Partnership Plan
Section 1115 Quarterly
Demonstration Year: 16 (10/1/2013 – 9/30/2014)
Federal Fiscal Quarter: 2 (01/01/2014 – 03/31/2014)

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 8/1/11 through 12/31/14, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team.

New York State has formally requested approval to extend the 1115 Demonstration for five years. 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.

In addition, on September 29, 2006, New York State received approval for a five-year 1115 demonstration entitled Federal-State Health Reform Partnership (F-SHRP). F-SHRP focused on restructuring the health care delivery system by: reducing excess capacity in its acute care hospital industry; shifting emphasis in long-term health care services from institutional to a community –based setting consistent with the President's New Freedom Initiative by reducing nursing home excess capacity and worker retaining investing in health information technology initiatives, including e-prescribing, electronic medical records and regional health information organizations; and reorienting New York's health care system away from inpatient facilities to outpatient and primary-care focused delivery systems, including pay–for-performance initiatives. This was effective October 1, 2006 through September 30, 2011. On March 31, 2011 F-SHRP was extended for three years, April 1, 2011 through March 31, 2014;

On November 27, 2013, a Phase-Out Plan focusing on transitioning remaining F-SHRP members into the Partnership Plan and addressing continuation or expiration of other F-SHRP components was submitted to CMS. The Phase-Out Plan has been implemented.

II. Enrollment : Second Quarter

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
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 under 1 through 20 in mandatory MC counties as of 10/1/06	**1,652,627**	**39,982**	**58,343**
Population 2 - TANF Adults aged 21 through 64	**495,495**	**15,856**	**19,505**

in mandatory MC counties as of 10/1/06			
Population 3 - SN Adults	**880,139**	**22,119**	**28,533**
Population 4 - FHPlus Adults with children	**327,060**	**9,235**	**14,926**
Population 5 – FHPlus Adults without children	**10,948**	**1,837**	**1,685**

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Total # Voluntary Disenrollments in Current Demonstration Year[1]	**88,939**

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]	**122,992**

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 3.1 million. Currently, 2.2 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).

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

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 17 Job Centers.

The Education and Enrollment Driven Referral (EED) process was responsible for 84% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 14 consumers per work session. A work session covers a half day of work activities.

A total of 2,649 presentations were scheduled by NYMC. Of these, 584 or 22% 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.

New York will phase out the Family Health Plus (FHplus) program from the Waiver and transition childless adults, parents and caretaker relatives with incomes up to and including 133% FPL into state plan coverage.

CMS approved expenditure authority to allow the state to claim federal matching dollars for a designated state health program (DSHP) that will provide 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.

An additional DSHP was approved that will allow federal matching dollars to provide FHPlus benefits to parents and caretaker relatives up to 150% FPL this allows for continued funding through the full phase-out of the program.

B. Health Plans

1. Changes to Certificates of Authority:

- SCHC Total Care COA updated 10/18/2013
  Acquired by Today's Options of New York, Inc.

- Name change for Total Care. The COA was updated 12/02/2013
  The new name is **Syracuse** Community Health Center Managed Care Holding Company, Inc. Added a limitation to the COA
  -precluded from marketing and enrollment. Run out activities only.

- Today's Options of New York, Inc. DBA Total Care was issued a COA on10/18/2013.
  Acquired SCHC Total Care, Inc.

Approved for Medicaid, FHP and CHP in Cortland, Onondaga and Tompkins Counties.
Approved for CHP in Oswego County.

- United Healthcare of New York, Inc had COA amended on December 1, 2013 to reflect its service area expansion for the Medicaid, Family Health Plus programs to the following Counties:
  Lewis, Ontario, Seneca, and Wayne.
  Also as of December 1, 2013 they added a MLTC Partially Capitated line of Business for Albany, Broome, Erie, Monroe, Oneida, Onondaga, Orange and Rockland Counties.

- MVP had its COA updated on December 17, 2013 to reflect the service area expansion to Genesee, Livingston Monroe and Ontario Counties for Child Health Plus.

MVP Health Plan, Inc.

- removal of MMC/FHP/CHP products from Dutchess and Ulster Counties effective January 1, 2014

- approval of CHP product in Genesee, Livingston, Monroe and Ontario Counties effective December 17, 2013

- approval of Medicare product in Westchester County effective February 3, 2014

United Healthcare of New York, Inc.

- approval of MMC/FHP products in Lewis, Ontario, Seneca and Wayne Counties effective January 1, 2014.

2. Routine surveillance activity for the quarter included operational surveys for the following plans:

- VNSNY Choice SNP: the survey was conducted December 4-5, 2013 and the plan was found to be in substantial compliance.

- Independent Health Inc.: The survey was conducted November 18-22, 2013. Correspondence issuing the results in pending.

No problems were found with access to health plan telephone lines during the Member Services phone survey conducted during the Period of October 1, 2013 to December 31, 2013.

Surveillance/Monitoring activities - FFY 2nd quarter 2014 (1/1/14 to 3/31/14)

New York State Catholic Health Plan, Inc.

- The survey was conducted January 13-16, 2014. No deficiencies were cited.

AMERIGROUP of New York, LLC:

- The survey was conducted February 24-27, 2014, and a Statement of Deficiency issued on March 28, 2014.

3. Routine provider directory surveys were conducted for 16 Medicaid Managed Care Plans (mainstream) and 3 HIV SNP plans with results issued in this quarter. Where deficiencies were

found, plans are required to provide plans of corrections. The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:

Capital District Physicians' Health Plan, Inc.
Excellus Health Plan, Inc.
HealthNow New York, Inc.
Independent Health Association, Inc.
MVP Health Plan, Inc.
Affinity Health Plan, Inc.
AMERIGROUP New York, LLC
Amida Care, Inc.
New York State Catholic Health Plan, Inc.
HealthFirst PHSP, Inc.
Health Insurance Plan of Greater New York
MetroPlus Health Plan, Inc.
MetroPlus Health Plan, Inc. Special Needs Plan
VNS Choice SNP
UnitedHealthcare of New York, Inc.

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.

D. Waiver Deliverables

1. Medicaid Eligibility Quality Control Plan (MEQC)

- MEQC 2008 – Appropriateness of Applications Forwarded to LDSS Offices by Enrollment Facilitators:

  Review activities were transitioned to the Department review staff for completion because the project agreement that supported this review expired. During the reporting period, the Department continued to compile the review results and draft a final summary.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Redeterminations 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 Health Benefit Exchange).

Implementation of the revised approach began in September 2013. Progress continues to be made with several of the universes; however, the process is labor intensive and very time consuming. A letter requesting copies of case records will be issued to the appropriate districts once the universes are successfully generated.

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

  Initial, peer, supervisory and quality assurance reviews have been completed. PHPG is in the process of drafting a summary report for review by the Department. It is expected that the final summary report will be issued on or about 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

  PHPG continued to finalize all reviews (initial, peer and supervisory), and record the results in their central database. PHPG also prepared an interim analysis for discussion purposes. It is expected that the Department will conduct quality control reviews in January 2014 and that a final summary report will be issued on or about March 31, 2014.

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

See Attachment 3 – DD Transformation.

E. Benefit Changes/Other Program Changes

Home Delivered Meals and Medical Social Services: Effective April 1, 2013, these two services were added to the Medicaid managed care benefit package for enrollees who have transitioned to a MMMC plan from the Long Term Home Health Care Program (LTHHCP) and were receiving home delivered meals under the LTHHCP. This addition to the benefit package will prevent the loss of access to this service for LTHHCP participants upon MMMC enrollment and may reduce the risk of failure for these specific enrollees to remain in the community.

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

Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC): The Department is awaiting authorization from CMS regarding the addition of ADHC and AIDS ADHC to the Medicaid managed care benefit package. These programs are designed to assist individuals to live more independently in the community or to eliminate the need for residential health care services. Individuals currently in receipt of these services will receive 90 days of transitional care with the current care plan, or until the MCO authorizes an alternate care plan, whichever is later. This addition to the benefit package will prevent the loss of access to this service for MMMC enrollees who transition from fee-for-service Medicaid and may reduce the risk of failure for these specific enrollees to remain in the community.

Directly Observed Therapy for Tuberculosis (TB/DOT): The Department is awaiting CMS approval to include TB/DOT in the Medicaid managed care benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

Hospice services: The Department received CMS approval to include Hospice services to the Medicaid managed care benefit package. Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care.

F. Federally Qualified Health Services (FQHC) Lawsuit

CHCANYS, et al vs NYS Dept of Health -- The case remains pending on appeal before the Second Circuit Court of Appeals (federal court), with both sides having filed appeals from different elements of District Court Judge Carter's February, 2013 decision.

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 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.

   - During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.

   - 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.

   - 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, 2 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 2 service area expansions. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.

   - 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.

- 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.

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

- 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 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 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).

2. Significant Program Developments

   - Initial mandatory enrollment process completed in NYC.
   - Mandatory initiative moving into Nassau, Suffolk and Westchester counties.
   - Continued incorporation of community based LTSS into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
   - Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
   - Continuity of care assured through transition period.
   - Monitoring of network capacity, delivery systems and coordination of care.
   - Development of data gathering systems to meet terms and conditions reporting requirements.
   - Development and submission of waiver amendments for the 1915 c LTHHCP.
   - 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.
   - 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.

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 for the reporting 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.

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

Period: 1/01/14 – 3/31/14			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	7714	7714	100%
# Standard/Expedited	1213	1074	89%
Total for this period:	8927	8788	98%

Period: 1/01/14 – 3/31/14	
Appeals	
Total appeals filed for this period:	
Total for this period:	14

Period: 1/01/14 – 3/31/14	
Grievances	
Reason for Grievances	**Total**
Dissatisfaction with quality of home care (other than lateness or absences)	**970**
# Same Day	700
# Standard	266
# Expedited	4
Home care aides late/absent on scheduled day of service	**849**
# Same Day	736
# Standard	113
# Expedited	0

Period: 1/01/14 – 3/31/14	
Dissatisfaction with quality of day care	**12**
# Same Day	3
# Standard	9
# Expedited	0
Dissatisfaction with quality of other covered services	**340**
# Same Day	243
# Standard	95
# Expedited	2
Dissatisfaction with transportation	**5728**
# Same Day	5316
# Standard	408

# Expedited	4
Travel time to services too long	**14**
# Same Day	8
# Standard	6
# Expedited	0
Wait too long to get appointment or service	**74**
# Same Day	51
# Standard	23
# Expedited	0
Waiting time too long in provider's office	**2**
# Same Day	2
# Standard	0
# Expedited	0
Dissatisfaction with care management	**174**
# Same Day	126
# Standard	48
# Expedited	0
Dissatisfaction with member services and plan operations	**211**
# Same Day	168
# Standard	43
# Expedited	0
Dissatisfied with choice of providers in network	**26**
# Same Day	21
# Standard	5
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**9**
# Same Day	5
# Standard	4
# Expedited	0
Language translation services not available	**5**
# Same Day	1
# Standard	4
# Expedited	0
Hearing/vision needs not accommodated	**2**
# Same Day	0
# Standard	2
# Expedited	0
Disenrollment issues	**21**
# Same Day	8
# Standard	13
# Expedited	0
Enrollment issues	**9**
# Same Day	4
# Standard	5
# Expedited	0
Plan staff rude or abusive	**32**

# Same Day	11
# Standard	21
# Expedited	0
Provider staff rude or abusive	**87**
# Same Day	65
# Standard	22
# Expedited	0
Violation of other enrollee rights	**18**
# Same Day	16
# Standard	2
# Expedited	0
Denial of expedited appeal	**0**
# Same Day	0
# Standard	0
# Expedited	0
Other:	**344**
# Same Day	230
# Standard	113
# Expedited	1
Total for this period:	**8927**
# Same Day	7714
# Standard	1202
# Expedited	11

Period: 1/01/14 – 3/31/14	
Reason for Appeal	**Total**
Denial or limited authorization of service including amount, type or level of service	**277**
# of Standard Filed	263
# of Expedited Filed	14
Reduction, suspension or termination of previously authorized service	163
# of Standard Filed	157
# of Expedited Filed	6
Denial in whole or part of payment for service	**1174**
# of Standard Filed	1174
# 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	**11**
# of Standard Filed	9
# of Expedited Filed	2
Total appeals filed for this period:	**1625**
# of Standard Filed	1603
# of Expedited Filed	22

Period: **1/01/14 – 3/31/14**	
Fraud and Abuse Complaints Reported during Quarter	50

Period: 1/01/14 – 3/31/14	
Reason for Complaints	**Total**
Home Health Care- unspecified	86
Billing- provider questions on coverage/payer	27
Billing- claims denied in error	24

- **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.

- **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.

- **Consistency of reporting has improved over the last quarter of 2012, but data discrepancies indicate that continued education and refining instructions is necessary.** Raw data shows total assessments conducted by MLTC plans during the period is 3,491. Of those, only 1,598 were conducted within the 30 day time frame, 1,899 were not. This represents less than 50% compliance with the base timeframes, however non compliance is appears to be isolated to certain plans. The State's enrollment broker NYMC has provided additional education regarding reporting and a steady improvement in quality and timelines is apparent. The Department issued notification that effective next quarter (July) plan specific remedial actions will be taken as indicated. Data improvement noted.

- **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.

- **Referrals outside enrollment broker (consumers who were referred but did not qualify for the 30 day age calculation because of bad dates in date field):** 158 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **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: 10/1/13-12/31/2013	
Rebalancing Efforts	
Number of Individuals enrolled in the plan from a nursing home	234
Number of Enrollees admitted to a nursing home but returned to the community	618
Number of Enrollees permanently admitted to a nursing home	349

Period: 1/1/14-3/31/2014	
Rebalancing Efforts	
Number of Individuals enrolled in the plan from a nursing home	**163**
Number of Enrollees admitted to a nursing home but returned to the community	**1971**
Number of Enrollees permanently admitted to a nursing home	**883**

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 7 is $76,880.897.

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; and have a process in place to collect payments from third party payers. For the year 2011, 112 Diagnostic &Treatment Centers (D&TCs) and 190 MH clinics were determined to be potentially eligible to receive funding for this program and

provided over $214 million in uncompensated care services to the uninsured. Of these, 76 D&TCs and 124 MH clinics met the qualifying criteria described above and received $98.6 million and $10.2 million respectively from the indigent care funding which covered approximately 50% on average of their uncompensated care costs. The numbers are similar for 2012: 112 D&TCs and 195 MH clinics were potentially eligible and provided over $207 million in uncompensated care; 76 D&TCs and 98 MH clinics met the qualifying criteria and received $99.1 million and $9.7 million respectively which, on average, covered approximately 50% of their uncompensated care costs. It is important to note that for each year after the receipt of the indigent care funding approximately $100 million in uncompensated care costs remained that impacted the provider's financial condition.

New York is requesting an amendment to the Partnership Plan to extend the Clinic Uncompensated Care Funding authorized in STC 58, which is currently due to expired December 31, 2013. The proposed amendment would extend the federal funding agreement through December 31, 2014.

New York is currently in discussion with CMS to transition and extend certain Designated State Health Programs (DSHPs) currently authorized under the Federal-State Health Reform Partnership (F-SHRP) Demonstration (due to expire March 31, 2014) and Partnership Plan DSHPs (due to expire December 31, 2014) through December 31, 2019.

VI. 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. Fifteen months into the project, hospitals continue actively implementing residency changes, patient-centered medical home transformation of participating outpatient sites, and the chosen care coordination and inpatient projects contained in their work plans to meet the program requirements.

PROGRAM ACCOMPLISHMENTS:

Reallocation of funding among the 61 hospitals continues to occur based on program changes, hospital closures and mergers, and residency program and continuity clinic changes.

Provided continuous clinical and technical support to 61 hospitals and 159 sites.

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 (IPRO) and within the NYS Department of Health (NYS DOH).

Implemented a process for all sites participating in the Care Transition & Medication Reconciliation project to submit a Patient Registry, allowing the NYSDOH to link reported data with claims data and begin validating and analyzing the submitted lists. Information will be used to evaluate the impact of medication reconciliation on outpatient avoidable readmissions.

According to hospital submissions in the 2013 Q4 time frame:

- 93% of sites have residents that have been assigned to a panel of patients.

- 47% of all sites have achieved Level 3 National Committee on Quality Assurance (NCQA) PCMH Recognition under the 2011 standards.
- Out of 53 sites, 60% showed improvement in decreasing the amount of time required to see a specialist
- Analysis of outpatient medication reconciliation across hospitals led to a 41% reduced risk of readmission
- Breast Cancer Screening: Out of 28 sites, 89% showed improvement in their Q4 rates compared to their baseline rates.
- Of sites that reported, 96% showed improvement in screening for depression.
- The number of sites reporting data correctly has grown each quarter with continued education and support by NYS DOH.

All hospital-reported data submitted through the web tool is now being aggregated in summary reports for each domain. Summary reports are used to determine the quality and completeness of reporting as well as site progress. The content in the reports vary by domain, but generally display the number of sites improving on certain metrics since the previous quarter, the number of sites reporting on a given metric, and the number of sites answering either 'yes' or 'no' to required questions about meeting milestones in each domain.

Received and reviewed the 2013, 4th quarter and Annual information from sites and provided feedback to the hospitals regarding the quarterly and annual submission. Data received included re-formatted goal rates from all hospitals and sites for metrics related to clinical performance, resident continuity, care coordination and integration, and inpatient projects. Reformatted goal rates will allow for comparison between the rate being reported for each measure and that measure's goal.

Held a one-day statewide conference on January 23, 2014 for Hospitals' Executive staff, Residency Program Directors, Primary Contacts for the demonstration and Residents. With over 300 attendees, 92% rated the overall value of information at the conference as excellent. The day included presentations on the critical components of this demonstration and a poster session that detailed project initiatives, best practices, and other innovative ideas that hospitals have implemented as a result of the demonstration on topics such as improving the primary health care for Medicaid members, improving workforce training and measure reporting capabilities.

Modified the project website to make publicly available all important aspects of the conference including the brochures, the posters, abstracts, morning plenary and the Keynote speaker presentation.

Held a coaching call on PCMH with a representative from NCQA as a guest speaker to provide additional information on the recognition process.

Began conducting site visits throughout NYS to learn about the accomplishments, changes and challenges hospitals are facing during this demonstration program.

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

ADMINISTRATIVE AND POLICY CHALLENGES

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

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

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

PLANNED ACTIONS FOR THE NEXT QUARTER

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

Receive and review Year 2 (2014) Quarter 1 report.

Continue site visits with hospitals and outpatient primary care sites.

Implement regular educational coaching calls as a result of survey feedback. In Q2 2014, a coaching call is planned on the topic of Regional Health Information Organizations (RHIOs).

Receive notification of hospitals' outpatient sites achieving NCQA PCMH Recognition by the end of Q2 2014.

Continue to collaborate with Hospital and Professional Associations to clarify the demonstration components and support hospitals.

Develop measure categories and composite measures in each domain to better evaluate demonstration effects and individual hospital / clinic achievements.

Consumer Issues

A. Complaints

On November 1, 2013, the Bureau of Consumer Services was formed in the Division of Health Plan Contracting and Oversight, to focus existing staff resources and improve consistency in response and investigation of consumer and provider managed care complaints.

Medicaid managed care plans reported 5,009 complaints/action appeals this quarter, an increase of 10% from the previous quarter. Of these complaints/appeals, 523 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 28% of the total. There were 324 complaints/appeals reported by the HIV SNPs. The majority of these complaints (236) were in the category of reimbursement/billing. The Department directly received 257 Medicaid managed care complaints and 8 FHPlus complaints this quarter.

The top 5 most frequent categories of complaints were as follows:

28% Balance Billing
23% Reimbursement/Billing Issues
7% Pharmacy
7% Emergency Services
6% Dental or Orthodontia Services

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	2
Non-Permanent Residential Health Care Facility	0
Personal Care Services	9
Personal Emergency Response System	0
Private Duty Nursing	0
Total	11

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

On December 19 2013, the Medicaid Managed Care Advisory Review Panel (MMCARP) met and discussed the following: Statutory Language; Managed Long Term Care Update; Auto-Assignment Rates; Explanation of Spenddown Process and Technical Problems with Spenddown; and Mail Order Pharmacy Issues.

C. Managed Care Policy and Planning Meetings

The Managed Care Policy and Planning meetings were held on July 18, August 15 and September 19, 2013. The July meeting included presentations on: Finance and Rate Development, Average Acquisition Cost (AAC)/Cost of Dispensing (COD), OPWDD DISCO/FIDA Update, Discussion of Exchange/Medicaid Update, Behavioral Health Update, and Early Intervention/Fiscal Agent.

The August meeting agenda included: Finance and Rate Development, FIDA Update, Behavioral Health/HARP Update, OMIG Managed Care Review Activities, and Encounter Data Monitoring.
Presentations at the September meeting included: Emergency Preparedness, Finance and Rate Development, FIDA Update, New York City Flu Immunization Program, Behavioral Health/HARP, Discussion of Basic Benefit Information, Encounter Data Monitoring, and an update on New York State of Health Exchange for the Medicaid/Child Health plus Programs.

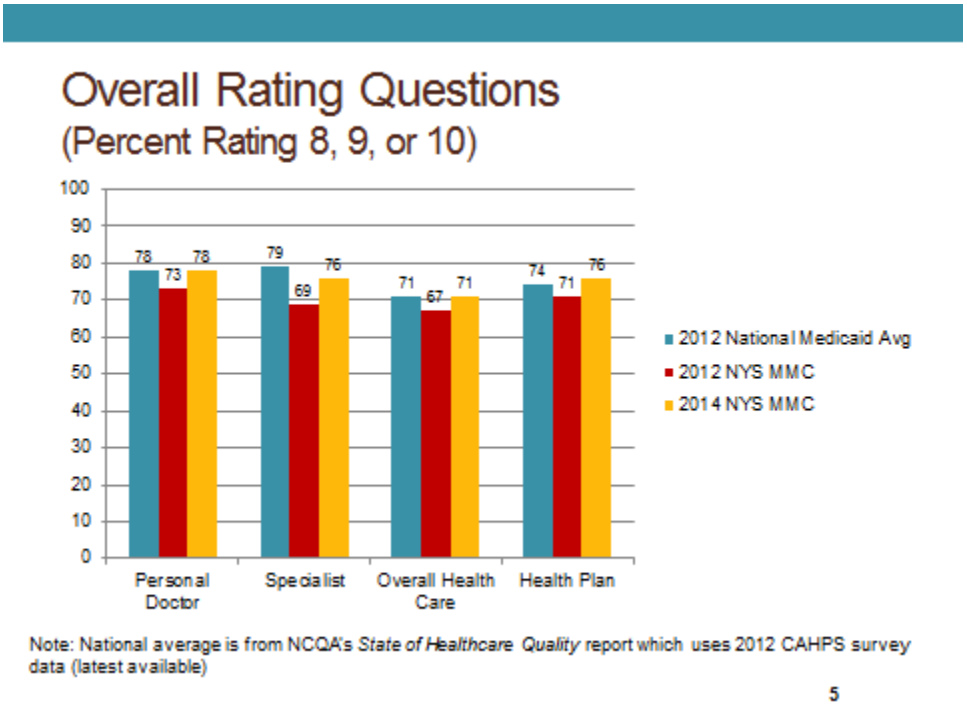
VII. Quality Assurance/Monitoring

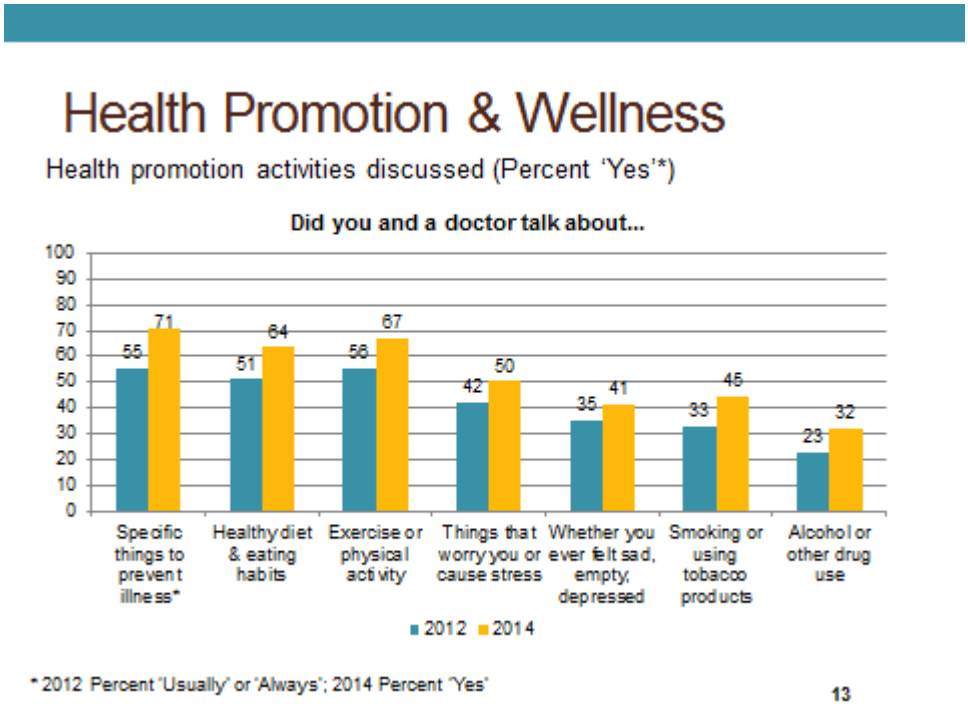
A. Quality Measurement

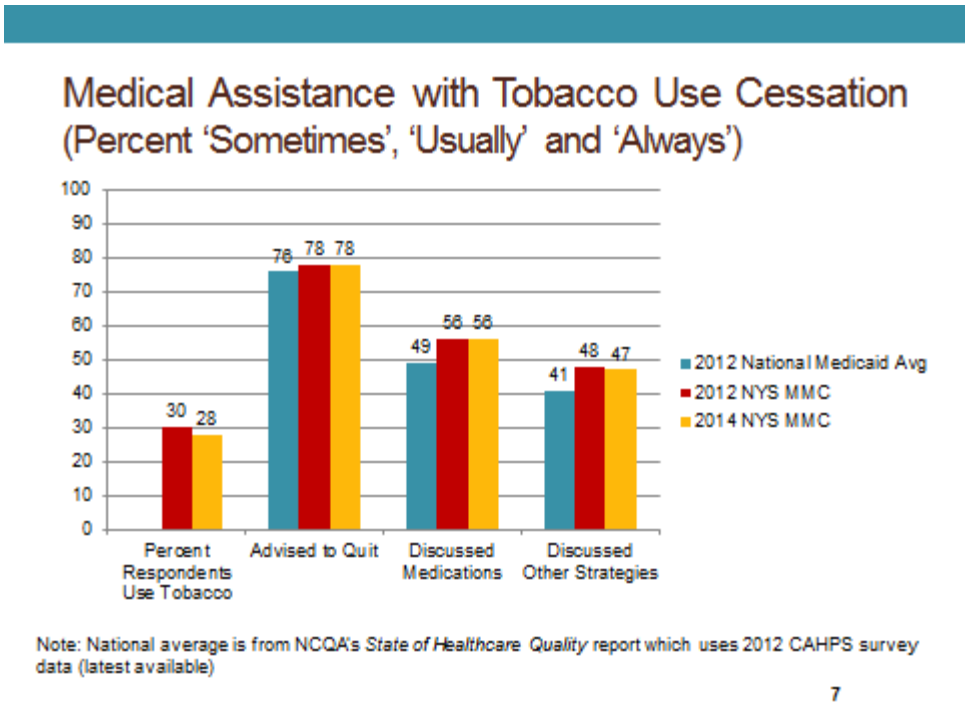
Satisfaction Survey

The New York State Department of Health (Department) conducted a satisfaction survey with adults enrolled in Medicaid managed care in the fall of 2013. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid 5.0 Adult survey was administered to adults, ages 18 to 64. The administration methodology consisted of a mailing protocol, with

telephone follow-up for non-responders. The overall response rate was 32 percent (with a range of 25 percent to 36 percent for response rates by plan). The findings demonstrate that adults have generally high levels of satisfaction with care. Ratings of providers and health plans had some increases compared to results from the survey conducted two years prior. There were also increases in discussion of preventive activities or reducing risk behaviors. Rates for Medical Assistance for Tobacco Cessation remained about the same as the previous survey results. (See graphs with ratings and composites below.)







Medicaid Managed Care Quality Incentive

The 2013 Quality Incentive awards for Medicaid managed care plans were released in February 2014. The data used to determine the results included: 1) 2013 QARR; 2) the 2013 Medicaid CAHPS survey for children in Medicaid and Child Health Plus; 3) two adult and two pediatric Prevention Quality Indicators (PQIs) using 2012 inpatient admissions; and 4) regulatory compliance information from 2012 and 2013. Two plans received the full award, twelve plans received partial awards and three plans did not qualify for any level of award.

Quality Incentive 2013 Quality Points NORMALIZED to 100 based on highest score							
Incentive Premium Award (%)	Plan Name	Quality Points (100 points possible)	Satisfaction Points (30 points possible)	PQI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Total Points	Percent (up to 100%)
100%	Healthfirst PHSP, Inc.	100	10	10	-4	116	77
100%	HIP (EmblemHealth)	94.286	10	10	-4	110.3	74
75%	Fidelis Care New York	81.429	15	10	-4	102.4	68
75%	Hudson Health Plan	63.135	25	12.5	-6	94.6	63
75%	CDPHP	57.262	25	10	-2	90.3	60
50%	MetroPlus Health Plan	79.286	15	2.5	-8	88.8	59
50%	MVP	67.54	15	10	-4	88.5	59
50%	Neighborhood Health Providers	72.857	15	7.5	-8	87.4	58
50%	Affinity Health Plan	58.571	20	12.5	-8	83.1	55
50%	Health Plus (Amerigroup)	55.714	15	10	-4	76.7	51
25%	WellCare of New York	50	10	11.5	-4	67.5	45
25%	Total Care	51.27	10	12.5	-8	65.8	44
25%	Independent Health's MediSource	36.19	20	10	-2	64.2	43
25%	UnitedHealthcare Community Plan	45.714	10	10	-4	61.7	41
0%	Excellus BlueCross BlueShield	30.833	15	10	-4	51.8	35
0%	HealthNow New York Inc.	23.81	20	10	-8	45.8	31
0%	Univera Community Health	16.587	20	10	-8	38.6	26

Managed Long Term Care

MLTC Consumer Guides

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

Reports

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

MLTC Quality Incentive Workgroup

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

B. Quality Improvement

External Quality Review

Approval was obtained to extend the current External Quality Review contract with the IPRO for an additional five month period, while preparations are completed to procure a new contractor. The contract extension will run from April 1, 2014 through August 31, 2014. A Request for Proposals is currently being prepared to solicit bids for a five year contract to conduct Medicaid managed care External Quality Review (EQR) as per the Balanced Budget Act of 1997 and CMS published EQR regulations.

Performance Improvement Projects (PIPs)

For 2013-2014, a collaborative PIP includes two parts. Part 1, the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD), includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in the following clinical areas: diabetes prevention and management, smoking cessation, and hypertension management. Part 2 focuses on implementing interventions to improve care in one of the four clinical areas noted above. For Part 1, MIPCD, six plans have begun to implement their interventions for the testing of patient incentives through diabetes prevention programs. Individual calls with each Medicaid managed care plan were conducted to accelerate progress and facilitate obstacles/barriers. To date, 30 Medicaid recipients enrolled in the study, with several plans with DPPs formalized. For Part 2, IPRO is conducting periodic conference calls with the health plans to monitor their progress. All plans are on track with proposed interventions.

MLTC

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

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

Patient-Centered Medical Home (PCMH) Satisfaction

The Department completed a satisfaction study involving Medicaid managed care members who had visits with providers certified by NCQA as PCMH providers. In the summer of 2013, the Department and IPRO began planning a study to look at the differences in experience of care between patients who had visits with a PCMH provider and those with visits to a provider without the PCMH designation. The Clinician and Group CAHPS^{R} survey including the PCMH module is the survey instrument. A random sample of 6,000 Medicaid members was selected, divided equally between children and adults, and between those with a visit to a PCMH provider

and a visit with a non-PCMH provider. Surveys were sent to enrollees following a combined mail and phone methodology in September 2013, resulting in a 35.4 percent response rate. The final report from that study was received in March, 2014. Results indicate satisfaction somewhat higher among the non-PCMH group for many questions; however, most differences were not statistically significant. PCMH respondents were more satisfied with the comprehensiveness of their care.

VIII. Family Planning Expansion Program

Family Planning Benefit Program Enrollment Summary

Second Quarter FFY 2013 (Jan 01, 2014 – Mar 31, 2014)

	Female	Male	Total
New Enrollees This Quarter	5,193	690	5,883
Total Enrollees This Quarter	37,951	8,811	46,762
Enrollees Using Services This Quarter	10,243	211	10,454
Cumulative Enrollment Since 04/01/12	91,042	23,089	114,131
Enrollees Using Services Since 04/01/12	47,945	2,179	50,124
Continuous Enrollment Since 04/01/12	3,471	314	3,785

Source of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart, Report Date: '01-Mar-2014'

Family Planning Benefit Program Utilization by Category of Service
Second Quarter FFY 2014 (Jan 1, 2014 – Mar 31, 2014)

TOTAL Medicaid Eligibles	**41,182**
TOTAL Medicaid Recipients	**10,454**
TOTAL Medicaid Expenditures	**2,155,050**
TOTAL Medicaid Eligible Months	**102,487**
AVERAGE Expenditures per Eligible	**52**
AVERAGE Months per Eligible	**2.5**
PMPM	**21**

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims/ Days per Recipient	COS Recipients
Physician	13,916	0.14	77	342	Claims	2	181
Eye care	108	0.00	108	2	Claims	2	1
Nursing	317	0.00	32	10	Claims	1	10
OPD Clinic (hospital outpatient)	168,799	1.65	386	532	Claims	1	437
FS Clinic (D&T center)	1,082,674	10.56	238	5,236	Claims	1	4,542
Inpatient	6,080	0.06	1,216	0	Days	0	5
Pharmacy	762,806	7.44	123	12,406	Claims	2	6,202
Laboratory	39,021	0.38	47	1,799	Claims	2	837
Transportation	2,447	0.02	163	81	Claims	5	15
CTHP	1,185	0.01	85	15	Claims	1	14
DME and Hearing Aid	517	0.01	86	10	Claims	2	6

Source of Data: DOH/OMM Audit, Fiscal and Program Planning Data Mart (Report Date: 01-Mar-2014)

IX. Transition Plan Updates

Attachment 2 contains the Department's updated Transition Plan indicating how New York State will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Partnership Plan demonstration.

X. 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 Medicaid Redesign Team 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.

Attachments

State Contact:

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Fax# (518) - 473 - 1764

Date Submitted to CMS:

May 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	$6,105,699,488
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,521,937,580	$2,467,348,368
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**	**$9,616,095,275**

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	$1,827,792,863
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,851,097,035	$1,159,889,284
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,479,171,065	$1,864,361,807
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$976,122,527	$502,539,894
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$322,462,923	$155,882,395
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$13,378,992	$4,164,485
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**	**$5,514,630,728**
Expenditures (Over)/Under Cap	**$20,708,750,711**	**$2,879,703,758**	**$2,808,034,445**	**$3,132,378,919**	**$4,095,646,003**	**$4,101,464,547**

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 16A (10/1/13-12/31/13) Projected	DY 16B (1/1/14-3/31/14) Projected	DY 16C (4/1/14 - 12/31/14) Projected	Current Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$6,124,915,586	$13,431,555,927	$14,853,389,777	$3,975,139,194	$3,975,139,194		**$87,461,632,823**	
Demonstration Group 2 - TANF Adults 21-64	$2,443,182,702	$5,362,266,874	$5,914,379,682	$1,579,889,213	$1,579,889,213		**$33,988,367,426**	
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	$5,140,241	$10,702,271	$1,856,551				**$17,699,062**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$247,394,784	$1,027,336,330	$260,284,563	$260,284,563		**$1,795,300,240**	
Demonstration Group 11 - MLTC age 65+ Duals		$2,554,212,091	$10,820,566,375	$2,796,750,566	$2,796,750,566		**$18,968,279,598**	
W/O Waiver Total	**$9,628,653,860**	**$23,947,199,400**	**$35,249,766,328**	**$9,336,721,578**	**$8,612,063,536**	**$0**	**$157,152,727,216**	**$301,792,605,739**

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 16A (10/1/13-12/31/13) Projected	DY 16B (1/1/14-3/31/14) Projected	DY 16C (4/1/14 - 12/31/14) Projected	Current Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$2,801,314,813	$6,274,647,760	$6,920,891,478	$1,841,829,404	$1,840,421,312		**$39,630,633,971**	
Demonstration Group 2 - TANF Adults 21-64	$1,546,569,069	$3,469,798,151	$3,820,998,638	$1,019,514,707	$1,019,416,724		**$21,726,502,639**	
Demonstration Group 5 - Safety Net Adults	$2,829,518,468	$6,893,620,899	$8,184,495,364	$2,210,213,971			**$36,510,793,012**	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$553,389,257	$1,173,058,143	$1,313,450,141	$360,124,781			**$7,472,090,824**	
Demonstration Group 7 - FHP Adults without Children up to 100%	$173,575,211	$352,894,110	$401,041,648	$110,970,648			**$3,083,077,012**	
Demonstration Group 8 - Family Planning Expansion	$6,573,308	$13,934,296	$2,462,132				**$72,721,817**	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)	$3,699,108	$3,699,108	$3,699,108	$924,777	$924,777		**$12,946,878**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$249,276,515	$999,765,437	$249,927,129	$249,927,129		**$1,748,896,210**	
Demonstration Group 11 - MLTC age 65+ Duals		$2,561,508,288	$10,403,512,554	$2,629,869,736	$2,629,869,736		**$18,224,760,313**	
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	$111,044,440	**$474,462,172**	
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	**$7,919,839,234**	**$21,122,103,937**	**$32,179,033,167**	**$8,555,529,318**	**$6,239,732,376**	**$2,168,562,373**	**$131,545,895,249**	**$255,477,023,061**
Expenditures (Over)/Under Cap	**$1,708,814,625**	**$2,825,095,463**	**$3,070,733,161**	**$781,192,260**	**$2,372,331,160**	**($2,168,562,373)**	**$25,606,831,967**	**$46,315,582,678**

New York State Partnership Plan
PMPM's and Member Months

WITHOUT WAIVER PMPMS

	DY09 2006-2007	DY10 2007-2008	DY11 2008-2009	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY 16a - Q1 (10/1/13-12/31/13)	DY 16b - Q2 (1/1/14-3/31/14)	DY 16c - Q3 (4/1/14-12/31/14)
TANF Kids	$482.15	$514.58	$549.19	$585.99	$624.67	$624.67	$665.90	$709.85	$756.70	$756.70	n/a
TANF Kids FSHRP											
TANF Adults	$661.56	$705.21	$751.73	$801.34	$852.63	$852.63	$907.20	$965.26	$1,027.04	$1,027.04	n/a
TANF Adults FSHRP											
FHPlus Adults with Children	$516.43	$550.50	$586.82	$625.55	$665.59	$665.59	$708.19	$753.51	$801.73	$801.73	n/a
Family Planning Expansion						$20.23	$21.06	$21.92	n/a	n/a	n/a
Duals 18-64							$4,009.38	$4,057.09	$4,105.37	$4,105.37	n/a
Duals 65+							$4,742.15	$4,895.32	$5,053.44	$5,053.44	n/a

WITH WAIVER PMPMS

	DY09 2006-2007	DY10 2007-2008	DY11 2008-2009	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY 16a - Q1 (10/1/13-12/31/13)	DY 16b - Q2 (1/1/14-3/31/14)	DY 16c - Q3 (4/1/14-12/31/14)
TANF Kids	$223.54	$249.89	$263.89	$254.70	$187.00	$285.70	$311.08	$330.75	$350.61	$350.34	n/a
TANF Adults	$448.12	$487.12	$497.81	$505.25	$400.82	$539.73	$587.03	$623.61	$662.76	$662.69	n/a
SN - Adults	$665.55	$699.86	$632.17	$600.41	$454.35	$671.00	$757.76	$835.31	$894.41	n/a	n/a
FHPlus Adults with Children	$248.43	$268.45	$300.69	$326.07	$320.68	$348.99	$354.86	$375.99	$398.43	n/a	n/a
FHPlus Adults without Children	$307.99	$291.75	$323.10	$357.90	$361.75	$394.92	$380.63	$403.00	$426.83	n/a	n/a
Family Planning Expansion	$17.53	$23.37	$24.39	$27.59	$16.39	$25.87	$27.42	$29.07	n/a	n/a	n/a
Duals 18-64							$4,039.88	$3,948.21	$3,942.01	$3,942.01	n/a
Duals 65+							$4,755.70	$4,706.64	$4,751.90	$4,751.90	n/a

MEMBER MONTHS

	DY09 2006-2007	DY10 2007-2008	DY11 2008-2009	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY 16a - Q1 (10/1/13-12/31/13)	DY 16b - Q2 (1/1/14-3/31/14)	DY 16c - Q3 (4/1/14-12/31/14)
TANF Kids	17,922,752	17,657,828	18,296,045	19,147,031	9,774,280	9,805,042	20,170,530	20,924,688	5,253,257	5,253,257	n/a
TANF Adults	4,603,637	4,561,952	5,130,509	5,642,970	2,893,809	2,865,467	5,910,788	6,127,240	1,538,294	1,538,294	n/a
SN Adults	4,534,323	4,590,976	6,040,438	7,460,186	4,103,355	4,216,837	9,097,365	9,798,142	2,471,136	n/a	n/a
FHPlus Adults with Children	3,276,258	3,295,069	2,976,138	2,993,640	1,567,102	1,585,684	3,305,705	3,493,301	903,868	n/a	n/a
FHPlus Adults without Children	1,908,233	1,941,703	1,275,271	900,978	430,909	439,524	927,125	995,132	259,985	n/a	n/a
Family Planning Expansion	597,505	453,527	456,734	484,940	254,090	254,090	508,180	84,697	n/a	n/a	n/a
Duals 18-64							61,704	253,220	63,401	63,401	n/a
Duals 65+							538,619	2,210,390	553,435	553,435	n/a

Monitoring of New Adult Group Spending
Total Computable

WITHOUT WAIVER (WOW)	DY 16 b and c (1/1/2014 - 12/31/2014)
PMPM	$722.57
Member months	18,245,631
Without Waiver Expenditures	$13,183,745,592

WITH WAIVER (WW)	DY 16 b and c (1/1/2014 - 12/31/2014)
PMPM	$722.57
Member months	18,245,631
Projected With Waiver Expenditures	$13,183,745,592

DIFFERENCE BETWEEN WOW AND WW	DY 16 b and c (1/1/2014 - 12/31/2014)
	$0

New Adult Member Month Workbook

	Monthly Eligibles	Assumptions	Month by month breakdown												Total DY 16bc (CY 2014) Member months
			1/1/2014	2/1/2014	3/1/2014	4/1/2014	5/1/2014	6/1/2014	7/1/2014	8/1/2014	9/1/2014	10/1/2014	11/1/2014	12/1/2014	
Current SN adults	823,712	All administratively transferred 1/1/2014	823,712	823,712	823,712	823,712	823,712	823,712	823,712	823,712	823,712	823,712	823,712	823,712	9,884,544
Current FH Plus Childless Adults	98,083	All administratively transferred 1/1/2014	98,083	98,083	98,083	98,083	98,083	98,083	98,083	98,083	98,083	98,083	98,083	98,083	1,176,996
Current FH Plus Adults with children	25,339	Transitioned to new adult group at redet, beginning 4/1/14	-	-	-	25,339	50,678	76,017	101,356	126,695	152,034	177,373	202,712	228,051	1,140,255
Current FSHRP Adults	3,153	All administratively transferred 1/1/2014	3,153	3,153	3,153	3,153	3,153	3,153	3,153	3,153	3,153	3,153	3,153	3,153	37,836
New Enrollment (Childless adults 100-133)	77,000	Added constantly each month throughout 2014	77,000	154,000	231,000	308,000	385,000	462,000	539,000	616,000	693,000	770,000	847,000	924,000	6,006,000
Total New Adult Group			1,001,948	1,078,948	1,155,948	1,258,287	1,360,626	1,462,965	1,565,304	1,667,643	1,769,982	1,872,321	1,974,660	2,076,999	**18,245,631**

DSHP 6

FHP with Children	Eligibles	PMPMs	Total Expenditures	
Projected January 2014	304,072			
Estimated monthly	25,339			
January 2014	304,072	$398.39	$121,139,244	
February	304,072	$398.39	$121,139,244	
March	304,072	$398.39	$121,139,244	
April	278,733	$398.39	$111,044,440	
May				
June				
July				
August				
September				$474,462,172
October				
November				
December				**$474,462,172**
January 2015				
DY 6b (1/1/14 - 3/31/14) subtotal			$363,417,732	
DY 6c (4/1/14 - 12/31/14) subtotal			$111,044,440	
Total				

DSHP 7

APTC				
Projected January 2014	35,000			
Estimated monthly	2,917			
January 2014	2,917	$400.00	$1,166,800	
February	5,834	$400.00	$2,333,600	
March	8,751	$400.00	$3,500,400	
April	11,668	$400.00	$4,667,200	
May	14,585	$400.00	$5,834,000	
June	17,502	$400.00	$7,000,800	
July	20,419	$400.00	$8,167,600	
August	23,336	$400.00	$9,334,400	
September	26,253	$400.00	$10,501,200	$52,506,000
October	29,170	$400.00	$11,668,000	
November	32,087	$400.00	$12,834,800	
December	35,004	$400.00	$14,001,600	**$91,010,400**
January 2015	0			
DY 6b (1/1/14 - 3/31/14) subtotal			$7,000,800	
DY 6c (4/1/14 - 12/31/14) subtotal			$84,009,600	
Total			$91,010,400	

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.

Although New York will transition individuals from the waiver to coverage under the ACA, the State intends to maintain the authority included in the waiver to mandatorily enroll individuals into managed care in counties **other than** Allegany, Cortland, Duchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

Table 1: Individuals Enrolled in Medicaid Managed Care

Current State Plan Mandatory and Option Groups	Current FPL and/or other qualifying criteria
Pregnant women	Income up to 200%
Children under age 1	Income up to 200%
Children 1 through 5	Income up to 133%
Children 6 through 18	Income up to 133%
Children 19-20	Income at or below the monthly income standard
Parents and caretaker relatives	Income at or below the monthly income standard

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 2: 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 3: 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. The State will be seeking authority through an amendment to the Partnership Plan waiver, for federal financial participation for an affordability wrap for those individuals who would have been eligible for Family Health Plus prior to January 1, 2014 and who are now able to purchase Qualified Health Plans. The goal is to mitigate the increased costs for these individuals as they move from the Medicaid waiver to the QHP. The State intends to implement an affordability wrap to pay the premium for the Qualified Health Plan for individuals in this income group who purchase a silver plan. 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 preliminary results, but is waiting for the re-run results for children along with the weighted averages for the separate applicant and beneficiary results.

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

Transformation Agreement

April 1, 2014

Quarterly Update and Annual Progress Report

Annual Reporting Period
April 1, 2013 – March 31, 2014

Submission to the Centers for Medicare and Medicaid Services

Table of Contents

Appendices

A. Housing Forum's Final Agenda

Introduction

In keeping with the Health System Transformation for Individuals with Developmental Disabilities Agreement as defined in the Standards Terms and Conditions of New York State's Partnership Plan Medicaid Section 1115 Demonstration, this document reports to the Centers for Medicare and Medicaid Services (CMS) the completion of the April 1, 2014 Transformation Deliverable Schedule which includes annual progress and quarterly updates in the following areas:

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

In addition to the above deliverables, the Final Plan to Increase Competitive Employment Opportunities for People With Developmental Disabilities and OPWDD's Final Self Direction Policy has been provided under separate cover. These documents have been updated to reflect recent discussion between the state and CMS.

Residential Transitions and Supportive Housing

Residential Transitions and Supportive Housing
(from CMS Special Terms and Conditions, Attachment H)

a. By January 1, 2014, New York will transition a total of 148 residents from the Finger Lakes and Taconic ICFs in accordance with the following milestones:

iii. the remaining 121 persons transitioned 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.

b. *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). New York will transition the balance of the persons in the Finger Lakes and Taconic ICF target population (who are not transitioned to MFP qualified residences) into residential settings that comport with CMS requirements for home and community-based settings as outlined in the 1915(i) NPRM.* ***New York must submit quarterly reports of the total number of persons transitioned to the community, the size and licensure category of the residential settings into which persons were transitioned (e.g. 4 person group home), and an assurance that the residential settings comport with CMS requirements.***

The Finger Lakes and Taconic ICFs were closed on December 31, 2013 and residents transitioned to settings in the community. During the time period January 1, 2014 through March 31, 2014 a total of 85 individuals moved out of OPWDD institutional settings and into settings meeting HCBS standards. Of the 85 individuals, 24

qualified for Money Follows the Person (MFP). The below table reports a total of 227 individuals transitioned into home and community based settings, of which 74 met MFP qualifications for the annual period of April 1, 2013 through March 31, 2014.

Individuals Assisted to Transition to Community Settings April 1, 2013 – March 31, 2014	
Meets HCBS Standards	**MFP Compliant**
227	74

Expanding Supportive Housing Options

Residential Transitions and Supportive Housing
(from CMS Special Terms and Conditions, Attachment H)

c. *New York will provide quarterly updates on the progress for increasing the availability of supportive housing options, including "non-traditional housing models" such as the "Home of Your Own", Family Care, Shared Living, Customized Residential Options, and AFI.* ***Each quarterly update will include the number of new housing units that are available to persons being transitioned from ICFs, and meet CMS standards for HCBS settings.***

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

Strengthening Federal Partnerships

CMS Housing Capacity Building Initiative:

During this quarter, OPWDD increased activities with the CMS-funded Housing Capacity Building Initiative Project Team through the implementation of one Webinar and two Coaching Calls. The Webinar was held on February 19th for OPWDD central and regional housing staff, and for New York State MFP Personnel. DOH and OPWDD MFP staff participated in the initiative. The main purpose of the Webinar was to provide an overview of non-certified housing models that are utilized across all disability groups and low income populations, and to highlight the correlation between the two. Another major emphasis was on state agency/cross systems affordable and accessible housing opportunities.

The first *Coaching Call* was held on February 27th and explored ways to make better use of current resources such as housing choice vouchers and Public Housing Authorities (PHAs). The second Coaching Call was held on March 13th and focused on non-PHA resources such as USDA, multifamily and Low Income Tax Credits. All of the activities strengthened the housing knowledge base of OPWDD and DOH personnel on housing options that exist currently in the community.

HUD Housing Counseling Activities:

OPWDD expanded training activities, credit counseling and 1st Time Homebuyer education classes for people with intellectual and developmental disabilities, their families and their workforce through increased activities with the Assets for Independence (AFI), Matched Savings Program. More than 499 individuals and families were trained during this Quarter; 50 have continued to save for their first home; and, 16 new applicants began saving for their first home this Quarter.

Strengthening State and Local Partnerships

Medicaid Redesign Team (MRT) Supportive Housing Program

OPWDD held a special session with Elizabeth Misa, Director of the Governor's Medicaid Redesign Team (MRT) Supportive Housing Workgroup, and local providers of OPWDD services that participated in the MRT project and people with intellectual and developmental disabilities who moved to a less restrictive residential setting – using MRT funds. The purpose of this historic meeting was to learn from providers and individuals about their successes, challenges, barriers and recommendations for future activities. Denard Cunnings from Long Term Care at DOH, and Henri Williams, Director of Housing at OASAS also participated in the meeting. One of the major outcomes is to request the expansion of OPWDD's MRT program and, another is to visit some of the participants 'new' home in the future.

Eight service providers participated in the session and six individuals told their stories in person, through video, DVD presentations, or by other forms of media. It was evident through this MRT Supportive Housing Initiative that individuals with intellectual and developmental disabilities (ID/DD) who have lived in more restrictive and supervised settings could be supported in the community with the proper support services being available to them. OPWDD plans to continue to work with DOH/MRT leaders and workgroup members to expand this successful program.

NYS Homes and Community Living (HCR)

OPWDD is continuing to strengthen its partnership with HCR, the lead agency for housing in the state. Several meetings have been held this Quarter to discuss the implementation of the 47 units awarded to OPWDD providers during the Early Round of HCR's Request for Proposals (Unified Funding). In addition to these 47 units, OPWDD is engaged in dialogue with HCR and the Office of Temporary and Disability Assistance (OTDA) to fund, with MRT monies, a project with one of OPWDD provider agencies in Western, New York. This opportunity would be cross systems and an example of integrated supportive housing.

OPWDD's Office of Home and Community Living 1st Housing Forum in 2014

On March 31, 2014, OPWDD's Division of Person Centered Supports, Office of Home and Community Living, hosted a Housing Forum. The idea behind the forum grew out of OPWDD's need to continue the creation of a Continuum of Housing Options for people with intellectual and developmental disabilities and the training conducted by the CMS/TA Project Team.

This Statewide Regional Forum was presented to national and regional stakeholders and experts through Webcast, Video Sites and on Face Book, Twitter and YouTube. The forum featured the innovative work and best practices in Region One as outlined in the attached Housing Forum's Final Agenda (Appendix 1). The purpose was to:

- To introduce forum participants to the region's housing resources and their track record of innovative practice in the provision of housing services;
- To describe the challenges facing our housing system and how we propose to move ahead on a long term plan for housing services within the region;
- To hear housing experts internal to and external from OPWDD system as we interact on ways to better advance housing choice within the region.

Residential opportunities within Region One are unsustainable in its current form, both unaffordable and falling short of consumer expectations. Additional pressure will be placed on the system by the elimination of institutional beds and the requirements of the Olmstead Plan. OPWDD needs to rebalance resources and investments for residential and community living to provide more choices, promote greater integration and is more easily modified in the face of changing demand.

Jennifer Burnett, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services, U.S. Department of Health & Human Services, Jennifer Ho, Senior Policy Advisor for Housing and Services to the Secretary, U.S. Department of Housing and Urban Development and other people will participate on the agenda, including people from financial institutions, university settings, advocacy, families, state and local officials and non-profit housing developers.

The Home of Your Own (HOYO) Program:

The HOYO program has had a great deal of activity this quarter due to the increase in the number of applicants seeking to purchase their first home and the increase in participation in the Assets for Independence (AFI) 1:8 Matched Savings Program. During this Quarter, 499 people received homeownership counseling and training. These trainings were provided primarily in New York City by the downstate housing staff for families, people with ID/DD and the workforce. In order to meet the needs of most of the population, housing counseling classes are offered on Saturdays and via video sites.

Fifty individuals, families and workforce members are continuing to save for their first home; 16 new applicants started saving this Quarter for their first home. 30 received credit counseling/credit repair; and 6 are actively involved in foreclosure prevention activities.

The Office of Home and Community Living received a Notice from HUD for their 2014 NOFA. OPWDD has taken steps to apply for funding from HUD and is seeking to align its housing strategic goals and priorities with the Department's NOFA priorities. One of the major changes by HUD is to allow some of the housing counseling programs (of which OPWDD is one) to apply for and receive funding for a two-year period, rather than the existing one-year. These Grants are provided by HUD to assist people with ID/DD, families and others understand the home buying process, renting, foreclosure prevention and other housing options. The

other major purpose of grant funding is to allow approved housing counselors to travel to various locations to obtain, and then maintain their certification status.

Since the 2013 Statewide Family Care Conference, the Family Care Program has received increased attention from individuals who are seeking to become providers, provider agencies and from regional coordinators. As a result, and one outcome, is the creation of a Family Care Advisory Workgroup that was formed to support issues and concerns generated from a regional, state and national perspective.

Total Number of New Housing Units Developed	
New Home Owners	9
Available Supportive Housing Units connected to the Governor's Medicaid Redesign Team Supportive Housing Development Program and, OPWDD's partnership with the NYS Homes & Community Renewal (NYSHCR)	90

Increasing Supported Employment Services and Competitive Employment

Supported Employment Services and Competitive Employment
(from CMS Special Terms and Conditions, Attachment H)

5. Supported Employment Services and Competitive Employment

a. T**he state must provide CMS with a quarterly report documenting the state's progress toward the agreed-upon goal of increasing the number of persons engaged in competitive employment, through Supported Employment, by 700 persons above the previous 12 month enrollment, with no exceptions for attrition during the period of April 1, 2013 and March 31, 2014. Given the expected fluctuations triggered by school timelines (e.g. graduations), 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**. Only integrated gainful employment at minimum wage or higher will be considered competitive employment. The quarterly report also must include a description of activities the state has undertaken during the quarter to increase the number of demonstration participants engaged in competitive employment.

b. Effective July 1, 2013, New York will no longer permit new admissions to sheltered workshops. **The state will report the number of enrollees that remain in sheltered workshops in each quarterly report as required under paragraph 62.**

d. **The state will report to CMS on an annual basis 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 VR, and the number who enter OPWDD because they are not found ready by DVR, and any websites/sources for employment data.

Supported Employment Services and Competitive Employment

During this reporting period OPWDD continued to work to create the infrastructure and capacity that will support significant improvements in competitive employment outcomes for individuals receiving supported employment services. Infrastructure and capacity building activities included: creation of the new Pathway to Employment Service, training of supported employment providers, improvements in the collection of employment data, initiatives to incentivize the transition of individuals from day habilitation and workshops to employment, initial efforts to redesign Supported Employment rates, strengthening partnerships with ACCES-VR and the Office for Special Education, and working with the State Employment Leadership Network (SELN).

Pathway to Employment

The definition of "career planning" from the September 2011 CMS Bulletin on Employment was used as a guide in creating the Pathway to Employment service. During the design of Pathway to Employment presentations and meetings were convened with parent organizations, self advocacy groups, voluntary and state operated day service providers, Medicaid service coordinators, regional staff of ACCES-VR, Commission for the Blind and Office for Special Education and high school administrators. These various dialogues were used to educate stakeholders about Pathway to Employment, solicit input on the design of the service and encourage utilization of the service once it becomes available. Regulations for Pathway to Employment have been developed and shared with stakeholders. The new service takes effect June 1, 2014. In addition to the regulation, an Administrative Memo (ADM) is currently in development which will provide further guidance and clarity on the delivery of Pathway to Employment services. It is anticipated that the ADM will be released by the end of May. There were also several internal discussions within OPWDD regarding the design and rollout of Pathway to Employment. These discussions included regional office staff that regularly interact with stakeholders and will be facilitating enrollment into the service, central operations and IT staff that will be tracking service delivery and billing, and research and quality improvement staff responsible for development of outcome measures.

Supported Employment Training

In anticipation of the roll out of Pathway to Employment, meetings were convened across the state with voluntary and state operated providers that might be interested in the service. Since a provider must already be authorized for supported employment services before Pathway to Employment services can be delivered, OPWDD facilitated three trainings for 100 providers who had not previously delivered supported employment services. Employment Trainings were also convened for approximately 300 Medicaid Service Coordinators. OPWDD also continued its efforts to increase the capacity of supported employment providers to deliver high quality services by continuing the Innovations in Employment Training Series. During this reporting period 558 supported employment and day habilitation staff representing 76 voluntary and state operated providers received training in employment discovery, assessment, job development and job coaching.

Incentivizing Transitions from Workshops and Day Habilitation to Employment

New York has used its state budget making process as an opportunity to incentivize better employment outcomes for people with developmental disabilities. Approximately $30 million in non Medicaid dollars is used to fund workshops. The Executive Budget proposed a $4.5 million reduction in this funding. The proposed reduction would take effect July 1, 2014. OPWDD is working with impacted providers to identify individuals who could transition to the new Pathway to Employment service, Supported Employment, Community Habilitation or other more appropriate services that create opportunities for individuals to be engaged in their community. The Executive Budget also proposed the transition of approximately 6,500 individuals to Pathway to Employment and/or Supported Employment services. It is anticipated that these proposed budgetary actions will be passed by the New York State Legislature by April 1, 2014.

Redesigning Supported Employment

During this reporting period, initial work began on the redesign of supported employment services. Current supported employment fees are billed on a monthly basis. Efforts are underway to transition supported employment from a monthly to an hourly service. OPWDD will be working with the Department of Health to establish new fees that incentivize employment and include performance based outcomes.

Strengthening Partnerships with ACCES-VR and the Office for Special Education

The Partnership in Employment Systems Change Grant continues to serve as a venue to strengthen collaborative efforts between OPWDD, ACCES-VR and the Office for Special Education. During this reporting period, ACCES-VR and OPWDD have had several discussions regarding our mutual efforts to improve employment outcomes for youth transitioning from high school. As ACCES-VR seeks to engage students and families in their services two-years prior to exiting high school, discussions with OPWDD have focused on ways to share data so that students and families are also aware of Pathway to Employment and other OPWDD services. Discussions have also focused on a joint ACCES-VR and OPWDD process for identifying individuals who may be interested in receiving Pathway to Employment services. This process will include agreed upon documentation indicating when an individual will not be receiving ACCES-VR services. This documentation will be maintained by providers for audit purposes. OPWDD has also collaborated with the Office of Special Education to provide employment information to high schools. Utilizing the Employment Training Program, OPWDD convened two train-the-trainer sessions with teachers on how to incorporate discovery into their transition planning. In addition meetings were convened with 20 high schools interested in participating in the Employment Training Program and transitioning students to employment upon their exit from high school.

Employment Outcomes

During this reporting period, efforts continued to collect employment data. Monthly reports were submitted to OPWDD on the total number of individuals with developmental disabilities enrolled in supported employment, number of individuals employed in an integrated setting earning minimum wage and the number of individuals who are not employed. There was also a focus on improving the integrity of data by scrutinizing employment settings to ensure that segregated settings were not captured in the competitive employment data. The March 31, 2013 baseline of individuals with developmental disabilities enrolled in

supported employment was updated and is now 9,972. Of these individuals 7,044 were competitively employed in an integrated setting earning at least minimum wage. Due to a lag in the reporting of data from supported employment providers, data is only available thru February 2014. As of the end of February there were 10,313 people enrolled in supported employment of which 7,362 were engaged in competitive employment which is a net increase of 318. Several factors led to the lower than anticipated growth in competitive employment including the lag in data collection and fluctuations in seasonal employment. In addition, with the exception of the July 1, 2013 policy to end new enrollments in workshops all other initiatives designed to improve employment outcomes will not be operational until 2014. Efforts between April 1, 2013 and March 31, 2014 focused on infrastructure and capacity building to ensure that enrollees in supported employment services received quality services. Over this same period there was a focus on building the infrastructure and capacity for new initiatives like Pathway to Employment and restructuring of supported employment fees to ensure that they will be successfully implemented. Once the Pathway to Employment service is available, it is anticipated that students transitioning from high school, workshop participants and individuals receiving day habilitation services will begin to utilize the service. An immediate decrease in workshop and day habilitation enrollment is not anticipated since individuals are expected gradually decrease the number of hours they receive these services as they increase hours in Pathway to Employment or Supported Employment. By June 2015, it is anticipated that competitive employment outcomes will begin to significantly increase due to delivery of Pathway to Employment and the restructuring of Supported Employment.

State Employment Leadership Network (SELN)

During this reporting period, OPWDD has had been receiving technical assistance from SELN. During on-site visits the SELN team has had an opportunity to meet with providers, parents, advocates; OPWDD regional offices and central office leadership; Medicaid service coordinators; and quality improvement, strategic planning/performance measurement, fiscal, revenue support and budget staff of OPWDD. The purpose of these meetings was to better understand the infrastructure within OPWDD that supports the achievement of better employment outcomes for individuals receiving supported employment services. The technical assistance team will use this information to make recommendations for system changes that can be made to assist OPWDD in implementing the Employment Transformation Plan. Preliminary feedback has already been provided on ways to strengthen collaboration between OPWDD, ACCES-VR and the Office for Special Education; ways to improve the collection of employment data; factors to consider in the restructuring of Supported Employment fees; and how to create an internal infrastructure that supports implementation of the Employment Transformation Plan.

Transformation Deliverables Employment Summary

OPWDD's Employment Plan has been updated to reflect final agreements made between the state and CMS and has been shared under separate cover. The plan further details OPWDD's strategies and plan toward increasing competitive employment.

As communicated in a series of conversation with CMS staff, the state's capacity to report employment data initially required time to work with partner agencies to establish an accurate baseline. The below table summarize employment outcomes through February 2014 as highlighted in the employment outcomes subsection on page 7 above. As of the end of February there were 10,313 people enrolled in supported

employment of which 7,362 were engaged in competitive employment which is a net increase of 318. As mentioned previously, OPWDD anticipates that competitive employment outcomes will begin to significantly increase due to delivery of Pathway to Employment and the restructuring of Supported Employment.

Individuals Receiving SEMP and Competitively Employed April 1, 2013 – March 31, 2014			
	March 31, 2013 (baseline)	February 2014	Net Increase
Number of individuals receiving SEMP	9,972	10,313	341
Numbers of individuals who are competitively employed	7,044	7,362	318

As of December 31, 2013 there were 8,020 enrollees in sheltered workshops. By the end March 31, 2014 workshop enrollment remained constant. The Employment Transformation Plan outlines strategies for workshop participants to transition to competitive employment, retirement or other community inclusion options.

OPWDD anticipates 2,296 students will be eligible for OPWDD services when they exit the educational system in 2014. It is unknown at this time the number of students who will receive ACCES-VR service or will be determined ineligible for such services. This data is not currently tracked by OPWDD.

Increasing Self-Direction

Consumer Self-Direction
(from CMS Special Terms and Conditions, Attachment H)

b. 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. This 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.*** *New York will share training materials and curricula for these sessions with CMS, and make them available statewide by May 1, 2013.*

e. 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.

iii. By April 1, 2014, 470 new beneficiaries will self-direct services.

f. By January 1, 2014, New York will submit to CMS for approval the state's policies on self-direction that demonstrate its commitment to and implementation of self-direction.

Self Direction Policy

OPWDD 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. 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 to live and work or engage in meaningful activities.

The submission of New York's final policies on self direction demonstrating its commitment to and implementation of self-direction is provided under separate cover and reflects feedback received and discussed with the state's CMS counterparts.

While significant progress has been made toward the transformation goals, there are various reforms needed to meet the broader goals of transformation related to self-direction. Specifically, work is moving forward to implement agreements made between OPWDD and CMS to revise the current consolidated supports services model to meet federal guidelines and streamline self direction. With a target implementation date of October 1, 2014, the state has begun the process of reaching out to stakeholders and will conduct a series of initial statewide videoconferences for individuals and families in the early weeks of April 2014.

Self Direction Education to Beneficiaries

The NYS Office for People with Developmental Disabilities (OPWDD) has promoted self direction for individuals receiving supports through educational efforts by OPWDD staff and stakeholder groups. Educational efforts include community training sessions and new staff practices at the "Front Door" which ensure that individuals coming to OPWDD to access services make an informed choice regarding self directed service options

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

Self-Direction Education Totals January 1 – March 31, 2014			
Self-direction Education Target	**Education Goal**	**Total Number of Individuals**	**Total Number of Sessions**
New people requesting supports from the OPWDD system and people who are transitioning from the education system into the OPWDD system of supports.	Increase awareness of self-direction options among the people engaging in supports from OPWDD	**2,454**	**50**
Individuals who are currently receiving OPWDD supports and services and new individuals who have expressed an interest in self-directing services.	For people who are expressing interest in self-direction, the goal is to ensure understanding of the key concepts of self-directed supports.	**86**	**16**
Individuals who are actively seeking to self-direct services with budget and employer authority	Detailed understanding of the operational components of self-directed supports; clear understanding of the responsibilities associated with self-direction.	**204**	**28**
	Total	***2,744***	***94***

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

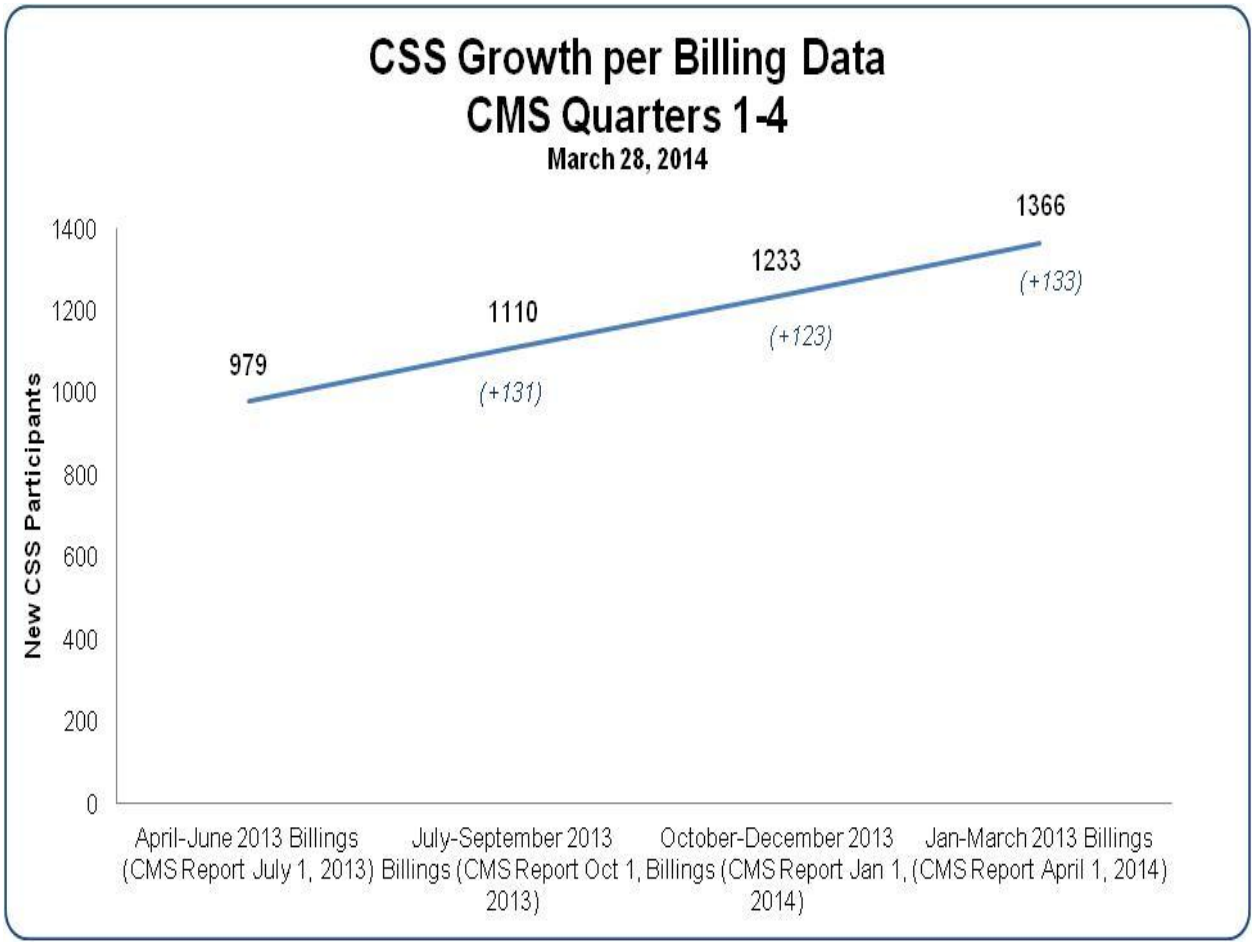
Self Direction Education Training April 1, 2013 – March 31, 2014		
	Number of Individuals	**Number of Sessions**
April 1 – June 30, 2013	1,844	85
July 1 – September 31, 2013	3,746	98
October 1 – December 31, 2013	4,440	267
January 1 – March 31, 2014	2,744	94
Total	12,774	544

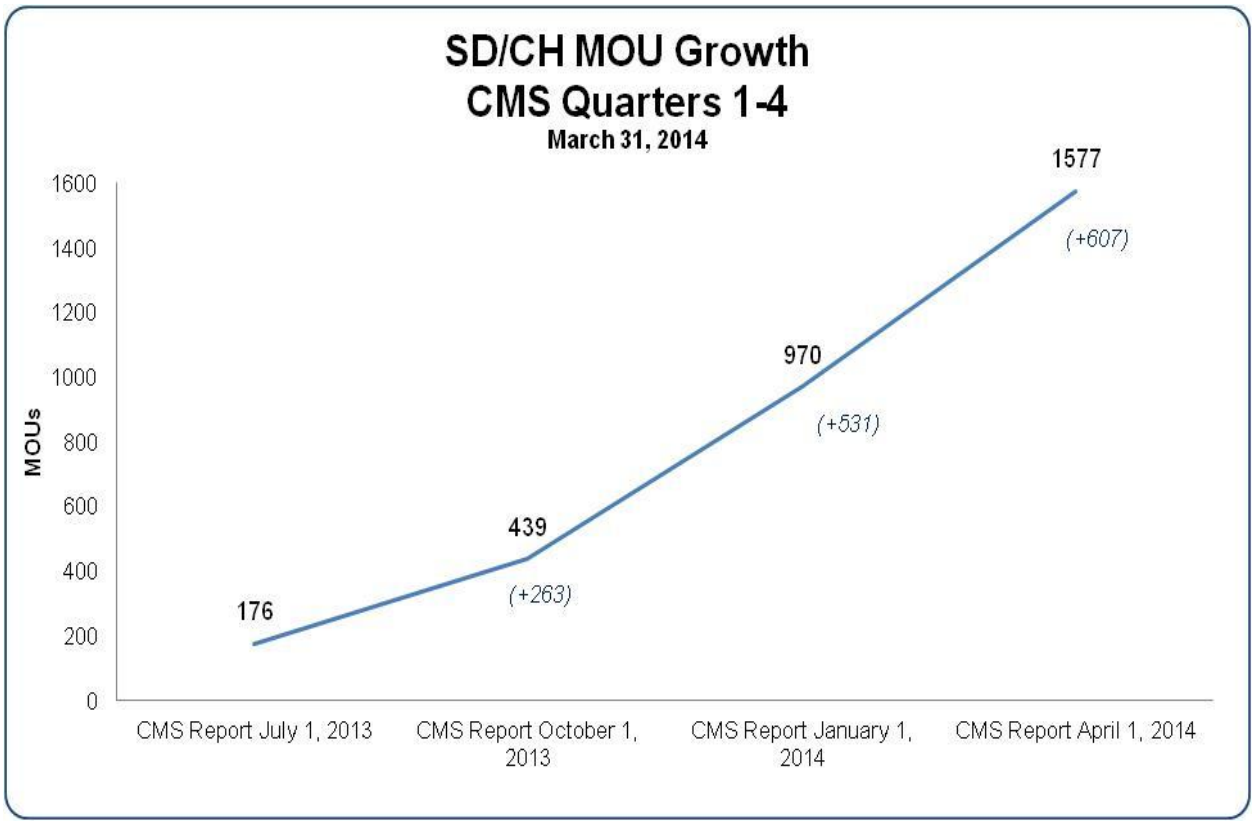
Beneficiaries with Developmental Disabilities who currently Self-Direct their Services

Since January 1, 2014 an additional 740 individuals are self directing services. Based on eMedNY data 133 additional participants self direct using Consolidated Supports and Services (CSS). Also, an additional 607 individuals self-direct their Community Habilitation service. As shown in the table below, OPWDD has exceeded the goal of 470 new beneficiaries self-directing their services by April 1, 2014.

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

The following charts show the quarterly increases for participants self directing using CSS and those who self direct their Community Habiliation services.





Progress on Approved Evaluation Design

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

NYS OPWDD Office of Home and Community Living

Rebalancing Residential Resources

One Region's Approach to Building a Sustainable Infrastructure that Provides Choice, Promotes Integration, and is Responsive to Changing Needs/Demands

March 31, 2014 • 10:00am-3:30pm

Andrew M. Cuomo
Governor

Laurie A. Kelley
Acting Commissioner

New York State Office for People With Developmental Disabilities

Office of Home and Community Living

PRESENTS

"Rebalancing Residential Resources"

One Region's Approach to Building a Sustainable Infrastructure that Provides Choice, Promotes Integration, and is Responsive to Changing Needs/Demands

March 31, 2014

HOUSING FORUM AT A GLANCE

AGENDA

WELCOME & OPENING REMARKS **10:00-10:30am**
***Laurie A. Kelley**, Acting Commissioner, NYS OPWDD*
***Jennifer Burnett**, Director, Division of Community Systems Transformation, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services, U.S. Department of Health & Human Services*
***Mark Kissinger**, Director, Division of Long Term Care, NYS Department of Health*
***Lucinda Grant-Griffin, Ph.D**., Director, Office of Home and Community Living, HUD-Approved Housing Counseling Program, NYS OPWDD*

SESSION PURPOSE AND ORGANIZATION **10:30 -10:35am**
***Gerald Huber**, Deputy Commissioner, Division of Person Centered Supports, NYS OPWDD*
***Kirk M. Maurer**, Director, DDRO, Region 1, NYS OPWDD*

ENVIRONMENTAL SCAN OF REGION 1 HOUSING SYSTEM: CURRENT AND POTENTIAL USERS **10:35-10:50am**
***J.R. Drexelius**, Governmental Relations Counsel, Developmental Disabilities Alliance of Western NY (DDAWNY)*

CURRENT SYSTEM PERFORMANCE: WHAT IS KNOWN, WHAT IS NOT KNOWN: How Future System Performance Should Be Quantified **10:50-11:10am**
***Kirk Maurer**, Director, DDRO, Region 1, NYS OPWDD*
***Barbara DeLong**, Family Committee Co-Chair, DDAWNY*

HOUSING CHALLENGES IN THE LARGER CONTEXT OF AFFORDABLE HOUSING **11:10-11:30am**

***George Hezel**, Clinical Professor of Law and Director of the Affordable Housing Clinic, University at Buffalo School of Law*

REVIEW OF CURRENT BEST PRACTICES IN PROVISION OF HOUSING SUPPORTS BY THE REGION'S DEVELOPMENTAL DISABILITY PROVIDERS **11:30-12:00pm**

***Ernest J. Haywood**, Vice President of Residential Services and Development, Lifetime Assistance, Inc.*

LUNCH (on your own) **12:00-12:30pm**

BANKING INDUSTRY PERSPECTIVE **12:30-12:45pm**

***Alexandra Wehr,** Vice President of Corporate Banking, First Niagara Bank*

NON-PROFIT DEVELOPER PERSPECTIVE **12:45-1:00pm**

***Michael Riegel,** Vice President of Housing Development, Belmont Housing Resources for WNY, Inc.*

PERSPECTIVE FROM REGIONAL HUD AND HCR REPRESENTATIVES **1:00-1:30pm**

***Joan K. Spilman**, Field Office Director, U.S. Department of Housing and Urban Development, Buffalo Field Office*
***Leonard Skrill**, Assistant Commissioner, NYS Homes and Community Renewal*

PANEL DISCUSSION ON ISSUES RAISED **1:30-2:45pm**

CLOSING REMARKS **2:45-3:00pm**

***Jennifer Ho**, Senior Policy Advisor for Housing and Services to the Secretary, U.S. Department of Housing and Urban Development*

WHERE DO WE GO FROM HERE? NEXT STEPS **3:00-3:30pm**
DISCUSSION LED BY ANN V. DENTON,
CMS/TA Housing Capacity Building Initiative for Community Living,
New Editions Consulting, Inc.

- **U.S. Department of Housing and Urban Development**
  Jennifer Ho
- **U.S. Department of Health & Human Services**
  Jennifer Burnett
- **NYS Office for People With Developmental Disabilities**
  Lucinda Grant-Griffin; Gerald Huber; Kirk Maurer; Housing Staff; Chester Finn
- **NYS Department of Health**
- **USDA Rural Development Section 502 & Multifamily Homes**
- **New Editions Consulting, Inc.**
  Ernest McKenney

Reasonable Accommodations

Anyone requiring a reasonable accommodation, please contact NYS OPWDD's Office of Home and Community Living by calling 518-473-1973 or e-mailing housing.initiatives@opwdd.ny.gov.

Registration Information

Webinar:
https://attendee.gotowebinar.com/register/1391510386995013378

Video Sites: Call (518) 473-1973 or email housing.initiatives@opwdd.ny.gov

Send all Questions on March 31, 2014 to: Housing.Forum@opwdd.ny.gov

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Division of Person-Centered Supports
Gerald Huber, Deputy Commissioner

Office of Home & Community Living
A HUD-Approved Housing Counseling Program
Lucinda Grant-Griffin, Ph.D., *Director*

Robert Addis, *Housing Counselor/Program Operations Specialist*

Alexander Brooks, *Housing Counselor/Project Assistant*

William Reid, *Housing Counselor/Project Assistant*

Timothy Elliott, *Housing Counselor/Downstate Coordinator/NYS Licensed Real Estate Salesperson*

Leon Dukes, *Clerk 1/Office Coordinator*

Cinda Putman, *Research Assistant*

Jasmine Frazier, *HUD-Intake Worker*

Regina Fowler, *Housing Counselor*

Veronica Johnson, *Housing Counselor*

Zefa Dedic, *Clerk 1*

Nelcy Ramirez, *Clerk 1*

Niesha Williams, *Clerk 1*

Jonathan Heard, *Support Staff*

Jewel A. Semple, *Support Staff*