** Due to delay in reporting of the current assessment data from Semi-Annual Assessment of Members (SAAM), the following data reflects activities prior to implementation of mandatory enrollment. This is statewide data for managed long term care plans, therefore a subset of individuals enrolled during that period (1,108 out of 58,846).

  For the January – June 2012 reporting period, the MLTC population had 1,108 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	59
Respite	4
Permanent Placement	34
Unsafe home	5.7
Other	2.9

For July - December 2012 reporting period, there were 1,227 nursing home admissions (out of 78,269). Percent admitted by reason:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30
Unsafe home	6.4
Other	3

For the January - June 2013 reporting period, the MLTC population had 1,422 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	64
Respite	3
Permanent Placement	27
Unsafe home	5.6
Other/Unknown	6

Quarterly reporting of Rebalancing Efforts has been implemented, effective with fourth quarter 2013 data submission. Previous data reported was based on a semi-annual data collection cycle.

Period: 4/01/14 – 6/30/14	
Rebalancing Efforts	
Number of Individuals enrolled in the plan from a nursing home	236
Number of Enrollees admitted to a nursing home but returned to the community	1379
Number of Enrollees permanently admitted to a nursing home	667

V. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

See Attachment 1. NYS Partnership Plan Projected 1115 Waiver Budget Neutrality Impact.

B. Designated State Health Programs

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

Total value for Designated Year 0 is $188,000,000.

C. Hospital Demonstration and Clinic Uncompensated Care

The Department processed Clinic Uncompensated Care distributions in the amount of $34,165,504, $17,082,754 FFP, during the quarter that ended March 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $9,196,209, $4,598,105 FFP, during the quarter that ended June 30, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $1,790,919, $895,459 FFP, during the quarter that ended September 30, 2012.

Cumulative distributions to date total $45,152,632, $22,576,316 FFP.

The Department processed Clinic Uncompensated Care distributions in the amount of $79,428,341, $39,714,171 FFP, during the quarter that ended December 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $28,385,795, $14,192,898 FFP, during the quarter that ended March 31, 2013.

The Department processed Clinic Uncompensated Care distributions in the amount of $896,912, $448,456 FFP, during the quarter that ended June 30, 2013.

Cumulative disbursements to date total $153,863,680, $76,931,843 FFP.

The Department processed Clinic Uncompensated Care distributions in the amount of $108,751,308, $54,375,690 FFP, during the quarter that ended December 2013.

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

least 5% of their annual visits providing services to uninsured individuals; have a process in place to collect payments from third party payors. For the year 2013, 133 Diagnostic & Treatment Centers (DTC"s) and 200 MH clinics were determined to be potentially eligible to receive funding for this program. Of the award amounts, the DTC's were awarded $92,429,009 while the MH clinics received $10,205,991 for a total of $102,635,000. In addition, the Supplemental award amount of $5,880,000 was distributed between 12 DTC's. This brings the total amount awarded in 2013 to $108,515,000.

New York requested an amendment to the Partnership Plan to extend the Clinic Uncompensated Care Funding authorized in STC 58, which expired December 31, 2013. The amendment extended the federal funding agreement through December 31, 2014.

New York received authorization to transition and extend certain Designated State Health Programs (DSHPs) which were authorized under the Federal-State Health Reform Partnership (F-SHRP) Demonstration which expired March 31, 2014. Continuance of these DSHP's will occur under the Partnership Plan due to expire December 31, 2014.

Update on Progress Activities Related to Quality Demonstrations and Clinic Uncompensated Care Funding

HOSPITAL-MEDICAL HOME DEMONSTRATION BACKGROUND

The Hospital-Medical Home Demonstration announced awards for funding and participation to 64 hospitals in early October 2012. Hospitals submitted work plans on December 3, 2012 for review. Hospitals officially began work plan implementation on January 1, 2013. The initial timeline was extended due to Hurricane Sandy. Eighteen months into the project, 157 resident clinics training over 5,000 primary care residents affiliated with 61 hospitals serving approximately 1,000,000 Medicaid members in all regions of New York State continue actively implementing residency changes, patient-centered medical home transformation of participating outpatient sites, and the chosen care coordination and inpatient projects contained in their work plans to meet the program requirements.

PROGRAM ACCOMPLISHMENTS:

- 156/157 of sites (99%) are recognized by the National Commission for Quality Assurance (NCQA) as Level II or III Patient-Centered Medical Homes by 2011 standards. Niagara Falls Memorial Medical Center achieved Level 1 recognition, and hopes to be recognized as Level 2 by September 1, 2014.
- Reallocation of funding among the 61 remaining hospitals continues to occur based on meeting of program milestones, hospital closures and mergers, and residency program and continuity clinic changes.
- All hospital-reported data submitted through the web tool continues to be aggregated in summary reports for each domain. Summary reports are used to determine the quality and completeness of reporting as well as site progress. (The content in the reports vary by domain, but generally display the number of sites improving on certain metrics since the previous quarter, the number of sites reporting on a given metric, and the number of sites

answering either 'yes' or 'no' to required questions about meeting milestones in each domain).

- Received and reviewed the 2014 first quarter submission from sites and provided feedback to the hospitals regarding the quarterly metric and narrative information. Data received included updated goal rates from all hospitals and sites for metrics related to clinical performance, resident continuity, care coordination and integration, and inpatient projects. Reformatted goal rates allow for better comparison between the rate being reported for each measure and that measure's goal.

- Provided continuous clinical and technical support to 61 hospitals and 157 sites. The number of sites reporting data correctly has grown each quarter with continued education and support by NYS Department of Health (NYS DOH). Continued to work with hospital, professional and community organizations such as the Hospital Association of New York, The Greater New York Hospital Association, the Primary Care Development Corporation, the NYS American Academy of Family Physicians, the New York Academy of Physicians and others to support transformation efforts.

- Conducted weekly meetings with a work plan review team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from Island Peer Review Organization and within the NYS DOH.

- Refined process for all sites participating in the Care Transition & Medication Reconciliation project to submit a Patient Registry, allowing the NYSDOH to link reported data with claims data and begin validating and analyzing the submitted lists. Clearly specified look back periods for hospital discharges have been defined and continued reporting guidance has been offered on calls pre-portal opening and pre-portal closing calls. Information will be used to evaluate the impact of medication reconciliation on outpatient avoidable readmissions.

- Modified the project website to post reports directly on the web portal ensuring that Quarterly Hospital Feedback Letters, Hospital Ranking Reports and Hospital Performance Reports are available to all project participants with user access to the portal. In addition, training was provided via teleconference on May 8, 2014 on utilizing the Hospital Performance report cards which allow hospitals to compare their rates (in a de-identified manner) with other hospitals and sites for a specific quarter to be used for quality improvement purposes.

- Held a coaching call on Regional Health Information Organization (RHIOs) with Steven R. Smith, RPH, MS – Director of Operations in the NYS Office of Health Information Technology Transformation to provide information and education on HIT requirements for the Hospital Medical Home Project, the Statewide Health Information Network of New York (SHIN-NY), RHIO's, new regulations, and allowed time for participants to ask questions and brainstorm challenges.

- Continued hospital and clinic site visits throughout NYS to learn about the accomplishments, changes and challenges hospitals are facing during this demonstration program. During this quarter, the Department OQPS Medical Director, Assistant Medical Director, Program Manager, Program Specialist, and other specialty advisors conducted

six site visits at Lutheran Medical Center, Westchester Medical Center, Kingston Hospital, Jamaica Hospital, Albany Medical Center, and Bronx Lebanon Hospital. Hospital presentations are posted publically on the Hospital Medical Home website.

- Conducted teleconferences to educate participants on upcoming changes prior to Year Two, first quarter (2014) portal opening on April 10, 2014 and provided an educational call one week prior to the portal closing on May 8, 2014 to allow for opportunities for question and answer to all hospitals/sites involved in project.

- An "IGNITE" presentation of the Hospital Medical Home Demonstration was featured in May in a simulcast to all Department offices throughout the state with archived video where the Hospital Medical Home Program manager explained the demonstration project in a unique way. In "Ignite," each speaker gets five minutes and 20 slides - with each slide advancing automatically after 15 seconds, forcing speakers to get to the point, fast.

- The Department processed Hospital Medical Home distributions in the amount of $25,254,235 on January 2, 2013. This represented 25% of the First Year Award amount.

- The Department processed Hospital Medical Home distributions in the amount of $75,762,705 on October 16, 2013. This represented 75% of the First Year Award amount.

- The Department processed Hospital Medical Home distributions in the amount of $19,084,775 on April 16, 2014. This represented 25% of the Second Year award amount.

- Cumulative Distributions awarded to date total $120,101,715.

- The Department plans to process Hospital Medical Home distributions in the amount of $75,000,000 in September 2014. That amount represents 75% of the Second Year award amount and 25% of the Third Year award amount.

- The Department plans to process Hospital Medical Home distributions in the amount of $56,000,000 in December 2014. That amount will represent 25% of the Year Three award amount.
- The two tentative amounts still to be awarded total $131,000,000.

Provisional Summary based on self-reported data received in the 2014 Quarter two timeframe:

- Of the 54 sites participating in the Improved Access and Coordination between Primary and Specialty Care project, sites most often identified gaps in access and coordination related to behavioral health (identified by 25 sites (46%), dermatology (identified by 16

sites (30%), endocrinology (identified by 16 sites (30%)), and cardiology (identified by 15 sites (28%).

- 72 % of sites showed improvement in decreasing the amount of time required to see a specialist as compared to baseline.

- Sites most often implemented the following measures to improve access to specialists: onsite specialist clinic/Co-location of services (identified by 24 sites (44%)), same day specialist appointments (identified by 18 sites (33%)), and clinical advice to PCP by telephone (identified by 15 sites (28%)).

- Resident Continuity Training Programs - Of all HMH sites, 147 (93%) have assigned residents a panel of patients to whom they are responsible over an extended period of time.

- 78% of sites showed improvement in breast cancer screening and colorectal cancer screening.

- 75% of sites reporting improved rates of tobacco use screening and/or tobacco cessation counseling.

- 76/157 are restructuring their care transitions to ensure all patients have medication reconciliation on admission and discharge, including at a clinic follow-up, and that high risk patients have a follow-up call or visit at their PCPs office within 48 hours of discharge from the hospital.

- 50 clinics are reporting meeting their goals for receiving a hospital transition record to the PCP within 24 hours after discharge

- 69 clinics are administering the CTM-15 to clinic patients routinely to assess the quality of their care transitions. The average score is over 3 (out of 1-4 scale.)

- 26 clinics committed to ensuring interpreter wait time is 15 minutes or less and 23 clinics report this is true greater than 89% of the time

- 27 clinics are committed to completing cultural competency training for all providers. Ten have completed this for at least 90% of their providers. The range is 24-100% of providers trained.

- 33 clinics are participating in Collaborative Care to integrate behavioral health into primary care. 23 of those are screening greater than 70% of all patients for depression. 32 clinics have depression care managers. Eight clinics are ensuring that greater than 90% of

patients needing behavioral health care are seen within the time-frame requested by the PCP.

- Out of 53 sites committed to improving coordination between primary and specialty care, 36 sites (68%) have documentation of referrals 100% of the time. 49 sites report a rejected referral rate of 10% or less.

ADMINISTRATIVE AND POLICY CHALLENGES

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

- The portal has been continuously updated to respond to the needs of the project as it evolves including refinements to data collections, new measures, resources for hospital and residency use, etc.

- Concern about sustainability has led to under screening of patients for collaborative care in some clinics. The Office of Mental Health, and Hospital Associations have developed work groups and are planning trainings for the next quarter to assist hospitals working on this project.

PLANNED ACTIONS FOR THE NEXT QUARTER

- Continue planning for the Hospital Medical Home Demonstration Program March 2015 final conference, which will bring together participants from more than 60 hospitals, 115 residency programs, and 157 outpatient clinics across New York State. Successes will be celebrated, such as the 99% rate of transformation to high level patient centered medical homes and the numerous projects to improve transitions of care, behavioral health integration, access to specialists, and cultural competence as well as inpatient quality and safety, and next steps for transforming primary care in the context of the State Health Innovation Plan (SHIP) and Delivery System Reform Incentive Payment Program (DSRIP).

- Beginning with this quarter, all sites must report on the percentage of visits patients have with their primary care provider and the percentage of time in clinic residents are seeing patients on their own panel.

- Provide ongoing support and education regarding project implementation & reporting processes via teleconferencing and web conferencing.

- Distribute payment of 75% of Year 2 payment for all hospitals achieving PCMH Level 2 or 3 by deadline as well as up to 25% of Year 3 payment for first quarter of year 2 payment to the hospitals

- Receive and review Year 2 (2014) Quarter 2 report.

- Continue site visits with hospitals and outpatient primary care sites.
- Continue educational coaching calls as a result of survey feedback. In third quarter 2014, a coaching call is planned on the topic of Resident Continuity/Attribution as well as a coaching call on Preventing Readmission for High Risk Patients/48 hour office visit post discharge.
- Continue to collaborate with Hospital and Professional Associations to clarify the demonstration components and support hospitals.
- Develop measure categories and composite measures in each domain to better evaluate demonstration effects and individual hospital / clinic achievements.
- Continued refinements adding additional resources to the demonstration's portal website for participant use.

Consumer Issues

A. Complaints

Medicaid managed care plans reported 5,456 complaints/action appeals this quarter, an increase of 9% from the previous quarter. Of these complaints/appeals, 511 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 27% of the total. There were 518 complaints/appeals reported by the HIV SNPs. The majority of these complaints (454) were in the category of reimbursement/billing. The Department directly received 299 Medicaid managed care complaints and 4 FHPlus complaints this quarter.

The top five most frequent categories of complaints were as follows:

27%	Balance Billing
24%	Reimbursement/Billing Issues
9%	Pharmacy
7%	Provider or MCO Services (Non-Medical)
6%	Quality of Care

This quarter, mainstream Medicaid managed care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	0
Consumer Directed Personal Assistant	0
Home Health Care	4
Non-Permanent Residential Health Care Facility	0

Personal Care Services	12
Personal Emergency Response System	0
Private Duty Nursing	0
Total	16

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 5,456 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 598 complaints and action appeals from their SSI enrollees. This compares to 490 SSI complaints/action appeals from last quarter. The top five categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Reimbursement/Billing Issues	19%
Balance Billing	17%
Quality of Care	12%
Provider or MCO Services (Non-medical)	12%
Dental or Orthodontia	7%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	20
AIDS Adult Day Health Care	0
Appointment Availability - PCP	5
Appointment Availability - Specialist	1
Balance Billing	103
Communications/Physical Barrier	0
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	19
Dental or Orthodontia	39
Emergency Services	24
Eye Care	7
Family Planning	0
Home Health Care	2
Mental Health or Substance Abuse Services/ Treatment	0
Non-covered Services	7
Non-Permanent Residential Health Care Facility	0
Personal Care Services	8
Personal Emergency Response System	0
Pharmacy	22
Private Duty Nursing	0

Provider or MCO Services (Non-Medical)	68
Quality of Care	70
Recipient Restriction Program/Plan Initiated Disenrollment	2
Reimbursement/Billing Issues	112
Specialist or Hospital Services	4
Transportation	8
Waiting Time Too Long at Office	4
All Other Complaints	64
Total	**589**

B. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on April 24 and June 20, 2014. The April meeting included presentations provided by the Department staff and discussions of the following: evaluation of auto-assignment of SSI Medicaid enrollees into managed care; FIDA and managed long term care update; Medicaid excess income (spenddown) and technical issues related to spenddown; and an update on the planned transition of the nursing home benefit and population to managed care. The June meeting agenda included: an update on managed care enrollment through the health benefit exchange; an overview of proposed model contract changes for special/vulnerable populations; and an update by the Office for People with Developmental Disabilities (OPWDD) on the progress of the development of DISCOs and the transition the OPWDD populations into managed care.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning Meetings were held on April 10, May 15, and June 12, 2014. The April meeting included presentations on: finance and rate development, including mainstream April 2014 rates; behavioral health/HARP databook and draft rates; Hepatitis C drugs; budget update; MTLC and FIDA update; senior center innovations to promote members' health and well-being (presented by NYC Department for the Aging); and training family caretakers of chronically ill persons (presented by Health People Community Preventive Health Institute). The May meeting agenda included: finance and rate development; MLTC and FIDA update; encounter data update; and an update on the Basic Health Plan (BHP) and enrollment through the health benefit exchange. Presentations and discussions at the June meeting included: OMIG integrity provisions for the managed care contract; finance and rate development; reducing unintended pregnancy by increasing access to immediate post-partum contraception (presented by NYC Department of Mental Health); MLTC and FIDA update; update on benefit limitations for percutaneous coronary intervention (PCI); adult behavioral health and HARP update; children's behavioral health update; and pharmacy budget items.

VI. Quality Assurance/Monitoring

Quality Measurement

Care Management Reporting

Sixteen Medicaid health plans submitted care management data for all members identified or enrolled in one or more of the plan's care management programs in calendar year 2013. The information involved all episodes for members. In addition, three HIV Special Needs Plans (SNPs) also submitted care management data for 2013. This is the first year of submission for the HIV SNPs who use a continuous model of care management. The HIV SNP data and Medicaid managed care data will be analyzed separately due to the different models of care management (continuous versus episodic).

For Medicaid managed care members, three percent of members are identified for care management with approximately one third of those who are determined to be appropriate and agree to participate in care management. The average length of time for care management segments is 79.2 days, with most segments closing because the member met goals. Information about the volume and enrollment for the Medicaid health plans are shown below.

Measure	Definition	Statewide Result		
		Denom	Num	Percent
Identifying for Case Management				
Trigger Rate	Number triggered / Number enrolled in health plan	4,126,230	128,852	3.1%
Contact Rate*	Number contacted / Number triggered	128,852	62,712	48.7%
Appropriateness Rate	Number deemed appropriate / Number contacted	62,712	51,088	81.5%
Refusal Rate	Number refused / Number contacted, appropriate, & offered CM	51,088	6,694	13.1%
Enrolling in Case Management				
Total Number Enrolled	Members who were contacted, deemed appropriate, and did not refuse to enter case management program.			**Plan Range**
…Annually*	Total number enrolled in CM in the measurement year	44,345		330 to 12,835
…Monthly Average	Total number enrolled in CM / 12	3,695.4		27.5 to 1,069.6
Percent Enrolled…				
…of Total Plan Membership	Number enrolled in CM / Number enrolled in health plan	4,126,230	44,345	1.1%
…of Triggered	Number enrolled in CM / Number triggered	128,852	44,345	34.4%
…of Contacted	Number enrolled in CM / Number successfully contacted	62,712	44,345	70.7%
…of Appropriate	Number enrolled in CM / Number deemed appropriate	51,088	44,345	86.8%
…of 'Not Refused'	Number enrolled in CM / Number who did not refuse participation	44,345	44,345	100.0%

Measure	Definition	2013 CY Statewide Result		
		Denom	Num	Percent
Length of Time to Identify and Engage				
Triggering to CM Contact				
Mean Days to Contact	Number of days between triggering for CM and contact by the CM staff.	62,712		17.0
Range of Days to Contact				0 to 1,252
CM contact to CM Enrollment				
Mean Days to Enrollment	Number of days between contact by the CM staff and CM enrollment	44,345		22.6
Range of Days to Enrollment				0 to 1,252
Provision of Case Management				
…By Total Interventions Received		**Denom**		**Mean**
Behavioral Health	Mean Number of Total Interventions (for members in that program type)	3,961		5.4
Catastrophic		5,551		7.3
Chronic Adult		11,660		7.7
High Risk OB		10,711		4.9
HIV/AIDS		1,624		4.4
Oncology		335		14.3
Pediatrics		3,845		5.8
Provider-based		11		3.5
Utilization-based		6,647		6.3

Managed Long Term Care

Reports

The Department publically released the 2013 Managed Long-Term Care (MLTC) Report. This report describes the Department's approved MLTC plans at the time of data collection and presents information about the quality of care they provide and enrollee's satisfaction with the plan.

MLTC Quality Incentive Workgroup

The Department continues to work with a workgroup of health plan representatives, advocates, and associations on the development of the MLTC Quality Incentive. The workgroup and the Department are reviewing measures of quality, satisfaction, compliance and efficiency related to performance.

Quality Improvement

External Quality Review

The first three months of an approved five month extension to the current External Quality Review contract with IPRO, were completed. A Request for Proposals (RFP) to procure a new External Quality Review (EQR) organization for a five year contract to conduct Medicaid managed care EQR, per the Balanced Budget Act of 1997 and CMS published EQR regulations, was issued on April 8, 2014. Responses to the RFP were due on May 15, 2014, with an anticipated contract start date of September 1, 2014. The bidding period has ended and responses are in the evaluation process. Once a bidder is selected, the state contracting process will begin.

Health plans participated in a variety of quality improvement activities including performance improvement projects and special studies. The EQR organization also prepared and released its annual technical evaluation of the Medicaid managed care plans for the reporting year 2012.

Breast Cancer Selective Contracting

During the April – June 2014 period, staff worked on streamlining the processes behind the Breast Cancer Selective Contracting Project by proposing a preliminary release of breast cancer surgery volume data in summer 2014. This summer run will provide facilities with their provisional volume status (low or high) as reflected in all-payer SPARCS (inpatient and outpatient discharge) data. Additionally, the summer run of data will provide facilities with adequate time to correct any discrepancies between facility-calculated volume and SPARCS volume. A reduction is anticipated in the number of facilities that will submit appeals in winter 2015. The proposal was approved and will be implemented by August 1, 2014.

Performance Improvement Projects (PIPs)

For 2013-2014, a collaborative PIP includes two parts: Part one, the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD), includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in the following clinical areas: diabetes prevention and management, smoking cessation, and hypertension management. Part two focuses on implementing interventions to improve care in one of the four clinical areas noted above. For Part one, MIPCD, 17 plans have implemented their interventions for the testing of patient incentives through diabetes prevention programs. Bi-monthly individual calls with each Medicaid managed care plan were conducted to accelerate progress and facilitate obstacles/barriers. To date, 142 Medicaid recipients are enrolled in the study, of which, 126 are in the diabetes prevention study arm, and 16 are in the diabetes management study arm. For Part two, IPRO is preparing to conduct periodic conference calls with the health plans to monitor their progress. All plans are on track with proposed interventions.

Managed Long Term Care (MLTC)

The EQR organization completed a focused clinical study to review individuals who were mandatorily enrolled in managed long term care plans and determine compliance with the required transition of care. Reviews included enrollees who selected a health plan and cases who did not select a plan and were, therefore, auto-assigned. Approximately 92% of the sample reviewed reflected at least the same level of personal care hours during the 60 day transition period as prior to enrollment. Increases to personal care hours were well documented and appeared justifiable based upon changes in member condition or caregiver support systems. There were virtually no differences between the auto-assigned and non-auto-assigned groups.

The EQR organization also worked to administer a survey examining the experience of care for MLTC recipients newly enrolled in a managed long term care plan through the mandatory expansion of MLTC. Clients were asked to compare their experiences both pre- and post-enrollment in the MLTC program. The final survey mailing was done in May 2014, with final responses collected in June, 2014. Data analysis is currently ongoing and the final report is anticipated in the next quarter.

The Department released the 2013 Managed Long-Term Care Report. This annual report describes 38 of New York's certified MLTC plans and presents information about the quality of care they provide and enrollee's satisfaction with the plans. The report is organized into four sections: 1) Quality of life and care based on the Semi-Annual Assessment of Members (July 1, 2012-December 31, 2012); 2) Quality performance over time (based on changes seen in assessments throughout 2012); 3) Enrollee satisfaction with care from the 2013 satisfaction survey; and 4) Potentially avoidable hospitalizations (based on inpatient hospitalizations during 2012).

VII. Family Planning Expansion Program

The intent of the Family Planning Benefit Program (FPBP), also known as the Family Planning Expansion Program, is to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies.

FPBP has moved into the Medicaid State Plan in early 2014.

VIII. Transition Plan Updates

Attachment two contains the Department's updated Transition Plan indicating how the Department will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Partnership Plan demonstration.

IX. Other

Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract

On June 21, 2013, the Department received CMS approval of the October 1, 2012 amendment to the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract.

The Department is currently in the process of drafting additional contract language changes related to implementation of various MRT initiatives and other programmatic changes. Upon CMS approval, these revisions will be incorporated into the new Model Contract for the period March 1, 2014 through February 28, 2019.

Delivery System Reform Incentive Payment Program

DSRIP is the main mechanism by which the Department will implement the MRT Waiver Amendment. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over five years. Up to $ 6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.

Attachment 5 contains the first report of Year 0 of DSRIP.

Attachments:
Attachment 1 Budget Neutrality
Attachment 2 Transition Plan
Attachment 3 DD Transformation Evaluation
Attachment 4 CMS 64
Attachment 5 DSRIP Quarterly

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Date Submitted to CMS:

August 28, 2014

Attachment 1

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
DY12 Actuals 21 Month Lag Final

Budget Neutrality Cap (Without Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Projected	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$10,048,004,954	$11,219,968,696	$6,068,361,712
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,521,937,580	$2,434,711,397
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,746,457,301	$1,872,671,502	$1,043,047,420
Demonstration Group 8 - Family Planning Expansion						
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
W/O Waiver Total	**$144,639,878,523**	**$13,378,994,889**	**$14,117,434,787**	**$15,651,219,785**	**$17,614,577,777**	**$9,546,120,529**

Budget Neutrality Cap (With Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Projected	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$4,828,196,168	$4,876,699,233	$1,991,953,729
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,851,097,035	$1,207,776,147
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,479,171,065	$1,965,328,896
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$976,122,527	$501,498,119
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$322,462,923	$157,262,083
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$13,378,992	$4,685,593
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						
Demonstration Population 5: Designated State Health Programs (Various)						
DSHP: Orderly Close out of Demo Group 6						
DSHP: APTC Wrap						
DSHP For DSRIP						
DSRIP						
IAAF						
With Waiver Total	**$123,931,127,812**	**$10,499,291,132**	**$11,309,400,341**	**$12,518,840,867**	**$13,518,931,775**	**$5,828,504,567**
Expenditures (Over)/Under Cap	**$20,708,750,711**	**$2,879,703,758**	**$2,808,034,445**	**$3,132,378,919**	**$4,095,646,003**	**$3,717,615,962**

Attachment 1

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
DY12 Actuals 21 Month Lag Final

Budget Neutrality Cap (Without Waiver)	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	DY 17 (1/1/14-3/31/14) Projected	DY 18 (4/1/14 - 12/31/14) Projected	Current Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 18
Demostration Group 1 - TANF Children under age 1 through 20	$6,164,400,977	$13,431,555,927	$14,853,389,777	$3,975,139,194	$3,975,139,194	$12,413,422,113	**$99,877,202,551**	
Demonstration Group 2 - TANF Adults 21-64	$2,477,573,533	$5,362,266,874	$5,914,379,682	$1,579,889,213	$1,579,889,213	$4,990,265,399	**$38,980,386,684**	
Demonstration Group 6 - FHP Adults w/Children	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042			**$14,921,448,066**	
Demonstration Group 8 - Family Planning Expansion	$5,133,302	$10,687,824	$1,854,045				**$17,675,170**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$247,394,784	$1,027,336,330	$260,284,563	$260,284,563	$811,742,494	**$2,607,042,734**	
Demonstration Group 11 - MLTC age 65+ Duals		$2,554,212,091	$10,820,566,375	$2,796,750,566	$2,796,750,566	$8,800,737,577	**$27,769,017,175**	
W/O Waiver Total	**$9,702,523,143**	**$23,947,184,953**	**$35,249,763,822**	**$9,336,721,578**	**$8,612,063,536**	**$27,016,167,583**	**$184,172,772,382**	**$328,812,650,904**

Budget Neutrality Cap (With Waiver)	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	DY 17 (1/1/14-3/31/14) Projected	DY 18 (4/1/14 - 12/31/14) Projected	Current Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 18
Demostration Group 1 - TANF Children under age 1 through 20	$2,599,026,093	$5,793,675,277	$6,387,309,768	$1,701,627,127	$1,700,951,915	$5,291,679,168	**$43,589,959,419**	
Demonstration Group 2 - TANF Adults 21-64	$1,526,466,744	$3,375,246,131	$3,715,840,773	$992,091,524	$992,144,119	$3,135,573,179	**$24,635,454,683**	
Demonstration Group 5 - Safety Net Adults	$2,698,974,172	$6,427,517,737	$7,604,368,008	$2,054,388,591			**$35,279,159,907**	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$588,618,554	$1,209,988,160	$1,354,817,453	$371,470,502			**$7,595,921,395**	
Demonstration Group 7 - FHP Adults without Children up to 100%	$188,509,524	$372,306,976	$423,128,705	$117,087,276			**$3,147,007,565**	
Demonstration Group 8 - Family Planning Expansion	$6,564,435	$13,915,485	$2,458,808				**$73,211,918**	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)	$3,699,108	$3,699,108	$3,699,108	$924,777	$924,777	$2,774,331	**$15,721,209**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$249,276,515	$999,765,437	$249,927,129	$249,927,129	$780,984,048	**$2,529,880,258**	
Demonstration Group 11 - MLTC age 65+ Duals		$2,561,508,288	$10,403,512,554	$2,629,869,736	$2,629,869,736	$8,298,486,190	**$26,523,246,503**	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)	$2,600,000	$14,650,000	$13,700,000	$3,400,000			**$34,350,000**	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)	$2,600,000	$10,583,333	$10,583,333	$2,645,833	$2,645,833	$5,291,667	**$34,350,000**	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)	$0	$100,000,000	$100,000,000	$25,000,000	$25,000,000	$50,000,000	**$300,000,000**	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)	$0	$4,433,333	$4,433,333	$1,108,333	$1,108,333	$2,216,667	**$13,300,000**	
Demonstration Population 5: Designated State Health Programs (Various)				$100,000,000	$100,000,000	$300,000,000	**$500,000,000**	
DSHP: Orderly Close out of Demo Group 6					$363,417,732	$635,987,007	**$999,404,739**	
DSHP: APTC Wrap					$7,000,800	$84,009,600	**$91,010,400**	
DSHP For DSRIP						$376,000,000	**$376,000,000**	
DSRIP						$240,000,000	**$240,000,000**	
IAAF						$1,000,000,000	**$1,000,000,000**	
With Waiver Total	**$7,617,058,630**	**$20,136,800,344**	**$31,023,617,282**	**$8,249,540,828**	**$6,072,990,374**	**$20,203,001,857**	**$146,977,977,996**	**$270,909,105,808**
Expenditures (Over)/Under Cap	**$2,085,464,512**	**$3,810,384,609**	**$4,226,146,540**	**$1,087,180,751**	**$2,539,073,162**	**$6,813,165,726**	**$37,194,794,386**	**$57,903,545,096**

Attachment 2

New York State

Partnership Plan Medicaid Section 1115 Demonstration

Transition Report

I. Introduction

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period August 1, 2011, through December 31, 2014, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA).

On January 1, 2014, New York will have made considerable progress in implementing the ACA. Specifically, New York will have expanded coverage, made changes to access to care, and reforms to the payment and delivery system. The ACA expands Medicaid eligibility for individuals under the age of 65, with income at or below 133 percent of the Federal Poverty Level (FPL). In New York State, some of these individuals are currently eligible under New York's Partnership Plan 1115 Waiver.

II. Transition Plan

Nearly 90 percent of individuals currently covered under New York's Partnership Plan 1115 waiver will transition to a State Plan eligibility group with coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. For most enrollees in Family Health Plus, the transition to Medicaid using MAGI eligibility rules will occur at renewal. Ideally, the State would choose to switch coverage for the waiver population from Family Health Plus to Medicaid on January 1, 2014. However, this is not possible for all enrollees because not enough information is known to the system about parent/caretaker enrollees to automatically switch them to a MAGI budget on January 1, 2014.

New York intends to stop accepting new applications for Family Health Plus after December 31, 2013. Anyone who submits an application prior to or on that date and are found eligible, will be enrolled in Family Health Plus for 12 months. Effective January 1, 2014, new applications will be evaluated using MAGI eligibility rules, and if eligible, applicants will be enrolled in Medicaid under an Alternative Benefit Plan. New York has chosen the Medicaid State Plan benefit as its Alternative Benefit Plan and will be submitting a SPA for Secretary Approval.

Family Health Plus single and childless couples will have their coverage changed to the Alternative Benefit Plan effective January 1, 2014. Family Health Plus parents and caretaker relatives with income up to 138% FPL will transition to the Alternative Benefit Plan as they renew, effective April 1, 2014. Family Health Plus parents and caretaker relatives with income over 138% FPL to 150% FPL will transition to a qualified health

plan, however the State will pay the enrollee's share of the premium, this does not include the individual's cost sharing.

As authorized by the waiver under section 1902(e)(14)(A) of the Social Security Act using existing rules, individuals renewing coverage from October 1, 2013 through March 31, 2014, if determined eligible, will enroll in the current plan under the waiver (e.g. Family Health Plus or Medicaid) for twelve months but no longer than through December 31, 2014 for Family Health Plus. Individuals determined ineligible from October 1, 2013 through December 31, 2014, will be sent a notice referring the person to apply for coverage through the Exchange. Individuals renewing from January 1, 2014 through March 31,2014, if found ineligible using existing rules (pre-ACA), must be budgeted using MAGI-like rules following the system migration on February 18, 2014.

New York is building a new eligibility system that automates the MAGI eligibility rules for Medicaid, CHIP, and Advance Premium Tax Credits. The State anticipates over one million individuals are eligible to obtain coverage during the open enrollment period that begins October 1, 2013, and even more may apply. Given the complexity of the system build, the short time for adequately testing all the eligibility permutations and the data services available through the Federal Hub, and the reality that rules and interfaces will continue to be built 3-6 months after open enrollment, New York has decided to mitigate risk by maintaining current Medicaid enrollees in the legacy system until the State is confident it has the automation and system stability to transition over three million current enrollees without a disruption in coverage. New York is prioritizing the ability to provide coverage on January 1, 2014 to the newly eligible populations while doing no harm to current Medicaid enrollees.

To maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI-like eligibility using the current legacy system for those individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI-like rules in the legacy system for at least six months or until the new eligibility system is fully automated and is stable enough to handle the transition of over 3 million current recipients. The legacy logic will include:

- No longer counting child support as income
- Not applying income disregards/deductions
- Increased federal poverty levels to comply with ACA income levels
- New AID categories for claiming
- Revised client notices

The current renewal form will be used.

New applications submitted to local departments of social services from October 2013 through December 2013, will have eligibility determined under existing rules in the legacy system and, if eligible, individuals will be enrolled for 12 months of coverage. Individuals that are not eligible due to income will be instructed to reapply through the

Exchange. Applications submitted to the Exchange from October 2013 through December 2013, will be determined using MAGI rules and if determined eligible, coverage will be effective January 1, 2014. Applications submitted on or after January 1, 2014, will have eligibility determined through the Exchange under the ACA rules. Individuals who have medical bills or are in need of coverage in the three month period prior to January 1, 2014, will be referred to the local department of social services for a determination of eligibility for payment/reimbursement of medical bills.

A. Seamless Transitions

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, regardless of disability status with income at or below 133 percent of the FPL;

The following chart outlines the current waiver population, current coverage, and the coverage options for individuals between 133% FPL and 150% FPL currently enrolled in Family Health Plus. These options include transitioning Family Health Plus enrollees to Advanced Premium Tax Credits. Regardless of which options are available in 2014, all populations will have eligibility determined under the ACA.

Table 1: Groups Transitioning from Demonstration to ACA

Demonstration Eligible Group	Current Federal Poverty Level	Current Coverage	2014 Coverage
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income based on Statewide standard of need, approximately 0%-78% FPL	Medicaid	0% ≤ 133% Benchmark
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 100% FPL	Family Health Plus	0% ≤133% Benchmark

Children 19 and 20 years old [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Standard coverage > 133% ≤150% Standard coverage >150% APTC
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) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Benchmark > 133%≤150% State will pay enrollee's share of APTC premiums and seek federal participation as a designated state health program >150% APTC (no state assistance)

*The current Partnership Plan 1115 approved NYS comparing income to 160% FPL, but this has not been implemented.

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;

All populations currently covered under the waiver will have coverage options under the ACA. In addition, New York plans to implement 12-months of continuous coverage for adults in conjunction with the implementation of the ACA.

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 2, 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 the Medicaid State plan, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under the Medicaid State plan, the individual is guaranteed a subsequent 12-month continuous eligibility period.

This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Authority for this population's eligibility during the 12 month continuous eligibility period is only in the 1115 waiver and therefore, individuals during this period would be eligible for expanded Medicaid levels and benchmark under ACA, and are also subject to continuous coverage. The Department is in the process of exploring the necessary system and program changes and anticipates implementing in January 2014.

Table 2: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	**Statutory Reference**
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	1931 and 1925

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

- Local departments of social services will process new applications for Medicaid using current eligibility rules through December 31, 2013.
- New applications submitted to the Exchange from October 2013 through December 2013, will have eligibility determined through the Exchange under ACA rules and, if eligible, enrollment will be effective January 1, 2014. The acceptance notice will inform individuals who have medical bills or are in need of coverage prior to January 1, 2014 to apply at the LDSS. Applicants will be informed of this process online so they may go directly to the LDSS rather than apply through the Exchange before January 1, 2014.
- Beginning January 1, 2014, new applications will go through the Exchange and will be processed through the new integrated eligibility system.

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;

Nearly all of the populations covered under the waiver will be covered under the ACA and those populations who are subject to continuous coverage will also have it applied under the waiver.

Parents/caretakers with MAGI income between 138% and 150% of FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for a tax credit under the ACA provided they do not have access to affordable coverage. CMS approved expenditure authority to allow the state to claim federal matching dollars for the designated state health program (DSHP), this will provide premium subsidies to parents and caretaker relatives with incomes between 138%-150% FPL, who enroll in a silver level Qualified Health Plan using Advanced Premium Tax Credits.

19 and 20 year olds who are living with parents with MAGI income between 138% and 155% of the FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for Medicaid under MOE requirements.

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

New York is developing a new eligibility system that will automate program eligibility based on the MAGI eligibility rules as defined by CMS. All applications submitted to the Exchange after January 1, 2014 will be processed using the MAGI eligibility rules in the new system.

As described above, to maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules

to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI-like eligibility using the current legacy system for individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI-like rules in the legacy system for at least six months, or, until the new eligibility system is fully automated and is stable enough to handle the transition of over three million current recipients.

New York opted for CMS to develop a modified adjusted gross income (MAGI) equivalency level for converting existing net eligibility levels to MAGI eligibility levels. New York received converted eligibility levels and they are currently in effect.

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;

The service delivery network for a Managed Care Organization ("MCO") is county specific and is comprised of primary, specialty and ancillary providers as well as related institutions consistent with the benefit package. Each county network must include at least one hospital, one inpatient and outpatient mental health facility as well as at least one substance abuse inpatient and outpatient facility. This applies to HMOs participating in government programs and those that have exclusive commercial membership.

The behavioral health network is required to have both individual providers, outpatient facilities and inpatient facilities. The facilities must include mental health and substance abuse services. In the case of outpatient mental health, at least one facility in the county must be licensed by the Office of Mental Hygiene pursuant to Article 31 of the Mental Hygiene Law, or be a facility operated by the Office of Mental Hygiene. The mental health inpatient facility can be either a psychiatric center under the jurisdiction of the Office of Mental Hygiene, or, a unit or part of a hospital operating under Article 28 of the Public Health Law.

The provision of alcohol and substance abuse services must also be provided in an outpatient facility and an inpatient facility. These facilities must have the capacity to provide substance abuse treatments. The inpatient facilities must have the capacity to provide detoxification and rehabilitation services.

In addition to the above, Medicaid networks must also include traditional Medicaid providers, i.e., presumptive eligibility providers, Designated AIDS Centers and Federally Qualified Health Centers (FQHCs), where available. With the implementation of the homeless population into Medicaid managed care, we also require the MCO to contract with available federally qualified 330 H providers in every county they are available in.

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 MCO is required to have the full array of contracted providers in each county. However, in rural counties, this may not be possible due to a lack of resources within the county. When there is a lack of a provider type in a county the MCOs may contract with providers in adjacent counties, or service area, to fulfill the network requirements. In some cases where counties border neighboring states and the normal access and referral pattern for obtaining medical services in those areas is to go across state boundaries, MCOs may request approval to augment their networks by adding those out of state providers. Attachment 1 provides a listing of the core provider types for all lines of business.

In addition to the full array of required health care providers, the network must include sufficient numbers of each provider type, be geographically distributed and ensure choice of primary and specialty care providers. The Public Health Law requires the MCO member a choice of at least three geographically accessible primary care providers. It is the department's policy that MCOs are required to contract minimally with two of each required specialist provider types per county. However, additional providers may be required based on enrollment and to ensure geographic accessibility.

The Department of Health has developed time and distance standards for provider networks to which MCOs are required to adhere. For all Medicaid, HIV Special Needs Plans, and Child Health Plus health products, the time and distance standard is as follows:

- metropolitan areas - 30 minutes by public transportation;
- non-Metropolitan areas - 30 minutes or 30 miles by public transportation or by car;
- in rural areas transportation requirements may exceed these standards if justified.

The provider networks for the Medicaid, HIV Special Needs Plans, and Child Health Plus managed care products are reviewed on a quarterly basis. The Department of Health maintains a database and MCOs are required to submit their networks electronically at schedule dates. The submitted data goes through an editing process to ensure the data contains all required information prior to accepting the network. Prior to a network analysis the information is matched against state and federal disciplinary files to remove providers unauthorized from participation in government programs. Subsequently, the network is analyzed for the presence of core provider types and sufficient numbers of providers to ensure choice of primary and specialty providers.

The first part of the review is an electronic analysis based upon program parameters established by the Department to determine if each county has an

adequate number of the required core providers. The second part of the analysis is a manual review of reports that are produced. Examples of these reports include whether there are a sufficient number of providers in the county to provide a choice of primary and specialty providers and a comparison of providers not contracting with a specific MCO but who have contracts with other MCOs in the same county. The reports are then summarized and MCOs are notified of any access issues identified within their certified areas of operation. MCOs are required to review the summaries and report back to the Department. The Department will then have MCOs sign an attestation that members may obtain services on an out of network basis to the nearest provider, but not greater than 30 minutes or 30 miles from the members' residence. This attestation remains in place until the MCO is able to successfully address the noted provider inadequacy.

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);

The State will pay the PPS rate through the eMedNY FFS system for eligible Medicaid enrollees. For enrollees in Medicaid managed care, the State will make supplemental payments to eligible FQHC/RHC's to make up the difference between the PPS rate and the average managed care payment.

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 automated processes to help support a smooth interface among coverage and delivery system options that is seamless to beneficiaries;**

New York is working to simplify and align both our rules and processes in accordance with the ACA requirements, and to automate MAGI eligibility determinations and verifications to the maximum extent practicable, and to promote a more seamless customer experience.

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;

The State will provide quarterly and annual reports.

E. **Implementation**

i. By July 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;

As described above, New York will transition eligible childless adult enrollees in the Demonstration to Medicaid on January 1, 2014. Parents/caretakers will be transitioned at their renewal beginning April, 2014 to either Medicaid or QHP coverage.

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;

New York plans to provide appropriate notices that minimize demands on enrollees to the maximum extent possible.

Attachment 1

Core Provider Types for All Lines of Business.

NOTE: Data will be provided when it becomes available

July 1, 2014

Evaluation of OPWDD's Transformational Goals

Submission to the Centers for Medicare and Medicaid Services

Strategic Planning and Performance Measurement

Lead Author: Christine Muller, Ph.D.

Strategic Planning Director: Chris Nemeth

Attachment 3

BACKGROUND:

As a component of the Special Terms and Conditions for the Health System Transformation for Individuals with Developmental Disabilities, the New York State Office for People with Developmental Disabilities (OPWDD) submitted a draft evaluation plan, which was approved, to the Centers for Medicare and Medicaid Services (contained in the Appendix).

This report, guided by the evaluation plan, assesses the degree to which the transformational goals have been achieved and/or key activities have been implemented. The layout of the report is in accordance with the evaluation plan, with each of the transformational goals identified and associated measures provided, unless otherwise noted.

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TRANSFORMATION PLAN GOALS:

Goal 1: To improve the quality of services in line with person centered on planning and with a focus on individualized outcomes

OPWDD is committed to using planning processes that focus on outcomes. By partnering with individuals to create and document outcomes and assess whether outcomes are being met, we know if the planning and the supports provided are successful. Outcomes are not goals; they determine whether the person's goals are achieved.

Goal 1a: Implementation of the Council on Quality and Leadership's Person Outcome Measures

OPWDD has embraced the Council on Quality and Leadership's (CQL) Personal Outcome Measures (POMs) as the person centered quality of life measurement that will be used as a critical quality measure. Personal outcome measures enhance the quality improvement system to focus on quality from the perspective of the individual receiving services. It is anticipated that the POMs will help OPWDD to:

- Ensure a more person centered system – meaning that supports will better match each person's unique identified interests and needs, including opportunities for self-direction;
- Serve people in the most integrated settings possible and in the communities they choose to live;
- Provide for better integrated, holistic planning and supports for individuals; and
- Measure quality based on individualized outcomes.

The use of the CQL POMs will be incorporated into the system over time. Several provider agencies currently use POMs to support person centered planning. However, the largest and most systematic roll out of the POMs will occur when OPWDD transitions to delivering services through managed care entities - Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs).

OPWDD's managed care transition plans include several components that allow for monitoring the quality of life for individuals receiving services through DISCOs. The POMs interview process will be one method used in OPWDD's quality oversight plan. Specifically, DISCOs will be required to conduct annual CQL interviews on a representative sample of individuals receiving services from the DISCO. OPWDD will verify, through its own quality assurance division or through an external quality review organization, that the results of the POM interviews are used for continuous quality improvement within the DISCO.

Language that conveys our expectations about the implementation of the CQL POM interviews will be specified within the DISCO contract, which is currently under development. A high level summary of these expectations, to be conveyed within the contract, is as follows:

- The DISCO is required to use CQL certified interviewers to conduct CQL interviews using the CQL interview methodology.

- The DISCO may contract with other entities approved by OPWDD to obtain CQL certified interviewers or may obtain certification for its own staff or network provider staff.

- The DISCO will adhere to OPWDD CQL Practice Guidelines, which will include technical information about sampling and recruiting individuals for the interview.

- DISCOs will utilize the results of the CQL interviews for each individual interviewed in the planning and care coordination process and aggregated results for continuous quality improvement. DISCOs will trend performance on outcome achievement over several interview cycles and will be expected to adjust care coordination and service delivery practices based on the cumulative CQL interview data in conjunction with results from their other quality oversight practices.

- DISCOs will provide the results of the CQL interviews to OPWDD annually in the form and format specified by OPWDD and such results may be published by OPWDD or used in any manner deemed appropriate by OPWDD.

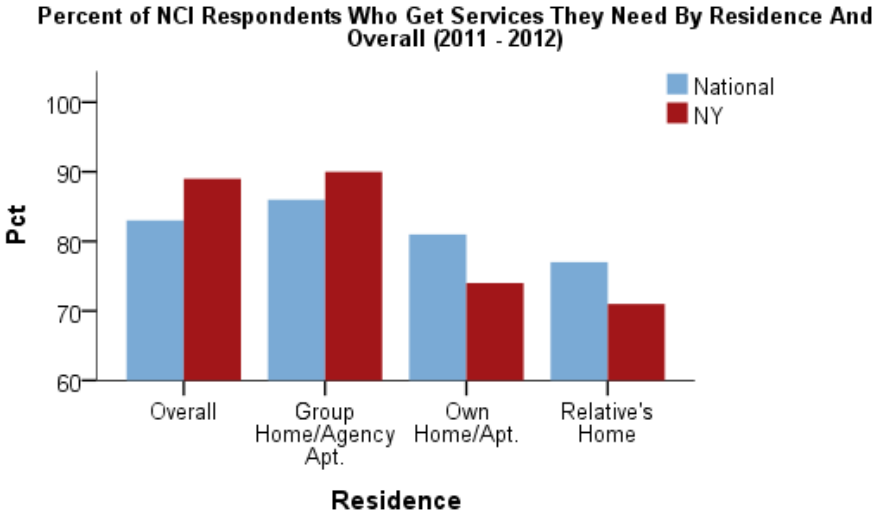
Summary on the progress on development of CQL protocols:

- ✓ Widespread use of CQL POMs will occur under managed care and is required via the DISCO contract
- ✓ DISCOs will use the aggregated results for continuous quality improvement, which will be verified by OPWDD
- ✓ DISCOs will be expected to track all 21 POMs and submit the data to OPWDD

Goal 1b: New York will show positive direction in system wide satisfaction trends for individuals receiving services

General Satisfaction with Services

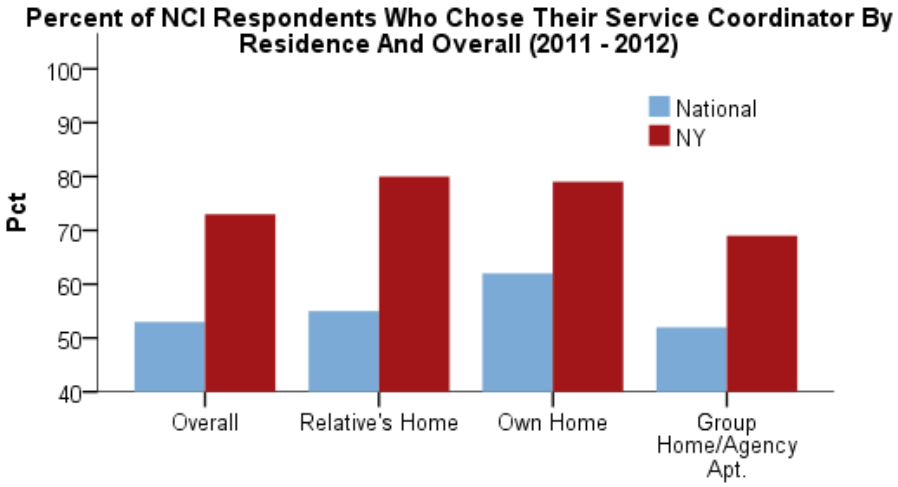
OPWDD has committed to reporting on a number of NCI indicators related to transformational goals. All indicators identified under goal 1b in the evaluation plan are analyzed within this section of the report except for the item relating to making changes to budgets (for individuals who self-direct services). That item is analyzed under goal 4, which provides information on progress in increasing the number of people who self-direct services. The most recent data is reported for each chart. The 2012-2013 collection cycle does not have sufficient data to break out results by living situation so the 2011-2012 data is presented. The 2013-2014 collection cycle is nearing completion and the data from that cycle is especially relevant given the evaluation timeframe of April 1, 2013 – March 31, 2014. The NCI data that is reported here acts as baseline data to compare to the 2013-2014 data, once available.

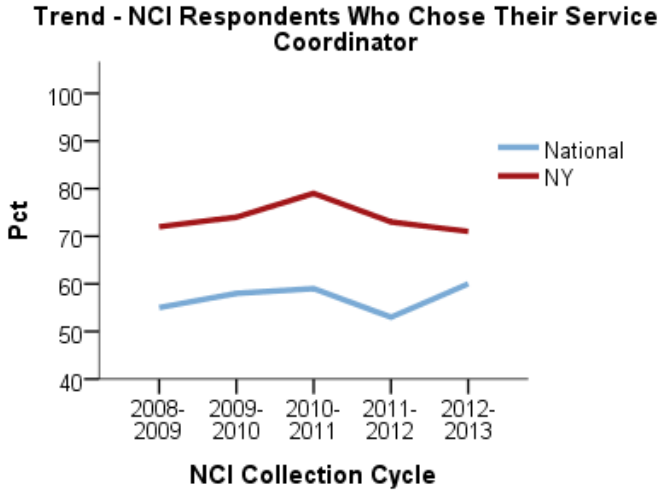


Summary on General Satisfaction:

- ✓ NYS, like many states, is more likely to have a smaller percentage of people respond that they get the services they need when living independently or with a relative, compared to those in a group home or agency operated apartment. This pattern is evident in the 2011-2012 cycle and holds for previous cycles.
- ✓ NYS increased from 85% to 89% positive responses between the 2008-2009 and 2012-2013 data collection cycles. Besides the downward spike in 2010-2011 (shown in the line graph), NYS responses have been fairly stable and even gained a few percentage points over time, while the national average has declined by a few percentage points .
- ✓ The percentage of people stating they are satisfied with health and medical services (an item NYS added to NCI) decreased from 93% to 87% between the 2011-2012 and 2012-2013 data collection cycles (not graphed).

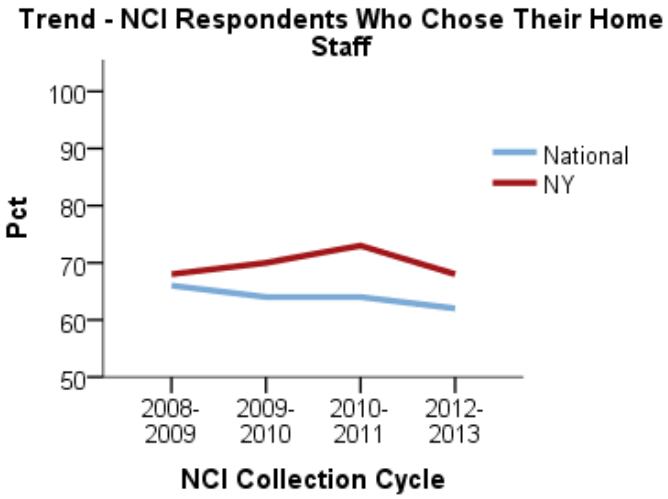
Choice of Staff



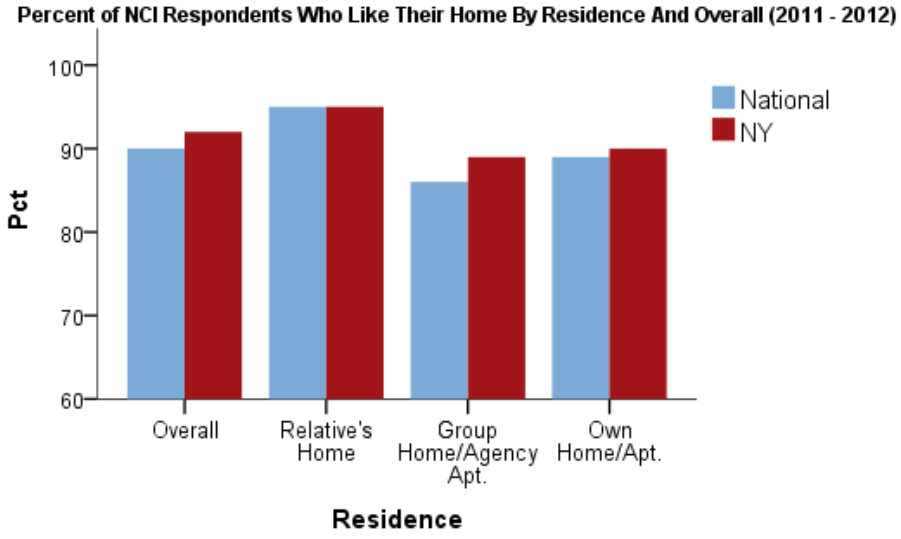


Summary of Staffing Choice:

- ✓ A higher percentage of individuals living either in a home of their own or a relative's home report having choice over their service coordinator compared to individuals living in a group home/agency apartment.
- ✓ NYS has consistently reported a higher percentage of people with choice over who provides service coordination compared to other NCI participating states (shown in 1st line graph).
- ✓ NYS has consistently reported a slightly higher percentage of people with choice over staff who help at home compared to other NCI participating states (shown in 2nd line graph)



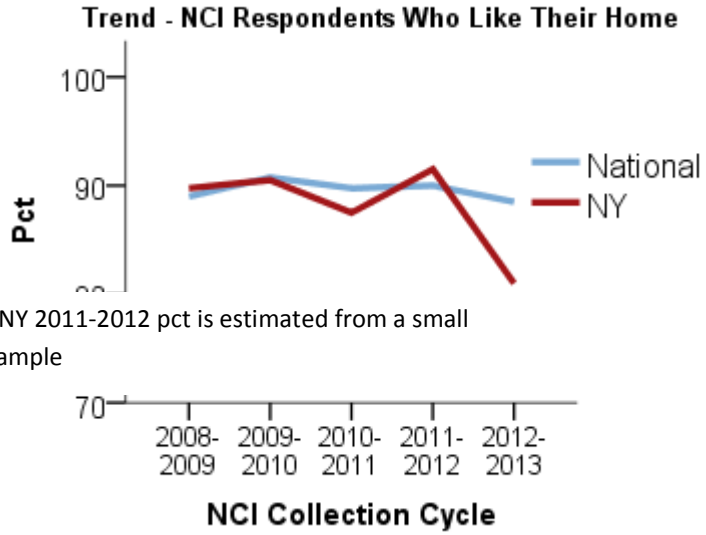
Satisfaction with Home



Summary of Satisfaction with Home:

- ✓ The NCI results suggest that the vast majority of people receiving services through OPWDD like where they live – this is true for people living with family, independently or in a group home/apartment.

- ✓ Historically, the percentage of people stating that they like their home has hovered at or just below 90% in NYS. This changed in 2012-2013 when this percent fell to 80%. The 2013-2014 data collection process is near completion. The results will determine whether this drop is likely to have occurred by chance or the decrease in satisfaction will be sustained, bolstering evidence there may be growing dissatisfaction in OPWDD's service system.



*NY 2011-2012 pct is estimated from a small sample

Goal 2: To ensure individuals are living in the most integrated setting possible, in accordance with the Olmstead decision.

OPWDD continues to work with individuals and families to provide people increased opportunities to live within the community. In 1975 over 20,000 individuals with a developmental disability lived in institutions, which decreased to approximately 1300 individuals by 2011. Goals 2a, 2b and 2d, as stated below, will be discussed together, as they are strongly related.

Goal 2a, 2b and 2d, respectively:

- **By January, 2014, New York will transition a total of 148 residents from the Finger Lakes and Taconic ICFs to community-based settings.**
- **Individuals transitioned will at least, in part, be eligible for and utilize the Money Follows the Person (MFP) process.**
- **The OPWDD system will be completely de-institutionalized.**

The Finger Lakes and Taconic ICFs closed on December 31, 2013 and residents transitioned to settings in the community. The timeline for decreasing the statewide institutional census is contained in the table below and was submitted in the October 2013 Transformation Progress Report.

Housing Options	August 1, 2013	2014	2015	2016	2017	October 1, 2018
Certified housing:						
SOICF- Campus	994	731	493	268	181	150
SO ICF- Community	659	593	504	428	257	0
VOICF	5669	5102	4337	3686	2211	456
IRA Supportive	2227	2326	2475	2624	2823	3221
IRA Supervised	26685	27088	27693	28298	29104	30721

Summary of Residential Transformation:

- ✓ Individuals formerly living in Finger Lakes and Taconic ICFs are now living in the community as the Developmental Centers are now closed, as reported in the Jan 1, 2014 Transformation Agreement Quarterly Report.
- ✓ Approximately 27% of individuals transitioned over the past fiscal year from institutions to community based setting qualified for MFP

OPWDD's goal was to reduce the census in campuses to no more than 731 people in 2014. This goal was achieved –

there were roughly 700 people living in institutions by the end of March 2014. Based on additional information since the submission of the April Transformation Agreement Quarterly Update, OPWDD assisted 447 individuals with developmental disabilities to move from institutional settings to community based settings between April 1, 2013 and March 31, 2014 across New York State. Of the 447 individuals, 121 individuals with developmental disabilities qualified for Money Follows the Person.

By October 2018, OPWDD will provide residential support to no more than 150 people within a campus setting and will not support anyone in state-operated community ICFs.

Goal 2c: Seven domains of quality of life of individuals transitioning from institutional care to a community based setting will be evaluated on an ongoing basis: living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.

The "Money Follows the Person Quality of Life Survey" was designed to measure quality of life for people transitioning from institutions to the community. The survey will be administered at three points in time: just prior to transition, 11 months after transition and 24 months after transition. As of mid-June 2014, there are only 11 people that have been in the program long enough to have an 11 month follow up QoL Survey. Due to the temporary of lack of data for the second collection cycle, this report will not present the pre/post transition comparison of QoL results. A more complete analysis will be conducted using all MFP QoL domains once most MFP participants pass the 11 month community transition mark. This report focuses on documenting the baseline data (data prior to transition) for several MFP QoL survey items and compares the baseline data to NCI results (where feasible) to document the difference between QoL for individuals residing in institutional settings compared to those in community residences. OPWDD will continue to examine the QoL survey results after community transition to track, what we expect, will be a lessening of that difference. Please note that though NCI and the MFP QoL survey contain some similar items, differences between the two results may stem from not only differences in living situation, but also from differences in the way items are worded. More detail on differences in survey language is included in the sidebar. The table below contains paraphrased items.

Item	MFP pct (baseline)	NCI pct (community	Difference

Detail on NCI and MFP QoL surveys

There is at least a 30 percentage point difference between those living in the community (group homes/agency apartments), with 80% of people living in the community claiming to like their home. There is possibly even a greater differential given that the NCI response reflects the percentage of people in the community that responded "Yes" to the questions of whether they liked their home. In contrast, MFP survey percentage includes counts those who said "Yes" or "Sometimes".

Approximately 75% of MFP QoL respondents said they felt safe at home while 89% of NCI respondents living in the community reported rarely feeling afraid or scared in their home.

A higher percent of NCI respondents claimed to have privacy compared to MFP QoL respondents. Please note the following difference in item wording between the two surveys: the MFP QoL survey asked respondents whether they could be by themselves while the NCI interview asked whether the individual has enough privacy at home.

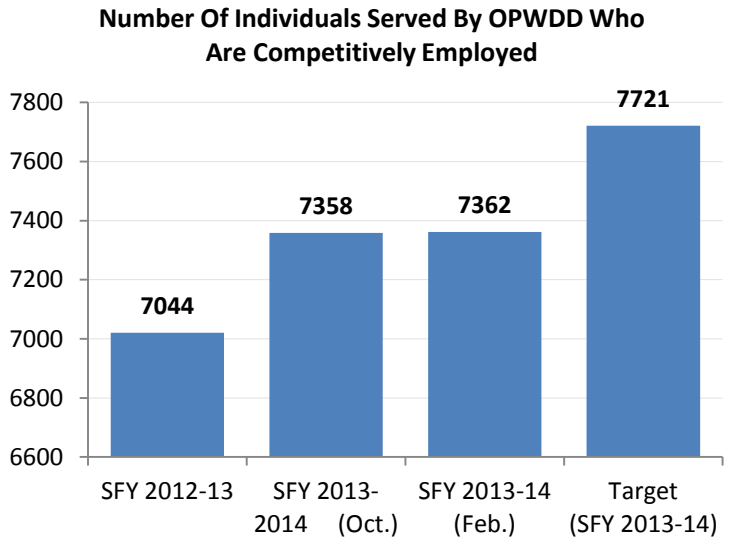
For each featured item in this report, the NCI results for people living in the community suggest that those living in the community experience higher satisfaction with their home situation compared to living in an institution. We expect the comparison between the MFP QoL baseline data and the 11 month post-transition data to support these results.

		residences 2012-2013)	
Likes home	52	82	30
Feels safe at home	75	81	6
Has privacy	74	89	15
Overall, is happy	73	-	-

Goal 3: To increase the number of individuals with developmental disabilities employed competitively in integrated employment at minimum wage or higher.

OPWDD's plan to increase competitive employment for people with DD involves facilitating access to ACCES-VR, implementing Pathway to Employment (described below), continuing to provide high-school students with job readiness training through the Employment Training Program and offering fees to providers to provide SEMP that are more competitive with the fees for other types of day services. More detail on OPWDD's plan to increase competitive employment can be found in the October 1, 2013 Transformation Agreement Quarterly Report.

Goal 3a: Increase the number of persons engaged in competitive employment through Supportive Employment



Summary of progress in increasing the number of individuals competitively employed:

- ✓ The latest count (February) portends that OPWDD will not meet its target of 700 (net) new people competitively employed during the 2013-2014 fiscal year.
- ✓ Significant growth in the number of people competitively employed is not expected to occur until summer of 2015
- ✓ Initiatives that are expected to drive an upward swing in the number of people competitively employed include Pathway to Employment and restructured fees.

A net increase of 318 individuals occurred between the baseline (SFY 2012-2013) and February 2014. OPWDD does not anticipate reaching the target of a 700 net increase from baseline to SFY 2013-2014. However, key initiatives that will drive increases in competitive employment are in the early phases of

implementation. Two of these, Pathway to Employment and restructuring supported employment fees are expected to drive an increase in the number of people who are competitively employed. Pathway to Employment provides person centered, comprehensive employment planning and support services, assisting participants to achieve competitive employment or self-employment. It is a focused, time limited service that engages a participant in identifying a career direction and provides instruction and training in pre-employment skills. OPWDD in partnership with the NYS Department of Health will establish new fees that will incentivize employment. These two initiatives are expected to have a positive impact on competitive employment by June 2015.

Goal 3b: New York will target youth as a priority in its employment initiative

OPWDD anticipates 2,296 students will be eligible for OPWDD services when they exit the educational system in 2014.

Data is not currently available to track the following:

- The number who enter ACCESS-VR
- The number who enter OPWDD because they are not found ready
- The number of transitioning youth who enter employment.

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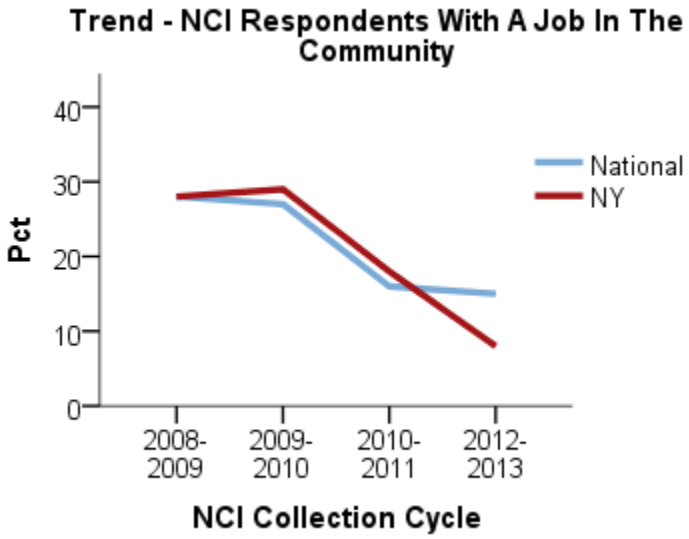
Goal 3c: Gauge the workforce participation satisfaction of individuals



011-2012
unavailable

The percent of individuals with a job in the community, as measured by NCI, plummeted precipitously since the 2008-2009 data collection cycle (the start of the national economic crash). This is true for people in NY and for people with DD interviewed across NCI participating states. These data, when examined alongside the NYS OPWDD increase in those competitively employed (reported in the transformation agenda) seem incongruous. However, our transformation agenda measures competitive employment numbers for individuals served through our Supported Employment option (SEMP), while NCI measures employment in the community across all adults provided services through OPWDD. Since the vast majority of people in OPWDD's service system are not recipients of SEMP, it is possible for the total percentage of those with a job in the community to decrease, as the number of those in SEMP with a job in the community increases over time.

In NYS, only 21% of people who have a job report that they would be interested in working somewhere else (a possible indicator of job dissatisfaction). Across all NCI participating states, 28% report they would like to work somewhere else.

For those without a job in NYS, 45% said they would like a job in the community.

Summary of Satisfaction on Workforce Participation:

- ✓ NCI results suggest a sizable minority of adults, almost half, in OPWDD's service system who do not have a job would like one.
- ✓ OPWDD's efforts toward increasing competitive employment occur primarily through Supported Employment.
- ✓ A comprehensive plan that describes efforts to achieve higher rates of competitive employment was submitted to CMS on October 1, 2013.

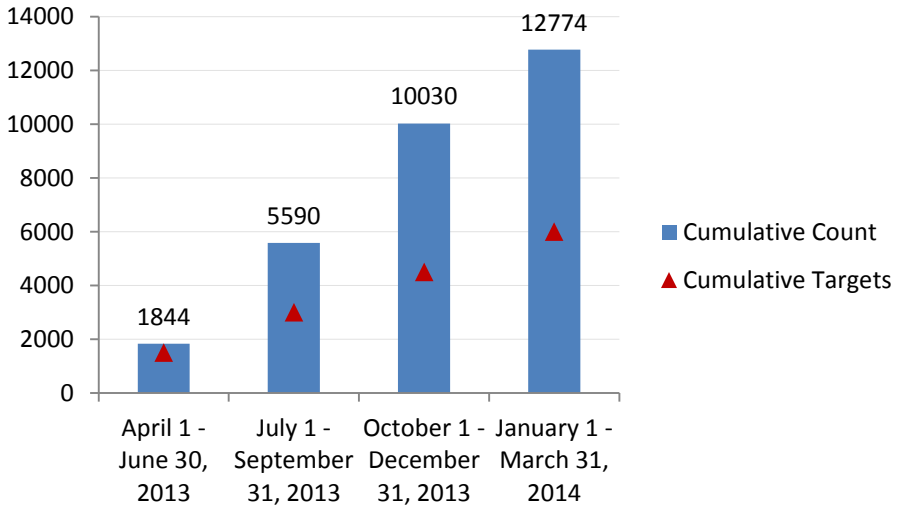
Goal 4: Increase the opportunity for individuals with developmental disabilities to self-direct their supports and services

The NYS Office for People with Developmental Disabilities is committed to provide opportunities for individuals to exercise the maximum amount of control over how they receive supports and services through self-directed support options, promoting personal choice and control over the delivery of waiver and state plan services, including who provides the services and how they are provided. Through employer and/or budget authority and the ability to customize plans of support, people with developmental disabilities can engage as full citizens in communities of their choosing. This means that self-directed Medicaid services participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services.

Goal 4a: New York will increase the number of people offered the option to self-direct their services through increased education to all stakeholders in a consistent manner statewide – the meaning of each element of self-direction will be fully explained to individuals with disabilities.

Educational efforts to promote self-direction primarily occur at the "Front Door" where staff members provide information to individuals and families new to OPWDD services about their options. OPWDD in partnership with CMS set a target of educating 1500 individuals on self-direction per quarter beginning April 1, 2013. By the end of the Fiscal Year, OPWDD had educated a total of 12,774 individuals, well exceeding our target.

Cumulative Count Of People Receiving Self-Direction Education Training

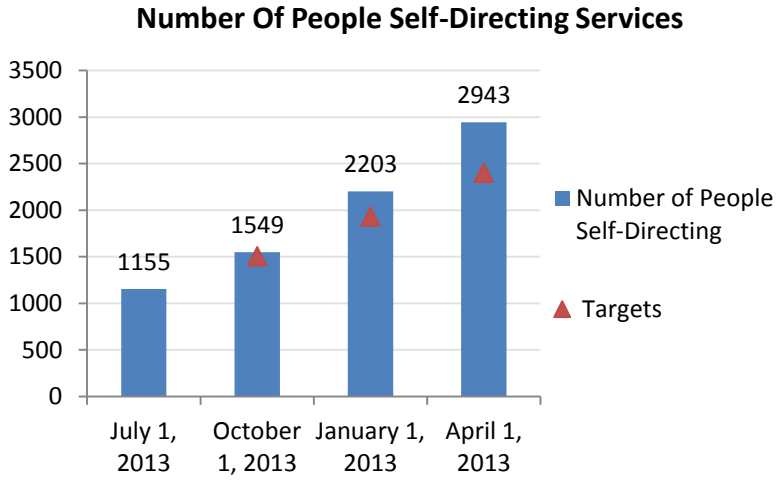


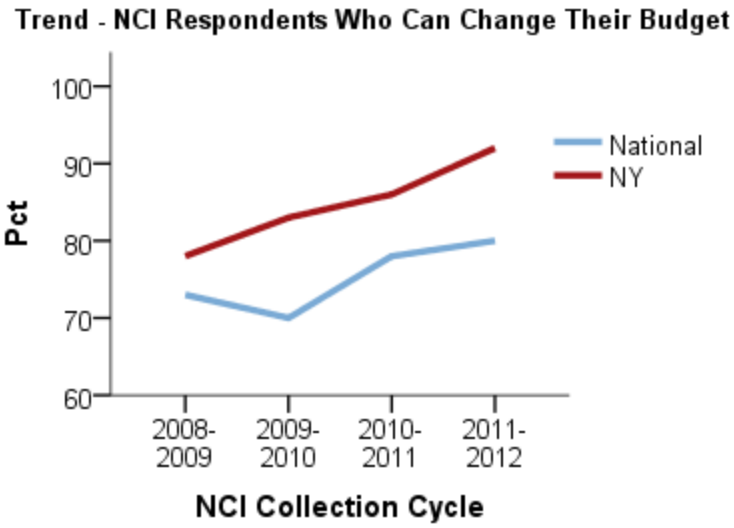
Summary of Progress on Educational Efforts on Self-Direction:

- ✓ OPWDD exceeded the target of educating 1500 people per quarter on self-direction. During the quarter of October 1 – December 31, 2013 OPWDD staff members educated 4440 people on self-direction, the greatest number of people educated in any quarter.

Goal 4B: More individuals with developmental disabilities will self-direct their services

OPWDD offers two options for self-direction. Individuals may choose the self-directed option for the Community Habilitation service (SDCH) or the Consolidated Supports and Services (CSS) model which provides individuals with a formal structured option within an HCBS service system. The resources that OPWDD is expending to educate individuals and families on self-direction may be one reason that OPWDD has been exceeding the targets for the number of people self-directing, as graphed below.





Summary of Progress on Self-Direction

- ✓ The number of people self-directing their services has exceeded quarterly targets.
- ✓ While the percentage of waiver enrollees self-directing services remains low, this percentage more than doubled from July 2013 to April 2014 (from 1.5% to 3.7%).
- ✓ NCI results have provided consistent evidence that individuals who self-direct can change their budgets if they choose to do so. The percentage of individuals who affirm this has been increasing steadily since the 2008-2009 data collection cycle. NYS has also had consistently higher positive responses compared to NCI participating states.

The demographic information on CSS participants is presented alongside the demographic information on waiver enrollees to explore whether there is unevenness in using self-directed services across different demographic breakout categories. One of the largest demographic differences between the OPWDD

waiver population and CSS participants is in the make-up of race and age. CSS participants are more likely to be white and between the ages of 22-35 compared to the waiver population. The difference in racial make-up is likely because self-direction has a stronger foothold in upstate NY, where the population is less diverse than the NY metro area. One possible explanation for the differences in age is that young adults (who are only now approaching the OPWDD service system after transitioning out of school) have the opportunity to access more information about self-direction, which is highlighted during the OPWDD's new intake process – the "Front Door." In addition (or alternatively) the administrative work associated with self-directing services may be less attractive to older individuals and more attractive to younger individuals who still have living parents and other near relative who act as strong members of circles of supports. These explanations are only conjecture at this stage, however it is clear that there are real demographic differences between people who choose to self-direct and the waiver service population.

		CSS participants		OPWDD waiver
Demographic	**Breakout**	**Number**	**Percent**	**Percent**
Region	NYC & LI	453	30.1	39.6
	Upstate NY	1051	69.9	60.4
Race/Ethnicity	White	1169	77.7	60.1
	Black	82	5.5	15.3
	Asian	15	1.0	1.9
	Native American	4	0.3	0.3
	Hispanic	31	2.1	9.1
	Unknown & Other	203	13.5	13.4
Age	21 and younger	366	24.3	25.7
	22 -35	758	50.4	29.8
	36-60	335	22.3	34.0
	61+	45	3.0	10.6
Gender	Male	950	63.2	60.4
	Female	554	36.8	39.6

Finally, OPWDD had committed to providing CMS with more information on the effectiveness of outreach methods for self-direction. Follow up on last year's self-direction information sessions revealed a great deal of local adaptation to deal with a big new initiative and involve as many individuals and families as possible. This extensive variety diminished the value that a single focus group would contribute towards understanding the effectiveness of outreach (exempting the unfeasible option of using participants grouped and gathered together from all regions of the state).

An alternative data source to help shed light on this issue is a large random sample survey of individuals and families who had participated in OPWDD's new 'Front Door' process for introductory information and intake processing. Individuals and families were surveyed on multiple aspects of the Front Door, including the content of its Information Sessions, which includes information on self-direction. The results from the survey indicate that respondents felt time allocated to self-direction was not sufficient. Often, self-direction was discussed at the end and was only cursorily addressed. However, respondents also indicated

that the Front Door staff was knowledgeable about self-direction, which meant that if individuals and families were interested they were able to receive information and follow up on their self-direction options. The survey also included positive feedback that individuals and families had not heard about self-direction before the information sessions which means that inclusion of self-direction in the information sessions has added value as an outreach approach.

SUMMARY:

In general, this report provided information on whether:

1. Infrastructure and activities are in place to support achieving transformational agenda goals
2. Process measures/supporting measures are pointing in a positive direction and
3. Quarterly targets are being achieved/objective measures are pointing in a positive direction.

Also presented are baseline satisfaction indicators associated with the transformational goals specified in the evaluation plan. All NCI items specified in the evaluation plan will be re-evaluated when the 2013-2014 data collection cycle is complete and these data can be compared to the baseline data presented in this report. The table below contains a global snapshot of OPWDD's progress related to each of the transformational goals, using the criteria bulleted above.

	Activities in place to achieve goals	Process /supporting measures are positive	Targets being achieved	Satisfaction indicators are positive
Goal 1: Improve quality of services with a focus on individual outcomes	Yes - CQL DISCO contract	Not applicable (not in first phase evaluation plan)	Not applicable (not in evaluation plan)	TBD once 2013-2014 NCI data is available
Goal 2: Ensure people live in the most integrated setting	Yes - Transition planning for each person	Yes - Many individuals qualify for MFP	Yes – De-institutionalization targets met	TBD once there is data for pre/post MFP QoL survey
Goal 3: Increase the number of people with DD who are competitively employed	Yes - Multiple initiatives from OPWDD's Competitive Employment Plan are in the early phase of implementation	Unknown - Data collection strategies for tracking youth transitioning to employment need further development	Not at this time – a substantial increase in competitive employment is not anticipated until initiatives are fully integrated into the service system	TBD once NCI 2013-2014 data is available.
Goal 4: Increase opportunities for self-direction	Yes - Options for self direction are in place in OPWDD service system	Yes – OPWDD exceeded targets for educating people about self-direction	Yes – OPWDD exceeded the targets for the number of people self-directing	Not applicable (not in first phase evaluation plan)

While this evaluation report was able to provide information on most of the agreed upon measures in the evaluation plan, some information is not currently available. OPWDD suggests that the next evaluation report provide follow-up analysis on the satisfaction indicators for goals one through three and a status report on the data collection mechanisms to track data related to transitioning youth to employment (listed under goal 3b). Data that are available and summarized in this report suggest that most agreed upon targets are being achieved and all transformational goals have activities in place that should support goal achievement in the foreseeable future.

Appendix: Approved Evaluation Plan for OPWDD Transformation Agreement

EVALUATION PLAN

New York Office for People with Developmental Disabilities

Service Delivery System Transformation Plan

Start Date of Plan Period:	July 1, 2013
End Date of Plan Period:	June 30, 2014

As a component of the Special Terms and Conditions (STCs) for the Health System Transformation for Individuals with Developmental Disabilities (Attachment H), the New York State Office for People with Developmental Disabilities (OPWDD) hereby submits this draft evaluation plan for approval to the Centers for Medicare and Medicaid Services (CMS).

This evaluation plan will assess the degree to which the transformational goals have been achieved and/or key activities have been implemented. The evaluation plan includes a discussion of the transformation's major goals and activities, and measures and data that will be used in the evaluation.

In accordance with the Special Terms and Conditions for the transformation agreement, the State will submit quarterly evaluation reports during the extension period, noting continuous progress toward the transformation plan goals.

OVERVIEW OF THE TRANSFORMATION PLAN

The transformation plan was approved as of April 1, 2013, to provide OPWDD with resources and guidelines to ensure high-quality, appropriate services for individuals with developmental disabilities served in Medicaid-funded programs overseen by the New York State Department of Health and Centers for Medicare and Medicaid Services.

The OPWDD transformation plan includes four major components:

- Offering opportunities for individuals moving from OPWDD campuses to live in smaller, more personalized settings.
- Establishing a strategy for increasing supportive housing options, and a timeline for the transitioning of residents of intermediate care facilities to community settings.
- Increasing the number of individuals in competitive employment by 700 within one year.
- Educating more than 6,000 stakeholders to increase the number of individuals who are self-directing their services in part or whole from 850 to over 2,000 in this fiscal year.

Goals and Major Activities

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

Reportable information consists of:

Key Transformation Agenda Reporting Elements	Reference	Reporting Frequency
Specific transition information for residents of Finger Lakes and Taconic ICFs including MFP utilization and new residential settings meeting HCBS requirements (occurring over the course of the transition)	Attachment H #4(a,b)	Each Quarter
Progress for increasing availability of supportive housing options	Attachment H #4(d)	Each Quarter
Progress toward increasing number of individuals engaged in competitive employment (includes updated counts in SEMP)	Attachment H #5(a)	Each Quarter
Number of individuals remaining in sheltered workshops	Attachment H #5(b)	Each Quarter
The number of students who are aging out of the educational system and who have been determined eligible for OPWDD services, the number who enter ACCES-VR, and the number who enter OPWDD because they are not found ready by ACCES-VR	Attachment H #5(d)	4th Qtr/Annual
Number of participant self-direction training/education sessions conducted and number of enrollees attending each session	Attachment H #6(b)	Each Quarter
Progress on approved evaluation design	Attachment H #3(a)(iv)(6)	Each Quarter

TECHNICAL APPROACH

As noted above, the primary goals of the transformation plan are to de-institutionalize OPWDD services, promote competitive supported employment and make available education and opportunities for the self-direction of services. To accomplish these goals, the transformation plan includes several key activities including transitioning individuals to alternate living arrangements, new workplaces and conducting education and outreach. This evaluation plan will assess the degree to which the key goals of the transformation plan goals were achieved and how the key activities of the transformation plan were implemented.

Evaluation Plan Approach

Designing the evaluation plan first involved a process to identify and document the transformation's key goals and activities (delineated across several agreements then structured around the reporting requirements and definitional guidance of the CMS Special Terms and Conditions).

The evaluation itself will align with the benchmarks set by CMS, which in turn will assess the degree to which the transformation has been effective in the key activities undertaken. Specific variables and measures are identified in this plan to correspond to each mandate of the transformation plan, along with the identification of appropriate data sources.

Analysis Plan

The evaluation team will seek to document and measure the effects of the transformation plan on observed outcomes in several ways:

1) The evaluation team will validate that targets set forth in the transformation plan agreement are reached with data which may be obtained from existing data systems, new systems created to augment the agency's current capacity, and/or direct analysis of deliverable products.

2) Where feasible, the evaluation will incorporate baseline measures for each of the selected variables included in the evaluation (baseline year may differ according to program activity). Data for each of the targeted variables and measures will be collected regularly so that changes in outcome measures and variables can be observed on a longitudinal basis.

3) The evaluation will compare rates of performance and measures with relevant State and national

benchmarks, where possible. Incorporating benchmark measures will allow for external comparisons of transformation progress to State and national trends.

The evaluation features described above (analysis of qualitative contextual information, the use of baseline measures, ongoing data collection, and benchmarking) are the means by which the evaluation team will fully determine the effects of the transformation plan. Evaluation conclusions will include key findings regarding the completion of the plan goals, as well as broad conclusions about the effects of the transformation as a whole.

In addition, the evaluation will include specific recommendations of best practices and lessons learned that may be useful for OPWDD, other States, and CMS.

TRANSFORMATION PLAN: EVALUATION GOALS, MEASURES, AND DATA

The evaluation template on the following pages forms the foundation of our plan by identifying and organizing the goals, outcome measures and data sources that will be used to measure the State's success in achieving the major goals of the transformation plan.

The table outlines four major goal areas, and concomitant measures and milestones:

- improve the quality of services in line with person centered planning and with a focus on individual outcomes
- ensure individuals are living in the most integrated setting possible, in accordance with the Olmstead decision
- increase the number of individuals with developmental disabilities employed competitively in integrated gainful employment at minimum wage or higher
- increase the opportunity for individuals with developmental disabilities to self direct their supports and services

The final evaluation report due to CMS by *June 30, 2014* will include all program components as detailed. Please also note that the timeframe of this evaluation plan pertains only to the planning stage of a managed care pilot, so no implementation or process measures are included this year. Furthermore, the eventual pilot will not fully integrate medical and habilitation care. At the appropriate time, updates to the evaluation plan will incorporate thorough assessment of integrated care coordination, but at this stage medical care and prevention performance measures are instead found in the state's Accountability Plan.

Evaluation Template for the New York State OPWDD Transformation Plan

Demonstration Period:

April 1, 2013 through March 31, 2014

Key goals, evaluation questions, measures/variables, activities and data sources for New York State

<u>Goal 1:</u> To improve the quality of services in line with person centered planning and

with a focus on individual outcomes			
	Transformational Goal	**Measures/Deliverables**	**Data Sources**
A)	New York will provide a report on its progress toward the development of CQL measures by September 1, 2013.	The progress report will include the state's work plan for the implementation of the measures, including: i. the roll-out of the measures ii. the specific outcome measures to be used, and iii. the baseline against which the measures will be compared.	Assessment and validation of finished product deliverable
B)	New York will show positive direction in system wide satisfaction trends for individuals receiving services	i. The number and percent of National Core Indicator (NCI) respondents who reported on the Adult Consumer Survey that the services and supports offered meet their needs ii. The number and percentage of NCI respondents who stated they are satisfied with their health and medical services ii. The number and percent of NCI respondents who responded that they were able to pick who comes to their planning meeting v. Number and percent of NCI respondents who report they can choose their own staff and/or service coordinator v. The number and percent of NCI respondents who report that their service planning meetings focused on what they want to do with their life vi. Number and percentage of NCI respondents who use self-directed supports who reported that they can make changes to their budget/services ii. Number and percentage of NCI respondents who stated they like where they live	NCI survey (annual statewide sample) - analysis of longitudinal trends over past 5 years, plus ongoing monitoring during transformation phases

<u>Goal 2:</u> To ensure individuals are living in the most integrated setting possible, in accordance with the Olmstead decision			
	Transformational Goal	**Measures/Deliverables**	**Data Sources**
A)	**By January 1, 2014**, New York will transition a total of 148 residents from the Finger Lakes and Taconic ICFs to community-based settings that meet CMS HCBS settings standards referenced in the 1915(i) Notice of Proposed Rulemaking published in the federal register in April 2012.	Milestones: i. 7 residents will be transitioned prior to July 1, 2013 ii. 20 additional people transitioned by October 1, 2013 iii. the remaining 121 persons transitioned by January 1, 2014	OPWDD Tracking and Billing System
B)	Individuals transitioned will at least in part be eligible for and utilize the MFP process.	**At least 30%** of those persons (or a total of 44 persons) transitioned from institutions, both campus-based and non-campus-based ICFs, will qualify for MFP (i.e. can be transitioned into an MFP qualified residence).	TABS/MFP Participant Tracking Report
C)	Seven domains of quality of life of individuals transitioning from institutional care to care in a community based setting will be evaluated on an ongoing basis: *living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction, and health status*	A quality of life survey (The **Money Follows the Person survey tool)** will be administered to all participants at three points in time— i. just prior to transition ii. about 11 months after transition, and **iii.** about 24 months after transition.	Compilation and analysis of survey data will allow for change score computations in all life quality domains, over periods i.– iii.
D)	The OPWDD system will be de-institutionalized completely.	By August 1, 2013, New York must submit a draft timeline for transition of the residents of the remaining campus and non-campus-based ICF's to community-based settings.	Assessment and validation of finished product deliverable
<u>Goal 3:</u> Increase the number of individuals with developmental disabilities employed competitively in integrated gainful employment at minimum wage or higher			

	Transformational Goal	Measures/Deliverables	Data Sources
A)	Increasing the number of persons engaged in competitive employment, through Supported Employment.	Milestones: i. Increase of individuals competitively employed by **700 persons above the previous 12 month enrollment, with no exceptions for attrition during the period of 4/ 2013 and 3/2014**. ii. New York will increase the number of persons in competitive employment by no less than **250 persons by October 1, 2013**, with no exceptions for attrition.	NYESS, provider reports
B)	New York will target youth as a priority in its employment initiative.	The state will report to CMS on an annual basis: i. the number of students who are aging out of the educational system and who have been determined eligible for OPWDD services ii. the number who enter ACCESS-VR iii. and the number who enter OPWDD because they are not found ready iv. the type of wrap around behavioral and/or medical supports available to youth as they transition from the educational system to competitive employment v. the number of transitioning youth who enter employment	TABS
C)	Gauge the workforce participation satisfaction of individuals	NCI survey questions: i. The proportion of individuals who have an integrated job in the community. ii. The proportion of individuals who do not have an integrated job in the community, but would like one iii. The proportion of individuals who would like to work somewhere else	NCI survey (annual statewide sample)

Goal 4: Increase the opportunity for individuals with developmental disabilities to self-direct their supports and services

	Transformational Goal	Measures/Deliverables	Data Sources
A)	New York will increase the number of people offered the option to self-direct their services through increased education to all stakeholders in a consistent manner statewide - the meaning of each element of self-direction will be fully explained to individuals with disabilities.	This outreach and education will be provided to at least 1,500 beneficiaries (with designated representatives as needed) per quarter beginning on April 1, 2013. New York will submit a quarterly report of the number of training/education sessions conducted and the number of persons attending the sessions. At year's end a focus group will be held to help learn the most helpful modes of outreach. The number and percent of HCBS waiver participants who were provided information to make an informed choice on whether to self-direct their supports and services during the service planning process.	Div of Person Centered Supports Tracking DQI field survey of care coordination
B)	More individuals with developmental disabilities will self-direct their services.	New York will provide a report to CMS no later **than July 1, 2013**, on the current number of persons with IDD and other disabilities who self-direct their services under this demonstration. New York will **enable a total of 1,245 new beneficiaries to self-direct services for the period of July 1, 2013 through March 31, 2014** subject to the following: i. By September 30, 2013, 350 new beneficiaries will self-direct services ii. By December 31, 2013, 425 new beneficiaries will self-direct services iii. By March 31, 2014, 470 new beneficiaries will self-direct services Final metric (from baseline to June 30 evaluation report): the increased number and percent of HCBS waiver participants who self-direct their supports and services with both employer authority and budget authority. Demographic and basic program data on people self-directing will also be included in future quarterly progress reports (initially limited to those in Consolidated	e-MedNy data

		Supports and Services).	

Partnership Plan - Medical Home Awards						
Designated State Health Program Disbursements						
Agency/Program		**08-09/11**	**10/11-9/12**	**10/12-9/13**	**10/13-9/14**	
DOH	**Claim Period**	**DY13**	**DY14**	**DY15**	**DY16**	**Available**
Childhood Lead Poisoning Primary Prevention	07-09/11	$1,453,405				$1,453,405
	10-12/11		$1,864,908			$1,864,908
	01-03/12		$2,185,854			$2,185,854
	04-06/12		$1,415,219			$1,415,219
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
Healthy Neighborhoods Program	07-09/11	$428,818				$428,818
	10-12/11		$586,458			$586,458
	01-03/12		$759,458			$759,458
	04-06/12		$142,328			$142,328
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
TB Treatment, Detection and Prevention	07-09/11					$0
	10-12/11					$0
	01-03/12					$0
	04-06/12					$0
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
TB Directly Observed Therapy	07-09/11					$0
	10-12/11					$0
	01-03/12					$0
	04-06/12					$0
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
General Public Health Work	07-09/11	$81,719,669				$81,719,669
	10-12/11		$54,395,249			$54,395,249
	01-03/12		$56,788,135			$56,788,135
	04-06/12					$0
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
Newborn Screening Programs	07-09/11					$0
	10-12/11					$0
	01-03/12					$0
	04-06/12					$0
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
Total DOH Programs		$83,601,892	$118,137,609	$0	$0	$201,739,501
Less Annual Match Healthy Neighborhood Programs		**-$257,000**	**-$257,000**			**-$514,000**
NET DOH		**$83,344,892**	**$117,880,609**	**$0**	**$0**	**$201,225,501**
Homeless Health Services - OTDA	07-09/11					$0
	10-12/11					$0
	01-03/12					$0
	04-06/12					$0
	07-09/12					$0
	10-12/12					$0
	01-03/13					$0
Total TDA		$0	$0	$0	$0	$0
Total DSHP Qualifying Expenditures		$83,344,892	$117,880,609	$0	$0	$201,225,501
Waiver Claim Proc on 10-12/13 CMS 64.9		**$83,344,892**	**$117,880,609**			**$201,225,501**

Adjustment to be processed in 10-12/13 CMS 64.9
Line 10B adj for 10/12-9/13 to be processed on 64.9 (original claims all submitted as Code 285 in Lump Sum Payments)
Line 8 Waiver adjustments to be processed on 64.9(dictated by DY below)

Medicaid Home Awards Reported on CMS 64.9 Base

Quarter	Total	Federal Share
10-12/13	$ 1,938,418.00	$ 1,938,418.00
7-9/13	$ 72,678,223.17	$ 72,678,223.17
4-6/13	$ 224,634.45	$ 224,634.45
1-3/13	$ 283,052.61	$ 283,052.61
10-12/12	$ 25,488,422.24	$ 25,488,422.24
7-9/12	$ -	$ -
4-6/12	$ -	$ -
Total	**$ 100,612,750.47**	**$ 100,612,750.47**

DSHP Programs to be matched $ 201,225,500.94

Line 8 Waiver	DY13	$ 83,344,892.00	7-9/11	$ 83,344,892
	DY14	$ 117,880,608.94	10-12/11	$ 56,846,615
			1-3/12	$ 59,476,447
			4-6/12	$ 1,557,547

Offset-current	10-12/13	$ 1,938,418.00
Line 10b Adj	7-9/13	$ 72,678,223.17
Line 10b Adj	4-6/13	$ 224,634.45
Line 10b Adj	1-3/13	$ 283,052.61
Line 10b Adj	10-12/12	$ 25,488,422.24
	Total Withdrawals	**$ 100,612,750.47**
	Current 10-12/13	$ 1,938,418.00
	PP Claims 12/12-9/13	$ 98,674,332.47

Partnership Plan - Medical Home Awards Jan -Mar 2014 CMS 64			
Designated State Health Program Claims Available			
Documented Cash Disbursements to Date			
Agency/Program			
		10/11-9/12	
DOH	**Claim Period**	**DY14**	
Childhood Lead Poisoning Primary Prevention	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
Healthy Neighborhoods Program	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
TB Treatment, Detection and Prevention	07-09/11		
	10-12/11		
	01-03/12		
	04-06/12		
	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
TB Directly Observed Therapy	07-09/11		
	10-12/11		
	01-03/12		
	04-06/12		
	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
General Public Health Work	01-03/12		
	04-06/12**	$2,033,330	
	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
	10-12/13		
Newborn Screening Programs	07-09/11		
	10-12/11		
	01-03/12		
	04-06/12		
	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
Total DOH Programs		$2,033,330	
NET DOH		**$2,033,330**	
Homeless Health Services - OTDA	07-09/11		
	10-12/11		
	01-03/12		
	04-06/12		
	07-09/12		
	10-12/12		
	01-03/13		
	04-06/13		
	07-09/13		
Total TDA		$0	
Total DSHP Qualifying Expenditures		$2,033,330	
** PARTIAL CLAIM			
Claim Proc on 1-3/14 CMS 64.9		**$1,016,665**	
DSHP expenditures to qualify		**$2,033,330**	

Federal-State Health Reform Partnership (F-SHRP)
Designated State Health Program Claim Sources
Demonstration Year 6 (October 1, 2011 - September 30, 2012)
Documented Cash Disbursements to Date

Agency/Program							
DOH	**Claim Period**	1-3/12 QER	7-9/12 QER	4-6/13 QER	7-9/13 QER	**1-3/14 QER**	Total
AIDS Drug Assistance Program	10-12/11	$3,909,434		$11,636,735			$15,546,169
	1-3/12		$0	$968,770			$968,770
	4-6/12			$11,072,157			$11,072,157
	7-9/12			$113,062			$113,062
Healthy New York	10-12/11			$182,400			$182,400
	1-3/12			$185,473			$185,473
	4-6/12			$1,073,472			$1,073,472
	7-9/12			$118,498,240	$37,663,252		$156,161,492
Tobacco Control Program	10-12/11			$10,108,585			$10,108,585
	1-3/12			$9,118,332			$9,118,332
	4-6/12			$7,618,122			$7,618,122
	7-9/12			$9,350,966			$9,350,966
Health Workforce Retraining	10-12/11			$2,019,921			$2,019,921
	1-3/12			$3,256,835			$3,256,835
	4-6/12			$552,374			$552,374
	7-9/12			$2,400,412			$2,400,412
Recruitment and Retention of Healthcare Workers	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
Pay for Performance Demonstration	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
Telemedicine Demonstration	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
Early Intervention Services	10-12/11			$32,066			$32,066
	1-3/12			$108,757			$108,757
	4-6/12			$13,934,254			$13,934,254
	7-9/12			$96,228,143			$96,228,143
OMH							
Local Assistance Programs	4-6/12					**$123,794,620**	$123,794,620
	7-9/12					**$123,794,620**	$123,794,620
SOFA							
Community Services for the Elderly	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
Expanded In-Home Services to the Elderly Prog	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
OMRDD							
Residential and Community Support Services	10-12/11						$0
	1-3/12						$0
	4-6/12						$0
	7-9/12						$0
OCFS							
Services to Special Education Children	10-12/11			$19,657,263			$19,657,263
	1-3/12			$26,700,790			$26,700,790
	4-6/12			$29,573,129			$29,573,129
	7-9/12			$14,106,781			$14,106,781
Total		$3,909,434	$0	$388,497,039	$37,663,252	**$247,589,240**	$677,658,965
Federal Share		$1,954,717	$0	$194,248,520	$18,831,626	**$123,794,620**	
Claims Reported to Date		$3,909,434	$3,909,434	$392,406,473	$430,069,725	**$677,658,965**	
Federal Share		$1,954,717	$1,954,717	$196,203,237	$215,034,863	**$338,829,483**	

Designated State Health Program Claim Sources

Demonstration Year 7 (October 1, 2012 - September 30, 2013)

Documented Cash Disbursements to Date

Agency/Program					
DOH	**Claim Period**	7-9/13 QER Claim	10-12/13 QER Claim	1-3/14 QER Claim	Total
AIDS Drug Assistance Program	10-12/12	$15,358,079			$15,358,079
	1-3/13	$4,359,823			$4,359,823
	4-6/13	$18,818,035			$18,818,035
	7-9/13				$0
Healthy New York	10-12/12	$822,562			$822,562
	1-3/13	$2,481,861			$2,481,861
	4-6/13		$1,383,256		$1,383,256
	7-9/13		$158,054,822		$158,054,822
Tobacco Control Program	10-12/12	$5,878,233			$5,878,233
	1-3/13	$9,349,215			$9,349,215
	4-6/13		$5,601,463		$5,601,463
	7-9/13		$7,596,408		$7,596,408
Health Workforce Retraining	10-12/12				$0
	1-3/13				$0
	4-6/13		$3,466,147		$3,466,147
	7-9/13		$2,962,326		$2,962,326
Recruitment and Retention of Healthcare Workers	10-12/12				$0
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
Pay for Performance Demonstration	10-12/12	$3,253,165			$3,253,165
	1-3/13	$5,309,981			$5,309,981
	4-6/13				$0
	7-9/13				$0
Telemedicine Demonstration	10-12/12				$0
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
Early Intervention Services	10-12/12	$11,249,943			$11,249,943
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
OMH					
Local Assistance Programs	10-12/12			$123,794,620	$123,794,620
	1-3/13			$36,838,391	$36,838,391
SOFA					
Community Services for the Elderly	10-12/12				$0
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
Expanded In-Home Services to the Elderly Prog	10-12/12				$0
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
OMRDD					
Residential and Community Support Services	10-12/12				$0
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
OCFS					
Services to Special Education Children	10-12/12		$15,917,705		$15,917,705
	1-3/13				$0
	4-6/13				$0
	7-9/13				$0
Total		$76,880,897	**$194,982,127**	**$160,633,011**	$432,496,035
Federal Share		$38,440,449	$97,491,064	$80,316,506	
Claims Reported to Date		$76,880,897	$271,863,024	$432,496,035	
Federal Share		$38,440,449	$135,931,512	$216,248,018	
HEAL EXP 1-3/14			**$408,222,251**		
DSHP Waiver Fed Share			$204,111,126		
4-6/12 Waiver #6					**$123,794,620**
7-9/12 Waiver #6					**$123,794,620**
10-12/12 Waiver #7					**$123,794,620**
1-3/13 Waiver #7					**$36,838,391**