NEW YORK
state department of
HEALTH

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Acting Commissioner of Health

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May 15, 2014

Jessica Woodard
Project Officer
Division of State Demonstrations and Waivers
Centers for Medicaid, CHIP and Survey & Certification, CMS
MS S2-01-16, 7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

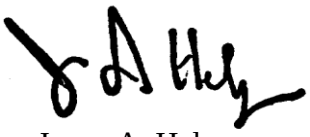
On December 31, 2013 Governor Andrew M. Cuomo submitted a formal request to Health and Human Services Secretary Kathleen Sebelius to extend New York's Medicaid Section 1115 Demonstration (Project Number 11-W-00114/2), also known as the Partnership Plan. New York is seeking a five-year extension, and this letter serves as a follow up with additional information requested by the Centers for Medicare and Medicaid Services (CMS). This extension request is being filed pursuant to Section 1115(a) of the Social Security Act. Under this section, demonstrations may be extended up to five years at the Secretary's discretion. New York's Partnership Plan currently expires December 31, 2014, and we are requesting an extension through December 31, 2019.

The extension of the Partnership Plan will provide the infrastructure necessary to support the expansion of care management for beneficiaries in New York State. Additionally, the extension will allow New York to realize the full potential of health reform initiatives outlined in New York's Medicaid Redesign Team (MRT) Action Plan, developed as a result of extensive stakeholder engagement. This will not only sustain current successful programs that support the Triple Aim by reducing costs while improving services, access and health outcomes, but will also provide the vehicle by which strategic investments can be made to transform the state's fragile health care safety net into a cost effective delivery system and benefit the state's 19 million residents.

New York has successfully managed its Partnership Plan goals and objectives in collaboration with CMS for nearly 17 years. In the past few years, the initiatives advanced by New York's Medicaid Redesign Team have helped to shape the goals and objectives of this waiver, most recently with the approval of the MRT Waiver Amendment. At this time, New York requests to rename this demonstration the "Medicaid Redesign Team (MRT) Waiver" to reflect the goals and objectives laid out over the next five years of the renewal period.

The cooperation between CMS and New York State Department of Health continues to be critical to the success of the Partnership Plan. We look forward to working closely with CMS to advance the objectives in the Partnership Plan. If you have any questions, please contact Kalin Scott of my staff at 518-474-3018.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosure
cc: Eliot Fishman, CMS
Andrea Casart, CMS
Mike Melendez, CMS
John Guhl, CMS
Ricardo Holligan, CMS
Kalin Scott, NYS DOH

Application for Partnership Plan Waiver Extension

New York State Medicaid Section 1115 Demonstration

Project No. 11-W-00114/2

The Partnership Plan

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Section 1: Historical Narrative and Objectives

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

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

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

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

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

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

health insurance coverage that provides family planning services. This program has been incorporated into the State Plan.

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

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

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

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

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

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

Uncompensated Care

The uncompensated care program provides over $108 million in payments to qualifying clinic providers, including mental health (MH) clinics, to assist in covering the uncompensated costs of services provided to the uninsured population. In order to receive these funds, each provider must deliver a comprehensive range of health care or mental health services; have at least 5% of their annual visits providing services to uninsured individuals; and have a process in place to collect payments from third party payers. For the year 2011, 112 D&TCs and 190 MH clinics were determined to be potentially eligible to receive funding for this program and provided over $214 million in uncompensated care services to the uninsured. Of these, 76 D&TCs and 124 MH clinics met the qualifying criteria described above and received $98.6 million and $10.2 million respectively from the indigent care funding which covered approximately 50% on average of their uncompensated care costs. The numbers are similar for 2012: 112 D&TCs and 195 MH clinics were potentially eligible and provided over $207 million in uncompensated care; 76 D&TCs and 98 MH clinics met the qualifying criteria and received $99.1 million and $9.7 million respectively which, on average, covered approximately 50% of their uncompensated care costs. It is important to note that for each year after the receipt of the indigent care funding approximately $100 million in uncompensated care costs remained that impacted the provider's financial condition.

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

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

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

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

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

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

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

Four major components comprise the Transformation Plan:

1. Offer opportunities for individuals moving from OPWDD campus and community based ICFs to live in smaller, more personalized settings;

2. Establish a strategy for increasing supportive housing options, and a timeline for the transitioning of residents of intermediate care facilities to community settings;

3. Increase the number of individuals in competitive employment; and

4. Educate stakeholders to increase the number of individuals who are self-directing their services.

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

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

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

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

Section 2: Successes and Projected Goals

2.1 Expanding Medicaid Managed Care

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

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

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

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

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

in any managed care plan, individuals who have a language barrier, individuals for whom a managed care provider is outside the travel time and distance standards, and individuals placed in the Office of Mental Health (OMH) licensed family care homes.

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

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

A. State Budget Changes to Medicaid:

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

B. Benefit Changes/Program Changes:

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

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

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

Directly Observed Therapy for Tuberculosis (TB/DOT): Effective August 1, 2013, the Department received authorization from CMS to include TB/DOT in the MMC benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

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

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

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

2.2 Managed Long Term Care

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

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

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

- Improved patient safety and quality of care for consumers;

- Reduction of preventable acute hospital and nursing home admissions; and

- Improved satisfaction, safety and quality of life for consumers.

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

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

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

A. Program Accomplishments:

- Implemented mandatory enrollment and transition process for Personal Care Services in New York City counties: completed as of September 2013.

- Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Assistance Program (CDPAP) can now receive that benefit through a MLTCP and are included in the mandatory enrollment

population. This was made effective in November of 2012. Additional education was developed and shared with MLTCPs addressing Consumer Directed Personal Assistance Services (CDPAS) and its use.

- Completed systemic process to identify recipients receiving Private Duty Nursing (PDN) and/or ADHC services and included these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population has been identified and is transitioning into MLTC.

- Expanded MLTCP availability by approving 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority for new partially capitated plans since September 2012. During the period October 2013 through December 2013, MLTCP availability was expanded by approving 2 service area expansions. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.

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

- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant. For the period from October 2013 to December 2013 post enrollment surveys were completed for 193 enrollees and 88% of the respondents are receiving services from the same home attendant. For the period from January 2014 to March 2014 post enrollment surveys were completed for 897 enrollees and 86% of respondents are receiving services from the same home attendant.

- Expanded the scope of the transition of community based services to include CHHA care, PDN and ADHC services in mandatory counties beginning in February 2013.

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

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

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

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

- Developed, with the Enrollment Broker, training for local social services in the transition process, identifying the districts' ongoing role during the transition, establishing clear communication mechanisms with MLTC plans, NYSDOH and stakeholders to ease transitions, while addressing potential systemic issues and ensuring informed choice by stakeholders and enrollees.

- Initiated activities for expansion of transition to Albany, Erie, Onondaga and Monroe counties in December 2013. Developed strategies to achieve the 2014 transition plan; expanding mandatory to additional counties incrementally each month. Expansion activities have commenced with April Districts (Columbia, Putnam, Sullivan, and Ulster). Initial outreach underway with the May Districts (Rensselaer, Cayuga, Herkimer, and Oneida).

Significant Program Developments

- Created a study protocol with an External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirements related to transition of care.

- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC, based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.

- Initiated training for use of the mandatory Uniform Assessment System for New York State (UAS-NY) which will replace the Semi-Annual Assessment of Members tool previously utilized by MLTC assessors.

- Developed Guidelines for MLTC plans and the State's Enrollment Broker on involuntary disenrollment to assure appropriate notice and ongoing care, as needed to support health and safety of enrollees in the community.

- Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.

- Enhanced monitoring of MLTC Provider Networks where deficiencies are identified and action taken.

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

B. Issues and Problems:

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

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

damage at their main facility, however schedules were back on track by December 2013.

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

- The electronic reporting system has been implemented and will continue to be refined as needed. There were 85 critical incidents reported to the Department for the fourth quarter utilizing the enhanced system. There were 215 critical incidents reported to the Department for the first quarter utilizing the enhanced system.

- During the first quarter of 2014, 9,594 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

2.3 Insuring More New Yorkers through Family Health Plus

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

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

2.4 Partnering with Private Insurers

In July 2007, state legislation was enacted to authorize the Employer Sponsored Health Insurance (ESHI) Initiative to increase coverage rates among uninsured but employed New York State residents with access to employer sponsored insurance. This initiative, called the FHPlus Premium Assistance Program (FHP PAP), allows individuals who are income eligible for FHPlus and have access to cost effective employer sponsored health insurance, to receive benefits. The state subsidizes the employee's share of the premium and pays for deductibles and co-payments in excess of the enrollee's co-payment obligations under FHPlus. Wrap-around

benefits are provided to the extent that such benefits are not covered by the enrollee's employer sponsored health plan. As of September 30, 2013, for years after going into effect, approximately 3,077 individuals are enrolled in this program.

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

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

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

2.5 Expanding Access to Family Planning Services

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

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

2.6 Increasing the Number of Health Care Providers Available to Beneficiaries

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

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

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

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

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

2.7 HOSPITAL-MEDICAL HOME (H-MH) DEMONSTRATION

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

PROGRAM ACCOMPLISHMENTS:

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

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

3. Conducted weekly meetings with a Work Plan Review Team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from IPRO and within the NYS Department of Health (NYS DOH)

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

5. According to hospital submissions in the 2013 Q4 time frame:
   - 93% of sites have residents that have been assigned to a panel of patients.
   - 47% of all sites have achieved Level 3 NCQA PCMH Recognition under the 2011 standards.
   - Out of 53 sites, 60% showed improvement in decreasing the amount of time required to see a specialist

- Analysis of outpatient medication reconciliation across hospitals led to a 41% reduced risk of readmission
- Breast Cancer Screening: Out of 28 sites, 89% showed improvement in their Q4 rates compared to their baseline rates.
- Of sites that reported, 96% showed improvement in screening for depression.
- The number of sites reporting data correctly has grown each quarter with continued education and support by NYS DOH.

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

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

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

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

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

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

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

ADMINISTRATIVE AND POLICY CHALLENGES

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

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

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

PLANNED ACTIONS FOR THE NEXT QUARTER

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

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

- Continue site visits with hospitals and outpatient primary care sites.

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

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

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

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

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

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

2.8 Potentially Preventable Readmissions (PPR) Demonstration

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

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

A. Outpatient Services for Potentially Preventable Conditions

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

B. Potentially Preventable Hospitalizations

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

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

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

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

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

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

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

A. Residential Transitions and Supportive Housing

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

B. Expanding Supportive Housing Options

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

C. Increasing Supported Employment Services and Competitive Employment

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

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

1) Improving the Quality of Supported Employment Services

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

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

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

- In anticipation of the roll out of Pathway to Employment, meetings were convened across the state with voluntary and state operated providers that might be interested in the service.

- Since a provider must already be authorized for supported employment services before Pathway to Employment services can be delivered, OPWDD facilitated three trainings for 100 providers who had not previously delivered supported employment services.

- Employment Trainings were also convened for approximately 300 Medicaid Service Coordinators.

- Between April 1, 2013 and June 30, 2013 seventeen Innovations in Employment Training sessions were convened. This training series provides participants with skills, tools and techniques that can be used to improve employment outcomes for people with developmental disabilities. The four-part series includes sessions on: Employment and Putting People First; Assessment and Planning; Job Development; and Job Coaching.

- By December 2013 an additional 558 supported employment and day habilitation staff representing 76 voluntary and state operated providers received training in employment discovery, assessment, job development and job coaching.

- As a follow up to these sessions, OPWDD convened ten Employment Management Forums with the directors and managers of supported employment programs. This was an opportunity to facilitate dialogue with provider agencies in regards to supporting their front line employment staff in the implementation of tools and techniques, provided in the Innovations in Employment Training Series. These forums also created an opportunity to discuss job attrition, the reasons why people have difficulty maintaining jobs and strategies that can be used to assist people in retaining jobs. There were 256 participants at these Employment Management Forums representing 165 out of 174 supported employment agencies in New York State.

- Convened two Employment Roundtables in Region 2 (Broome, Central NY and Sunmount). The first employment roundtable was designed to recruit new supported employment providers. This session focused on OPWDD's employment expectations, goals and strategies for delivering quality supported employment services. Billing and documentation requirements were also covered. The second employment roundtable was a follow-up to the Statewide Promising Practices in Employment video conference. This session enabled supported employment providers within the region to share promising practices and successful techniques for transitioning people from day habilitation and

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

2) <u>Fostering Partnerships with Business and the State Education System</u>

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

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

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

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

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

D. Increasing Self-Direction Education to Beneficiaries

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

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

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

Self-Direction Education Training

April 1, 2013 – March 31, 2014

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

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

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

E. Progress on Approved Evaluation Design

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

2.10 MRT Waiver Amendment

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

A. Designated State Health Programs (DSHPs)

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

B. Delivery System Reform Incentive Payment (DSRIP) Plan

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

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

Only initial funding of this structure is authorized in 2014; continued authority for operations and funding must be authorized upon renewal of the overall Partnership Plan demonstration, and is contingent on satisfactory initial implementation.
In addition, the special terms and conditions also commit the state to comprehensive payment reform and continuing New York's effort to effectively manage its Medicaid program within the confines of the Medicaid Global Spending Cap.

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

2.11 Proposed Waiver Amendment for Behavioral Health

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

the highest need individuals. In addition, there is insufficient accountability for the provision of quality care and for improved outcomes for patients/consumers.

The MRT report also documented that BH is not well integrated or effectively coordinated with physical health (PH) care at the clinical level or at the regulatory and financing levels. Currently, the BH system is funded primarily through fee-for-service (FFS) Medicaid, while a substantial portion of PH care for people with mental illness or SUDs is financed and arranged through Medicaid Managed Care plans. This further contributes to fragmentation and lack of accountability within the BH system. This lack of coordination within the BH system extends well beyond PH care, into the education, child welfare, and juvenile justice systems for those under the age of 21, as well as for those who are homeless and within forensic systems for adults.

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

- **Mainstream MCOs**: For all adults served in qualified mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid covered services for MH, SUDs and PH conditions under this demonstration.

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

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

- To improve clinical and recovery outcomes for participants with SMI and/or SUDs;

- Reduce the growth in costs through a reduction in unnecessary emergency and inpatient care; and

- Increase network capacity to deliver community-based recovery-oriented services and supports.

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

A. Prospective Reporting and Program Monitoring

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

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

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

B. Quality Management (QM) (Please see Attachment 6 for the Proposed Evaluation Plan)

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

C. Implementation of the Demonstration

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

- New York issued a request for qualifications (RFQ) in February 2014 to determine the competence of MCOs/HARPs to manage specialty BH benefits for adults in New York City, with an implementation date of January 2015. If an MCO or HARP is not qualified to manage BH benefits for adults, they will need to subcontract with a managed BH organization and resubmit their RFQ.

- New York issued the RFQ in February 2014 to determine the competence of MCOs and HARPs to manage BH benefits for adults in the remainder of New York State, with an implementation date of July 2015. If an MCO is not qualified to manage BH benefits for adults, they will need to subcontract with a managed BH Organization and resubmit their RFQ.

- New York will phase in a pilot for self-direction of 1915(i)-like HCBS services over a three year period in this waiver. Supports for self-direction are included in the benefit

package under this 1115 amendment and operationalization of those supports will be tested in a pilot.

2.12 ASSESSING QUALITY OF CARE

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

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

Select MLTC Member Quality and Utilization Results

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

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

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

The Department has surveyed satisfaction with plans and providers for various populations, i.e. children, MLTC, PCMH. To assess all dimensions of quality, the Department administers a

biennial survey to measure member satisfaction, called the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey.

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

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

Transitions of Care Focused Clinical Study for MLTC

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

Plan Performance Improvement Projects (PIPs) and Quality Improvement Initiatives

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

1. Data Validation Studies

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

plans in New York will have to contract with a certified HEDIS® auditor for the required QARR/ HEDIS® audit.

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

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

2. Performance Improvement Projects (PIPs)

a) Pediatric Obesity

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

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

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

b) Eliminating Disparities in Asthma Care (EDAC)

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

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

c) Reducing Potentially Preventable Readmissions

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

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

d) Collaborative PIP 2013-2014 includes Two Parts:

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

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

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

During the PIP proposal development phase, the health plans were provided information on a free provider practice training entitled, Detection and Management of High Blood Pressure - A Blood Pressure Train-the-Trainer Master Training Course. In June 2013, IPRO and NYSDOH conducted a conference call with all of the MMCPs. A guest speaker from the NYSDOH, Bureau of Community Chronic Disease Prevention, spoke about the Diabetes Self-Management Education Programs and Certified Diabetic Educator availability across New York State. IPRO and DOH also presented on the Diabetes Prevention Programs available.

3. Focused Clinical Studies

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

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

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

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

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

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

The Department, in collaboration with IPRO, conducted a clinical study on the HEDIS® measure, AAB. The purpose of this study was to evaluate demographic and clinical factors associated with antibiotic prescribing for acute bronchitis in adults, to better understand observed clinician prescribing patterns and inform improvement efforts. The Department observed antibiotic prescribing rates were higher for adults with acute bronchitis than those based on the HEDIS® AAB measure; and, over half of adult Medicaid managed care members presenting with acute bronchitis had a major chronic condition as defined by CRG health status. Few clear

clinical drivers of antibiotic prescribing were identified; however, prescribing was associated with purulent sputum and a longer duration of cough, potentially indicating providers' concerns with non-viral etiologies. Also, members who did not receive antibiotics were more likely to be seen in the emergency department, were in receipt of chest X-ray, presumably to rule out pneumonia, and were associated with avoidance of antibiotics. Since there may be some subsets of patients who might benefit from antibiotics, further study of members with co-morbidities, older members, members with longer duration of illness, and members without upper respiratory infection may areas for further study.

A. ASSESSING SATISFACTION OF CARE

Patient-Centered Medical Home (PCMH) Satisfaction

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

Managed Long Term Care

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

Medicaid Adults CAHPS Survey

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

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

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

10)						

CAHPS Clinician and Group (C&G) Survey Pilot

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

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

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

Managed Long Term Care Satisfaction Surveys

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

In addition, New York's Medicaid section 1115 Demonstration was recently expanded and the biennial member satisfaction survey was recently concluded. New members' experience with

the transition from FFS to managed care was of interest. To that purpose, NYSDOH, with its EQRO, Island Peer Review Organization (IPRO), initiated a study to assess members' satisfaction with MLTC versus FFS. A survey instrument was developed to assess members' initial experiences with the health plans, while also comparing the quality and timeliness of care providers and access to care before and after the members joined the plans. A random sample of 1,500 newly enrolled members has been selected to receive the survey, which is expected to be mailed in by the end of 2013.

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

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

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

Child Satisfaction Survey with Chronic Condition Module

In the fall of 2012, the Medicaid CAHPS for Children, including children with chronic conditions, was administered to parents and guardians of children enrolled in Medicaid or Child Health Plus managed care plans. A total of 26,250 children, enrolled in either Medicaid or CHPlus for at least six months, were randomly selected. The response rate from this pool was 35 percent and the results of the survey are available on the Department's website: http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/index.h

tm. Results from this study will be used for the State's Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements.

B. IMPLEMENTING NEW STANDARDS FOR CARE

1) Patient-Centered Medical Home (PCMH)

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

2) Prenatal Care Standards Development

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

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

3) 2011 Prenatal Care Study

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

C. SELECTIVELY CONTRACTING WITH PROVIDERS

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

1) Breast Cancer Surgery

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

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

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

2) Bariatric Surgery

Bariatric surgery emerged as an alternative method of weight loss and long term weight maintenance for many obese and morbidly obese individuals for whom diet, exercise, and the normally prescribed medical therapies have proven ineffective. While there are benefits to this procedure, there are also substantial potential risks. Recent research conducted by the Department illustrated a significant postoperative complication rate following bariatric surgery, as well as a substantial hospital 30 day readmission rate following discharge for such surgeries.

This research also found tremendous variation in the risk-adjusted complication and readmission rates among hospitals. Given such wide variation in hospital performance, the Department restricts Medicaid reimbursement for bariatric surgical services to those hospitals achieving CMS certification as a Bariatric Surgical Center. Currently, approximately 40 hospitals in New York State have achieved certification and may be reimbursed for bariatric surgical services, for both managed care and FFS Medicaid recipients. This restriction is intended to ensure that Medicaid recipients receive bariatric surgical services at hospitals with the best outcomes.

D. REWARDING QUALITY

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

MLTC Quality Incentive Workgroup

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

Section 3: Extension Requests

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

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

Team (MRT). In August 2012, CMS approved the Managed Long Term Care (MLTC) amendment.

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

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

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

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

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

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

Therefore, New York is seeking approval for five years in this extension application for the Partnership Plan, from January 1, 2015 through December 31, 2019 in order for the State to reinvest federal savings generated by the MRT reform initiatives and to reinvest in the state’s

health care system currently authorized by the Partnership Plan. This time period will prospectively support changes as a result of national health reform initiatives.

New York State is requesting the 1115 extension for the purpose of: changing the delivery system fee-for-service to a more cost effective managed care delivery system, continuing financing arrangements that have supported our current programs (i.e., Managed Care DSHPs), altering benefits and expanding coverage for individuals leaving institutional settings (i.e., provide more HCBS services and eligibility criteria to allow individuals to live in the most integrated community settings) and leveraging managed care payment reform.

The goals for the new extension:

- Meeting the CMS Triple Aim: improving quality of care, improving health outcomes and reducing per capita for health care
- Encourage healthy behaviors through a managed behavioral health delivery system
- Reduce health care costs by measuring outcomes and pay for performance
- Reduce health care disparities
- Reduce avoidable hospital admissions and re-admissions
- End fee-for-service and institute a comprehensive, high quality integrated care management system to lower costs and improve health outcomes

The objectives for the 1115 extension are to:

- Implement the Delivery System Reform Incentive Payment Program to achieve a 25% reduction in avoidable hospital use over 5 years
- Promote community collaboration to implement safety net system reform at the state and system levels to facilitate financing flexibility for coverage of the uninsured
- Ensure sustainability of delivery system transformation through leveraging managed care payment reform

This extension request is being submitted under the existing waiver and expenditure authorities of the Partnership Plan Medicaid Section 1115 Waiver. As a result of negotiations regarding the Behavioral Health proposal, expenditure authorities may need to be revised.

The Department is requesting that an expenditure authority for the Developmental Disabilities Transformation be added for the period of 4/1/2014 through 3/31/2015.DOH and OPWDD will be proposing a multi-year transformation plan to continue to qualify for $250 million for each year of the plan to implement the next phase of the Intellectual and Developmental Disabilities System Transformation. This agreement will build upon the initial success of the plan and continue with transformational elements related to

deinstitutionalization; the expansion of integrated housing options; and the promotion and expansion of opportunities for individuals to self-direct their services and achieve employment outcomes. In addition, the proposal will include the continued reform of the fiscal platform and the move of the service system to a specialized system of managed care that promotes quality outcomes for people with intellectual and developmental disabilities.

In addition, the state is requesting Designated State Health Program funding be continued until 12/31/2019. Discussions are ongoing between CMS and the Department regarding this funding through 12/31/2019.

New York State would like to continue its current progress and future endeavors by requesting an extension to the following STCs through December 31, 2019.

- Section IV. Population Affected by and Eligible under the Demonstration

  This section needs to be extended to continue financing for programs that are currently supported under the 1115 Partnership Plan and for additional populations as fee for service is ended.

- Section V. Demonstration Benefits and Enrollment

  This section needs to be extended to continue MMC program accomplishments in the area of coverage and access necessary for increased enrollment and the expansion of mandatory enrollment.

  As of September 2013, New York had enrolled 3 million people in MMC under the Partnership Plan Demonstration. From September 2010 through September 2013, enrollment in the MMC program increased by 23.9 percent, or more than 580,000 beneficiaries statewide.

  In 2013, the state legislature eliminated all previous exclusions or exemptions from mandatory enrollment into MMC. The State is in the process of establishing and obtaining required Federal approvals for two new types of managed care arrangements within the Medicaid program to address the unique needs of previously excluded populations: Developmental Disability Individual Support and Care Coordination Organizations (DISCOs) for people with developmental disabilities and Health and Recovery Plans (HARPs) for people with behavioral health needs, such as severe and persistent mental illness and substance abuse disorders.

- Section VI. Delivery System

  This section needs to be extended to maintain success in the areas of coverage and access necessary for enrollment growth. Operational policies need to be extended and maintained to assure the existing quality of the current managed care delivery system and the expected growth from eliminating fee for service.

- Section VII. Quality Demonstration Program and Clinic Uncompensated Care Funding

  This section needs to be extended to continue the funding of Designated State Health Programs to support the goals of health system transformation for certain state program expenditures, subject to annual limits and restrictions.

A. Current Amendment Requests submitted to CMS:

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

- The Department is seeking the authority to extend Medicaid coverage for recipients who lose Medicaid eligibility after the 15th of the month, until they become eligible for APTC, or a Qualified Health Plan (QHP). The requested effective date for this amendment is January 1, 2014.

- The Department submitted a proposal to transition behavioral health state plan services from fee-for-service (FFS) to Medicaid Managed Care (MMC) under the Partnership Plan. Additionally, this proposal includes the provision of 1915(i) like home and community based services tailored to the needs of individuals with significant mental health and substance use disorder needs. These services will be delivered through specialized managed care plans called Health and Recovery Plans (HARPSs). There are essentially three components to the behavioral health (BH) amendment: Inclusion of BH services for adults in the mainstream MCOs currently under the 1115 demonstration; enrollment of participants meeting targeting criteria and risk factors in HARPs; and expansion of BH home and community based supportive services to participants meeting targeting, risk factors, and needs-based criteria.

- The Department submitted a request for a technical amendment to extend the effective period of the Designated State Health Program which supports New York State's Transformation of the Office for People with Developmental Disabilities (OPWDD) service delivery system from April 1, 2014 through the term of the term of the waiver. The additional funding is necessary to continue to provide a multi-year transformation to deinstitutionalize and transition individuals to the most integrated setting, ensure new and existing services meet CMS' home and community based standards and to facilitate person centered planning with an emphasis on self-direction, competitive employment and integrated housing. The Department is requesting CMS' assistance in developing a plan to continue the health systems transformation for people with developmental disabilities.

  The current evaluation plan is in effect through July 2014. The Transformation Agreement, Quarterly Update and Annual Progress Report (Annual Reporting Period April 1, 2013 – March 31, 2014) is attached, as requested.

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

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

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

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

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

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

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

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

ATTACHMENT 6: BEHAVIORIAL HEALTH EVALUATION PLAN

Evaluation Tool for the New York State Behavioral Health Partnership Plan Demonstration Amendment –

Demonstration Period:

January 1, 2015 through December 31, 2020

This tool describes the key goals, evaluation questions, measure/variables, activities and data sources related to New York State

<u>Goal:</u> Expand behavioral health care and community-based recovery-oriented services and supports.

Make community-based recovery-oriented services and supports available to a greater number of Medicaid recipients under Medicaid Managed Care.

	Research Questions	**Measure/Variable**	**Data Sources**
1	How has enrollment in Health and Recovery Plans (HARP) increased over the length of the demonstration?	Number of beneficiaries enrolled in HARPs, by county and percent change over time.	OHIP Data Mart
2	What are the demographic characteristics of the HARP population? Are they changing over time?	Year to year comparison of demographic composition of HARP beneficiaries, including age, race, gender, risk factors, enrollment, living situation, and diagnoses.	OHIP Data Mart Uniform Assessment System (UAS)
3	What is the functional capacity of the HARP population? Are they changing over time?	Year to year comparison of average statewide HARP beneficiary scores on Activities of Daily Living Measures, Social Connectedness, Employment and Educational Status, Criminal Justice Involvement.	Uniform Assessment System (UAS)
4	Are the individual care plans consistent with the	This evaluation question will be included when there is sufficient data	

	functional and cognitive abilities of the enrollees?	available in 2016 to provide accurate measures.	
5	Access to Care: To what extent are enrollees able to receive access to HCBS services?	Number of HARP beneficiaries who receive HCBS services	OHIP Data Mart
6	To what extent has the demonstration improved access to behavioral health HCBS services?	Number of HARP behavioral health programs offering HCBS services Number of HCBS services accessed PMPM	OHIP Data Mart Provider Network Data System (PNDS)
7	To what extent are HARP enrollees satisfied with access to HCBS services?	Percentages of HARP beneficiaries who reported that they had timely access to desired HCBS services Percentages of HARP beneficiaries who reported that they were satisfied with services received	HARP Member Satisfaction Survey
9	Have HARPs been successful in integrating behavioral and physical health services for beneficiaries?	Change in physical health quality outcome measures of HARP beneficiaries against pre-HARP enrollment and compared to status change for all beneficiaries in the mainstream plan	HEDIS; QARR, OHIP Data Mart
10	Has the creation of HARPs and expansion of behavioral health services in mainstream plans impacted quality outcomes?	Evaluation of patient behavioral health outcomes	HEDIS; QARR; OHIP Data Mart
11	Are recovery outcomes improving for persons with behavioral health needs?	Evaluation of patient recovery outcomes as they pertain to HCBS services including, but not limited to employment, education, housing, community/social integration, etc.	HEDIS; QARR; OHIP Data Mart

12	How has the creation of HARPs and expansion of behavioral health services in mainstream plans reduced emergency care, inpatient care, and readmissions?	Evaluation of data on preventable emergency care, inpatient care and readmissions	HEDIS; QARR; OHIP Data Mart
13	Are enrollees' medications (including psychiatric and addiction medications) being managed effectively?	Measure adherence to anti-psychotic medications among individuals with psychotic disorders	HEDIS; QARR; OHIP Data Mart
14	What are the levels of satisfaction with the timeliness (how often services were on time/how often the enrollee was able to see the provider at the scheduled time) and quality of network providers?	Tracking Plan service denials and appeals	Plan reporting
15	To what extent are behavioral health enrollees satisfied with the cultural sensitivity of providers?	Percentages of HARP and mainstream beneficiaries who report that they were satisfied/ dissatisfied with cultural sensitivity of providers	CAHPS and HARP Supplemental Satisfaction Survey
	How has moving BH benefits into qualified mainstream plans allowed for better identification and treatment of BH conditions in primary care settings?	This evaluation question will be included when there is sufficient data available	
16	How has moving BH benefits into qualified mainstream plans allowed for better prevention and early intervention efforts for individuals with BH conditions (for example First Episode Psychosis (FEP))	Number of individuals screened for behavioral health conditions in primary care settings	HEDIS; QARR

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

NOTICE OF PUBLIC HEARING

Department of Health

Pursuant to 42 CFR Section 431.408, the Department of Health hereby gives notice of the following:

Operating since 1997, New York State's Medicaid Section 1115 Partnership Plan Waiver has been critical in successfully improving access to health services and outcomes for the poorest and most at risk residents. The waiver allows the State to operate a managed care program which provides comprehensive and coordinated health care to Medicaid recipients, thereby improving their overall health coverage.

New York State is requesting approval from CMS to extend the Partnership Plan Demonstration for an additional five years, from January 1, 2015 through December 31, 2019, in order for the State to reinvest federal savings generated by the Medicaid Redesign Team (MRT) reform initiatives and to reinvest in the state's health care system currently authorized by the Partnership Plan. Additionally, the New York State Department of Health is currently in negotiations with CMS to amend the Partnership Plan to continue MRT initiatives, and implement the MRT/Delivery System Reform Incentive Payment (DSRIP) plan, and to integrate behavioral health benefits and populations into managed care.

The complete extension application, which includes an interim evaluation of the Partnership Plan which assesses the degree to which the Demonstration goals have been achieved and key activities that have been implemented, can be found on the Partnership Plan Section 1115 Waiver Information website at: http://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm

The public is invited to review and comment on the State's proposed waiver extension request. Public Hearings are scheduled for:

Waiver Extension Public Hearing – Albany
April 16, 2014, 10 AM -1 PM
University at Albany
School of Public Health Auditorium
1 University Place
Rensselaer, New York

Waiver Extension Public Hearing – New York
April 18, 2014, 12:30 PM to 3:30 PM
New York City Regional Office (MARO)
90 Church Street
Conference Room 4 A and B
New York, New York

A conference call number will be available for this public hearing, so that individuals may provide comment by phone.

Registration information will be made available on the Partnership Plan Section 1115 Waiver Information website at: http://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm

Comments concerning the Application for Partnership Plan Extension can be sent to the email or postal address below for a period of thirty (30) days from the date of this notice.

Email: 1115waivers@health.state.ny.us
Address: Department of Health
Office of Health Insurance Programs
Division of Program Development and Management
Waiver Management Unit
Empire State Plaza, Corning Tower -OCP 1208
Albany, NY 12237

PUBLIC NOTICE

New York State and Local Retirement Systems Unclaimed Amounts Payable to Beneficiaries

Pursuant to the Retirement and Social Security Law, the New York State and Local Retirement Systems hereby gives public notice of the amounts payable to beneficiaries.

The State Comptroller, pursuant to Sections 109 (a) and 409 (a) of the Retirement and Social Security Law has received, from the New York State and Local Retirement Systems, a listing of beneficiaries or estates having unclaimed amounts in the Retirement System. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement Systems located at 110 State St., in the City of Albany, New York.

Set forth below are the names and addresses (last known) of beneficiaries and estates appearing from the records of the New York State and Local Retirement Systems, entitled to the unclaimed benefits.

At the expiration of six months from the date of publication of this list of beneficiaries and estates, unless previously paid to the claimant, the amounts shall be deemed abandoned and placed in the pension accumulation fund to be used for the purpose of said fund.

Any amounts so deemed abandoned and transferred to the pension accumulation fund, may be claimed by the executor or administrator of the estates or beneficiaries so designated to receive such amounts, by filing a claim with the State Comptroller. In the event such claim is properly made, the State Comptroller shall pay over to the estates or to the person or persons making such claim, the amount without interest.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 23, 2014

Dear Colleague:

In July 1997, New York State received approval from the federal government for the Section 1115 waiver request known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid Managed Care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. On September 29, 2006, the Centers for Medicare and Medicaid (CMS) approved an extension of 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 for the period August 1, 2011 through December 31, 2014.

This letter is to notify you that New York is seeking approval for a five year extension to the Partnership Plan, from January 1, 2015 through December 31, 2019. This extension will allow currently existing Partnership Plan programs to continue, and anticipates reinvestment of federal savings generated by Medicaid Redesign Team initiatives to reinvest in New York's health care delivery system.

As you know, under the State's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. Under these amendments to the 1115 waiver, this exemption from mandatory enrollment for Native Americans will be continued. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued. We anticipate these changes will have minimal impact on Tribal Nations.

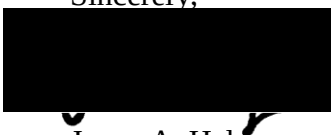
My office has scheduled a conference call to provide an overview of the waiver extension process and to take any questions you may have.

The call is scheduled for Tuesday, March 11, 2014 at 10:00 A.M. If you would like to participate please use the following call-in information:

Call-in #: **518-549-0500**
Conference Code: **965 05 906#**

Please forward any additional comments or questions to the Waiver Management Unit email at: 1115waivers@health.state.ny.us. We look forward to our continued collaboration.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Wendy Stoddart, DOH
Kalin Scott, DOH
Karina Aguilar, HHS
Venetta Harrison, CMS

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Children and Adolescents' Access to Primary Care Practitioners (Ages 12-19 Years)	92	92	93
Children and Adolescents' Access to Primary Care Practitioners (Ages 12-24 months)	96	97	97
Children and Adolescents' Access to Primary Care Practitioners (Ages 25 Mos-6 Years)	93	93	93
Children and Adolescents' Access to Primary Care Practitioners (Ages 7-11 Years)	95	95	96
Adults' Access to Preventive and Ambulatory Health Services (Ages 20-44)	82	83	84
Adults' Access to Preventive and Ambulatory Health Services (Ages 45-64)	89	90	90
Adults' Access to Preventive and Ambulatory Health Services (Ages 65 and over)	89	90	90
Use of Imaging Studies for Low Back Pain	79	79	78
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	27	28	24
Advising Smokers to Quit	.	78	.
Discussing Smoking Cessation Medications	.	56	.
Discussing Smoking Cessation Strategies	.	48	.
Colon Cancer Screening	.	56	.
Adult BMI Assessment	70	.	79
Flu Shot for Adults	.	40	.
Controlling High Blood Pressure	67	.	63
Cholesterol Screening Test	.	90	.
Cholesterol Level Controlled (<100 mg/dL)	.	52	.
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	.	.	82
Persistence of Beta-Blocker Treatment	.	77	81
Drug Therapy for Rheumatoid Arthritis	76	77	78
Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	91	91	92
Annual Monitoring for Patients on Persistent Medications- Digoxin	94	94	93
Annual Monitoring for Patients on Persistent Medications- Diuretics	90	90	91
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	67	66	68

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Annual Monitoring for Patients on Persistent Medications- Combined Rate	89	90	90
Use of Appropriate Medications for People with Asthma (Ages 12-18)	.	87	82
Use of Appropriate Medications for People with Asthma (Ages 19-50)	.	84	82
Use of Appropriate Medications for People with Asthma (Ages 19-64)	.	84	82
Use of Appropriate Medications for People with Asthma (Ages 51-64)	.	83	81
Use of Appropriate Medications for People with Asthma (Ages 5-11)	92	90	86
Use of Appropriate Medications for People with Asthma (Ages 5-18)	.	89	85
Use of Appropriate Medications for People with Asthma (Ages 5-64)	.	87	83
Appropriate Asthma Medications- 3+ Controllers (Ages 12-18)	.	69	64
Appropriate Asthma Medications- 3+ Controllers (Ages 19-50)	.	72	69
Appropriate Asthma Medications- 3+ Controllers (Ages 19-64)	.	74	71
Appropriate Asthma Medications- 3+ Controllers (Ages 51-64)	.	77	75
Appropriate Asthma Medications- 3+ Controllers (Ages 5-11)	76	72	67
Appropriate Asthma Medications- 3+ Controllers (Ages 5-18)	.	71	66
Appropriate Asthma Medications- 3+ Controllers (Ages 5-64)	.	72	68
Medical Management for People with Asthma 50% Covered(Ages 12-18)	.	50	49
Medical Management for People with Asthma 50% Covered(Ages 19-50)	.	63	63
Medical Management for People with Asthma 50% Covered (Ages 19-64)	.	68	68
Medical Management for People with Asthma 50% Covered (Ages 51-64)	.	78	77
Medical Management for People with Asthma 50% Covered (Ages 5-11)	.	51	48
Medical Management for People with Asthma 50% Covered (Ages 5-18)	.	50	48
Medical Management for People with Asthma 50% Covered (Ages 5-64)	.	59	57
Medical Management for People with Asthma 75% Covered (Ages 12-18)	.	25	25
Medical Management for People with Asthma 75% Covered (Ages 19-50)	.	38	38
Medical Management for People with Asthma 75% Covered (Ages 19-64)	.	44	43

QARR Rates 2010-2013
Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Medical Management for People with Asthma 75% Covered (Ages 51-64)	.	54	53
Medical Management for People with Asthma 75% Covered (Ages 5-11)	.	26	25
Medical Management for People with Asthma 75% Covered (Ages 5-18)	.	26	25
Medical Management for People with Asthma 75% Covered (Ages 5-64)	.	35	34
Asthma Medication Ratio (Ages 12-18)	.	.	52
Asthma Medication Ratio (Ages 19-50)	.	.	54
Asthma Medication Ratio (Ages 19-64)	.	.	55
Asthma Medication Ratio (Ages 51-64)	.	.	58
Asthma Medication Ratio (Ages 5-11)	.	.	56
Asthma Medication Ratio (Ages 5-18)	.	.	55
Asthma Medication Ratio (Ages 5-64)	.	.	55
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	46	50	53
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	66	68	72
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	85	84	88
Monitoring Diabetes - HbA1c Testing	.	89	.
Monitoring Diabetes - Lipid Profile	.	87	.
Monitoring Diabetes - Dilated Eye Exam	.	64	.
Monitoring Diabetes - Nephropathy Monitoring	.	83	.
Monitoring Diabetes - Received All Tests	.	51	.
Managing Diabetes Outcomes -Poor HbA1c Control	.	33	.
Managing Diabetes Outcomes - HbA1C Control (<8.0%)	.	58	.
Managing Diabetes Outcomes - HbA1C Control (<7.0%) for Selected Populations	.	41	.
Managing Diabetes Outcomes - Lipids Controlled (<100 mg/dL)	.	47	.
Managing Diabetes Outcomes - Blood pressure controlled (<140/80 mm Hg)	.	44	.
Managing Diabetes Outcomes - Blood pressure controlled (<140/90 mm Hg)	.	66	.

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Managing Diabetes Outcomes - HbA1c and Lipids Controlled	.	37	.
Engaged in Care	80	84	83
Viral Load Monitoring	58	64	72
Syphilis Screening	58	66	71
Annual Dental Visit (Ages 2-18)	54	55	57
Annual Dental Visit (Ages 2-21)	53	54	56
Antidepressant Medication Management-Effective Acute Phase Treatment	52	51	53
Antidepressant Medication Management-Effective Continuation Phase Treatment	35	34	37
Follow-Up After Hospitalization for Mental Illness Within 7 Days	70	72	65
Follow-Up After Hospitalization for Mental Illness Within 30 Days	85	83	79
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	.	.	64
Board Certified Family Medicine	80	80	78
Board Certified Internal Medicine	81	81	80
Board Certified OB/GYN	76	77	74
Board Certified Pediatrics	82	82	81
Satisfaction with Provider Communication	.	.	.
Satisfaction with Personal Doctor	.	.	.
Satisfaction with Specialist	.	.	.
Getting Care Needed	.	.	.
Getting Care Quickly	.	.	.
Customer Service	.	.	.
Rating of Health Plan	.	.	.
Collaborative Decision Making	.	.	.
Care Coordination	.	.	.
Wellness Discussion	.	.	.

QARR Rates 2010-2013
Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Rating of Overall Healthcare	.	.	.
Getting Needed Counseling or Treatment	.	.	.
Rating of Counseling or Treatment	.	.	.
Access to Prescription Medicines for Children	.	.	.
Coordination of Care for Children with Chronic Conditions	.	.	.
Getting Care Needed for Children	.	.	.
Satisfaction with Provider Communication for Children	.	.	.
Customer Service for Children	.	.	.
Collaborative Decision Making for Children	.	.	.
Family-Centered Care: Getting Needed Information for Children	.	.	.
Rating of Overall Healthcare for Children	.	.	.
Rating of HP - High Users for Children	.	.	.
Family-Centered Care: Personal Doctor Who Knows Child	.	.	.
Getting Care Quickly for Children	.	.	.
Rating of Counseling or Treatment for Children	.	.	.
Rating of Health Plan for Children	.	.	.
Satisfaction with Personal Doctor for Children	.	.	.
Satisfaction with Specialist for Children	.	.	.
Access to Specialized Services for Children	.	.	.
Childhood Immunization-MMR	.	93	.
Childhood Immunization-Varicella	.	91	.
Childhood Immunization-3 or more Hibs	.	93	.
Childhood Immunization-3 or more HepB	.	92	.
Childhood Immunization-3 or more IPVs	.	93	.
Childhood Immunization-4 or more DTPs	.	83	.

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Childhood Immunization - 4 or more Pneumococcals	.	81	.
Childhood Immunization - 2 or more HepA	.	37	.
Childhood Immunization - 2 or more Influenza	.	57	.
Childhood Immunization - 2 or 3 Rotavirus	.	69	.
Childhood Immunization - Combo 2	.	78	.
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)	.	74	.
Childhood Immunization - Combo 4	.	34	.
Childhood Immunization - Combo 5	.	59	.
Childhood Immunization - Combo 6	.	49	.
Childhood Immunization - Combo 7	.	30	.
Childhood Immunization - Combo 8	.	26	.
Childhood Immunization - Combo 9	.	41	.
Childhood Immunization - Combo 10	.	23	.
Lead Testing	.	89	.
Adolescent immunization-Menignococcal	.	70	72
Adolescent immunization-Tdap/Td	.	91	92
Adolescent immunization-Combo	.	67	69
Adolescent immunization-HPV	.	.	26
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	77	83	83
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	80	83	82
Adolescent Well-Care Visits	56	59	59
Appropriate Treatment for Upper Respiratory Infection (URI)	91	92	93
Appropriate Testing for Pharyngitis	84	86	87
Follow-Up Care for Children Prescribed ADHD Medication:Initiation Phase	58	59	57
Follow-Up Care for Children Prescribed ADHD Medication:Continuation Phase	64	66	63

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Weight Assessment- BMI Percentile	65	73	.
Weight Assessment for Children and Adolescents 12-17 Yrs	66	73	.
Weight Assessment for Children and Adolescents 3-11 Yrs	65	73	.
Counseling for Nutrition	71	77	.
Counseling for Nutrition for Children and Adolescents 12-17 Yrs	69	75	.
Counseling for Nutrition for Children and Adolescents 3-11 Yrs	72	77	.
Counseling for Physical Activity	58	66	.
Counseling for Physical Activity for Children and Adolescents 12-17 Yrs	63	72	.
Counseling for Physical Activity for Children and Adolescents 3-11 Yrs	56	63	.
Assessment, Counseling, or Education:Preventive Actions Associated with Sexual Activity	60	66	.
Assessment, Counseling, or Education:Depression	52	59	.
Assessment, Counseling, or Education:Tobacco Use	64	70	.
Assessment, Counseling, or Education:Alcohol and Other Drug Use	60	67	.
Breast Cancer Screening	68	67	68
Cervical Cancer Screening	72	71	71
Chlamydia Screening (Ages 16-20)	67	70	71
Chlamydia Screening (Ages 21-24)	69	72	73
Chlamydia Screening (Ages 16-24)	68	71	72
Timeliness of Prenatal Care	90	.	88
Postpartum Care	73	.	70
Frequency of Ongoing Prenatal Care	74	.	70
Use of Appropriate Medications for People with Asthma (Ages 12-50)	88	.	.
Appropriate Asthma Medications- 3+ Controllers (Ages 12-50)	77	.	.
Appropriate Asthma Medications- 3+ Controllers (Ages 5-50)	76	.	.
Use of Appropriate Medications for People with Asthma (Ages 5-50)	90	.	.

QARR Rates 2010-2013

Medicaid Managed Care Plans

Measure	2010 Average	2011 Average	2012 Average
Board Certified Geriatric Specialists	73	73	70
Rating of HP - High Users	.	.	.
Board Certified Other Specialists	79	80	78
Recommend Plan to Others	.	.	.
Diabetes Monitoring for People with Diabetes and Schizophrenia	.	.	75
Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	.	.	79

NEW YORK STATE DEPARTMENT OF HEALTH

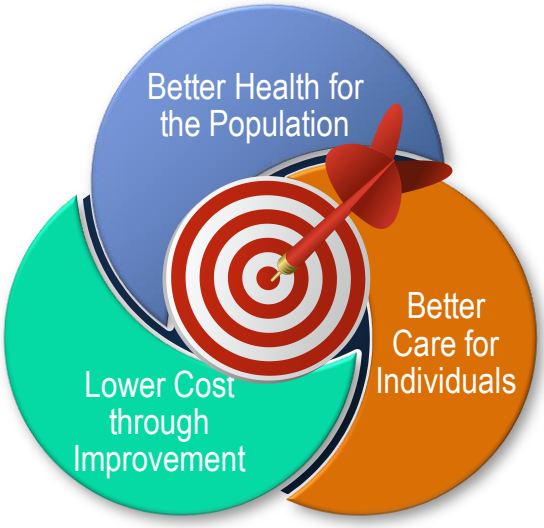
PARTNERSHIP PLAN MEDICAID SECTION 1115 DEMONSTRATION (NO. 11-W-00114/2)

INTERIM EVALUATION REPORT

March 20, 2014

EXECUTIVE SUMMARY

New York has experienced great success with its Partnership Plan Demonstration (a Medicaid Section 1115 Waiver) and is seeking an extension to continue to realize improvements in access, quality and cost effectiveness, consistent with the Triple Aim.



The Partnership Plan has achieved significant results in support of its major goals:

- Improvement in access and coverage.
- Improvement in quality.
- Improvement in cost effectiveness.

Measures of success for major components of the Partnership Plan over the past four years are discussed in this Interim Evaluation Report.

Figures are for the four year period ending September 2013 unless otherwise noted.

MEDICAID MANAGED CARE (MMC)

- 3 million Temporary Assistance for Needy Families (TANF) and Safety Net beneficiaries enrolled.
- 23.9 percent increase in enrollment.
- 86 percent of national quality benchmarks met.
- Without the Partnership Plan, projected expenditures would have been 235 percent higher for TANF children and 164 percent higher for TANF adults.

FAMILY HEALTH PLUS (FHP)

- 434,600 individuals enrolled.
- 12.5 percent increase in enrollment.
- 91 percent of national quality benchmarks exceeded.
- Without the Partnership Plan, projected expenditures for the FHP Adults with Children would have doubled.

FAMILY PLANNING BENEFIT PROGRAM (FPBP)

- 114,500 beneficiaries served.
- Reduction in unintended pregnancies.

MANAGED LONG TERM CARE (MLTC)

- 110,400 beneficiaries enrolled.
- 89 percent increase in enrollment from 2012 to 2013.
- Without the Partnership Plan, projected expenditures would have been 3.1 percent higher in 2013 than they were in 2012 for all age groups.

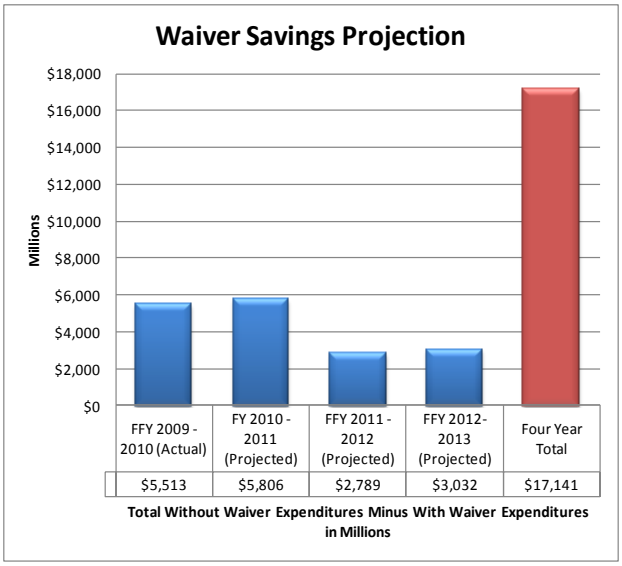
CONCLUSIONS

The Partnership Plan Demonstration has significantly expanded health coverage to previously underinsured and uninsured populations.

- Four million Medicaid beneficiaries enrolled in Managed Care programs.
- 75.9 percent of Medicaid recipients enrolled in Managed Care.

The Partnership Plan Waiver has achieved budget neutrality and realized significant savings.

- Projected savings over the last four years are $17.1 billion as shown in the graph below.



NEXT STEPS

The Partnership Plan has well-prepared New York to undertake a major reform of its health care service delivery system. New York's Medicaid Redesign Team Action Plan builds on the many successful components of the Partnership Plan Demonstration. In the coming years, the State plans to continue its successful partnership with the Centers for Medicare and Medicaid (CMS) to incorporate the following new initiatives:

- Health System Transformation for Individuals with Developmental Disabilities: to shift the Medicaid health system from a fee-for-service delivery system to a Medicaid managed care system, to assure person-centered services, and to create an integrated care coordination model.
- Delivery System Reform Incentive Payment Plan (DSRIP): A proposed investment of $7.3 billion to rebalance the delivery system as well as reduce hospitalizations and emergency department use by 25 percent over the next five years
- Behavioral Health System Transformation: to integrate all Medicaid covered services for mental illness, substance use disorders, and physical health conditions while transitioning these services to Medicaid Managed Care.

New York State will continue to seek and implement options for improving access, coverage, quality and cost effectiveness of the Medicaid program.

TABLE OF CONTENTS

EXHIBITS

ATTACHMENTS

ACRONYMS

ACA	Affordable Care Act
ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CHPlus	Child Health Plus
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
D&TC	Diagnostic and Treatment Center
DANY	Doctors Across New York
DHSP	Designated State Health Programs
DISCO	Developmental Disabilities Individual Support and Care Coordination Organizations
DOH	Department of Health
DSRIP	Delivery System Reform Incentive Payment Plan
DY	Demonstration Year
EQRO	External Quality Review Organization
ESHI	Employer Sponsored Health Insurance
ESRD	End Stage Renal Disease
FFP	Federal Financial Participation
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHPlus	Family Health Plus
FHP-PAP	FHPlus Premium Assistance Program
FHPBI	FHPlus Buy-In
FPBP	Family Planning Benefit Program
FPL	Federal Poverty Level
F-SHRP	Federal-State Health Reform Partnership
H-MH	Hospital-Medical Home
HCBS	Home and Community-Based Services
ICP	Indigent Care Pool
IPRO	Island Peer Review Organization
LDSS	Local Department of Social Services
LTHHCP	Long Term Home Health Care Program
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MCP	Managed Care Plan
MEDS	Medicaid Encounter Data System
MEG	Medicaid Eligibility Group
MEQC	Medicaid Eligibility Quality Control
MLTC	Managed Long Term Care
MMC	Medicaid Managed Care
MMCARP	Medicaid Managed Care Advisory Review Panel
MMIS	Medicaid Management Information System
MMMC	Mainstream Medicaid Managed Care
MRT	Medicaid Redesign Team
NCQA	National Committee on Quality Assurance
NHTD	Nursing Home Transition and Diversion
NYMC	New York Medicaid Choice
NYS	New York State
OHIP	Office of Health Insurance Programs
PCCM	Primary Care Case Management
PCP	Primary Care Physician or Primary Care Provider
PCMH	Patient Centered Medical Home
PDF	Portable Document Format
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PQI	Prevention Quality Indicators
PPR	Potential Preventable Readmission
QARR	Quality Assurance Reporting Requirements
QI	Quality Incentive/Quality Improvement
QSIP	Quality and Safety Improvement Project
RFA	Request for Application
SAAM	Semi-Annual Assessment of Members
SCHIP	State Children's Health Insurance Program
SCP	Specialty Care Provider
SEIU	Service Employees International Union
SN	Safety Net
SNP	Special Needs Plan
SPARCS	Statewide Planning and Research Cooperative System
SSA	Social Security Act/Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
UAS-NY	Uniform Assessment System for New York
UFT	United Federation of Teachers

1.0 INTRODUCTION

New York State Department of Health (the Department) has experienced great success with its current Medicaid Section 1115 Waivers (Partnership Plan and Federal-State Reform Partnership (F-SHRP) Demonstrations) and is seeking an extension of the Partnership Plan Demonstration in order to continue to realize improvements in access, quality and cost effectiveness. When a state requests an extension of a Medicaid Section 1115 Waiver under the authority of Section 1115(a), (e) or (f) of the Social Security Act (SSA), the Federal Government requires that the state submit an Interim Report describing the progress of the Demonstration to date. To address this requirement, the Department commissioned Island Peer Review Organization (IPRO), an independent not-for-profit company, to prepare this Interim Report.

This report briefly describes the history of New York State's Partnership Plan Demonstration and the Department's strategy to ensure achievement of the goals of enhanced access and coverage, quality improvement and cost neutrality. It then summarizes accomplishments as they pertain to the most significant components of the demonstration. It concludes with a brief overview of recently approved components and pending amendment requests of the demonstration. The period covered by this report, data permitting, is the four years between October 1, 2009 and September 30, 2013.[1]

In preparing this report, IPRO reviewed a wide range of documents including quarterly and annual reports, Special Terms and Conditions, member satisfaction surveys, contract surveillance tools and reports. IPRO also consulted with the Department's senior managers and staff. A complete list of reference materials in provided in Attachment 6, Technical Notes and Reference Materials.

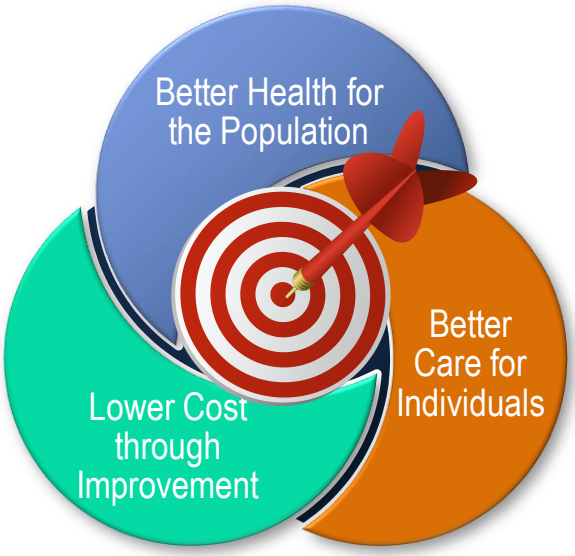
1.1. Partnership Plan Overview

The State's goal in implementing the Partnership Plan is to improve the health status of low income New Yorkers by improving access to health care, improving the quality of health services delivered and expanding coverage to additional low income New Yorkers via the Medicaid program. Through the original Demonstration, the State implemented a mandatory Medicaid Managed Care (MMC) program in counties with sufficient managed care capacity and the infrastructure to manage the enrollment processes essential to a mandatory program. The Demonstration has also enabled the expansion of coverage to certain individuals who would otherwise be without health insurance.

These objectives remain consistent with the State's overall Medicaid Redesign Team Action Plan and the Centers for Medicare and Medicaid Services (CMS) Triple Aim, illustrated in Exhibit 1: The CMS Triple Aim.

[1] This is the period covered by Federal Fiscal Year (FFY) 2009-2010 through FFY 2012-2013, or Partnership Plan Demonstration Years 12 through 15.

Exhibit 1: The CMS Triple Aim



This report focused on four major program components of the Partnership Plan, some of which expired at the end of December 2013:

1. **Mainstream Medicaid Managed Care:** provides Medicaid State Plan benefits through comprehensive managed care organizations (MCOs) to most recipients eligible under the State Plan. MMC expired for Safety Net adults December 31, 2013.
2. **Family Health Plus**: provides a more limited benefit package of Medicaid State Plan benefits, with cost-sharing imposed, for adults with and without children with specified income. Although FHPlus technically ended in December 31, 2013 some enrollees are still in the process of transitioning to alternate coverage.
3. **Family Planning Benefit Program:** provided services to men and women who are in need of family planning services but were otherwise not eligible for Medicaid. FPBP expired December 31, 2013.
4. **Managed Long Term Care**: provides some Medicaid state plan services including personal care and home and community-based waiver services through a managed care delivery system to individuals eligible who require more than 120 days of community-based long-term care services.

1.2. Coverage and Program Expansions

In July 1997, New York State received approval from the CMS (formerly the Health Care Financing Administration) for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times, most recently through December 31, 2013. The primary purpose of the initial Demonstration was to enroll a majority of the State's Medicaid population into managed care. There have been a number of amendments to the Partnership Plan Demonstration since its initial approval in 1997:

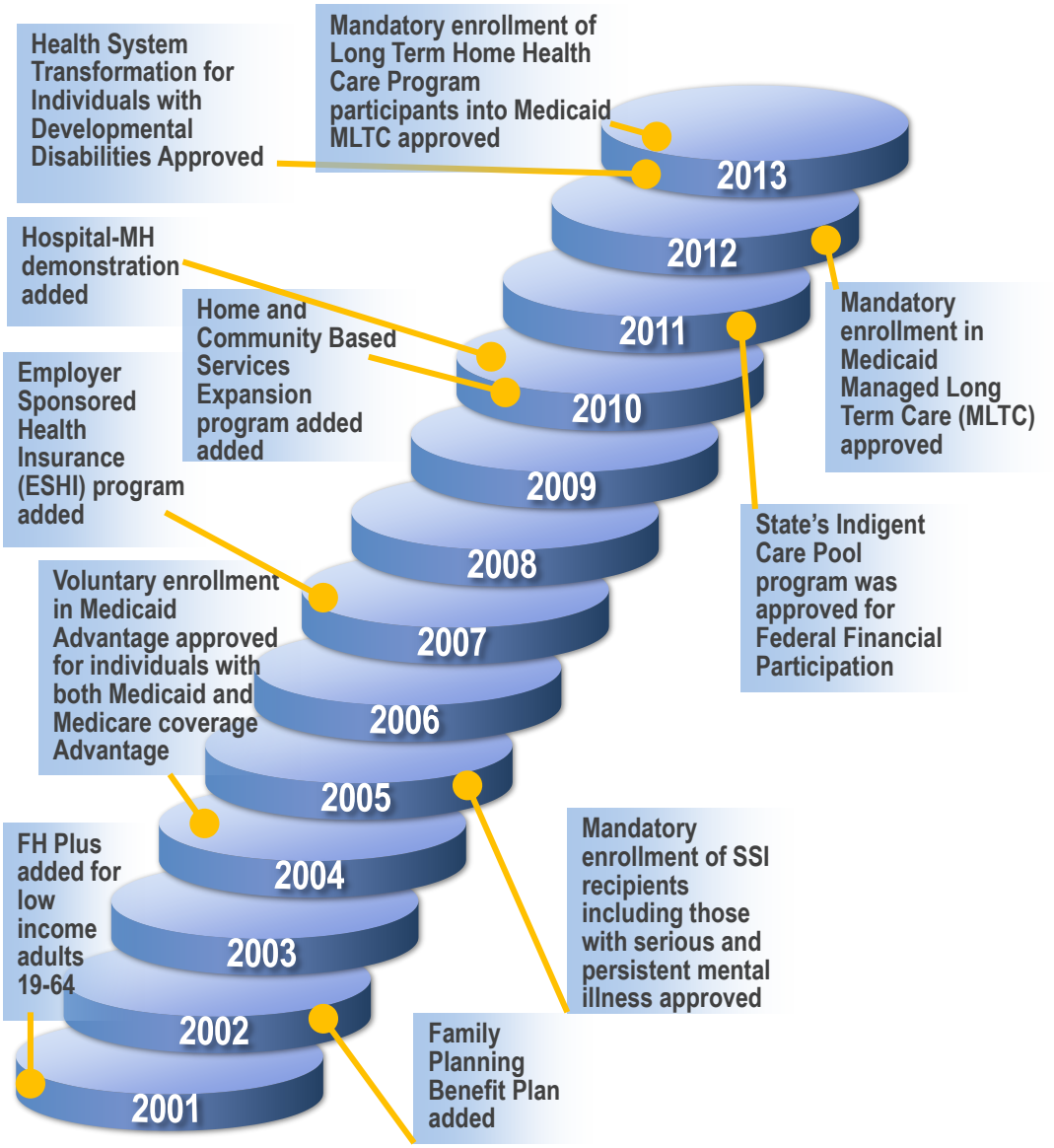
- 2001 – Family Health Plus (FHPlus) was added for low income adults between the ages of 19 and 64 who do not have health insurance, but have incomes too high to qualify for Medicaid.
- 2002 – Family Planning Expansion Program was added to provide family planning services to women who would lose eligibility at the conclusion of their 60-day postpartum period, and to certain other men and women.
- 2004 – Individuals eligible for Medicare and Medicaid were permitted to enroll in Medicaid Advantage.
- 2005 – Mandatory enrollment of the Supplemental Security Income (SSI) population began and was expanded to include those with serious and persistent mental illness.
- 2006 – SSI recipients and new MMC enrollees in 14 counties were moved to the Federal-State Health Reform Partnership (F-SHRP) Waiver.
- 2007 – FHPlus was expanded to include the Employer-Sponsored Health Insurance program.
- 2010 – The Home and Community-Based Services (HCBS) Expansion program was added to provide in-home and community-based services to certain adults with significant medical needs as an alternative to institutional care.
- 2010 – The Hospital-Medical Home (H-MH) demonstration was added to assist outpatient departments in teaching hospitals achieve national standards and certification as Patient Centered Medical Homes (PCMH).
- 2011 – Federal Financial Participation (FFP) was approved for the Indigent Care Pool (ICP) program for clinic uncompensated care.
- 2012 – The Managed Long-Term Care (MLTC) program became mandatory for individuals who require more than 120 days of community-based long-term care.
- 2013 – The transition of Long-Term Home Health Care Program (LTHHCP) participants from New York's 1915(c) Waiver into the MLTC program was approved.
- 2013 – The exclusion of foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled from MMMC was eliminated.
- 2013 – Federal Financial Participation for certain Designated State Health Programs (DSHP) was approved.[2] These include:
    - Health System Transformation for Individuals with Developmental Disabilities and the following twelve programs[3]:

[2] Continuation of these DSHPs is contingent upon discussions with CMS regarding the MRT waiver amendment.
[3] During this period, the Department must submit several deliverables to demonstrate that transformation of the health system for individuals with developmental disabilities is proceeding on schedule.

- Homeless Health Services
- HIV-Related Risk Reduction
- Childhood Lead Poisoning Primary Prevention
- Healthy Neighborhoods
- Local Health Department Lead Poisoning Prevention
- Cancer Services
- Obesity and Diabetes
- TB Treatment, Detection and Prevention
- TB Directly Observed Therapy
- Tobacco Control
- General Public Health Work
- Newborn Screening

A summary of the coverage and program changes is illustrated in Exhibit 2: Summary of Coverage and Program Changes.

Exhibit 2: Summary of Coverage and Program Changes



1.3. Coverage and Programs Ending in 2013 and 2014[4]

As previously mentioned, some Partnership Plan components are scheduled to phase-out or expire in the next year. The status of the Department's requests related to these components is summarized below.

Expired December 31, 2013

- Family Health Plus (FHPlus). As of December 2013, no new applications were accepted. Current enrollees will be transitioned into alternate coverage by April

[4] *http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf*

2014. Individuals renewing coverage between October 2013 and March 2014, if determined eligible, may be authorized coverage for up to twelve months while obtaining alternate coverage, but not to extend beyond December 31, 2014.

- Medicaid Managed Care for Safety Net (SN) adults. The Demonstration Eligible Group Safety Net Adults expires in the Partnership Plan on December 31, 2013. The Department is seeking approval to continue coverage through the Partnership Plan's managed care program for Safety Net Adults through December 31, 2014.
- Indigent Care Pool and Clinic Uncompensated Care Funding. New York has requested an amendment to extend the Indigent Care Pool/Clinic Uncompensated Care Funding. The proposed amendment would extend the federal funding agreement through December 31, 2014.
- Family Planning Benefit Program has been incorporated into the State Plan as a covered service in the State's Medicaid program.

Expiring March 31, 2014

- Medicaid Managed Care. The Department is seeking an extension of Medicaid Managed Care (MMC) until December 2014 in order to: continue enrollment of some populations in the managed care delivery system, transition the nursing home benefit into mainstream managed care, and to integrate behavioral health benefits and populations into managed care.
- HCBS Expansion Program. Extension of the Home and Community-Based Services (HCBS) Expansion Program until the end of the Partnership Plan. The HCBS Expansion Program allows for the provision of cost-effective home and community based services to certain adults with significant medical needs as an alternative to institutional care, and allows for the provision of spousal budgeting for certain populations.
- Facilitated Enrollment. The Department is seeking an extension of these services until December 2014, and permission to offer these services to individuals enrolling in the Child Health Plus program.
- Designated State Health Programs (DHSP). The state has proposed the extension of at least some previously approved DSHPs on a continuing basis. Which of these programs will be extended is subject to further discussion with CMS.

Expiring December 31, 2014

- Hospital-Medical Home Demonstration.

1.4. Goals and Measures of Success

The overarching goals of the Partnership Plan are to expand access to coverage, improved quality and maintain budget neutrality.

1.4.1. Coverage and Access

Measures of success in the areas of coverage and access include enrollment growth, managed care penetration rates, policy changes that affect coverage, the ratio of primary and specialty care physicians to enrollees, action and strategies to inform consumer choice.

1.4.2. Quality

The Department employs a multi-faceted approach to ensuring accountability and improving the quality of care provided to plan enrollees. The Department assesses the program through analysis of the quality and appropriateness of care and services delivered to enrollees, and by monitoring MCO activities on an on-going or periodic basis. Evaluating progress towards meeting objectives is based on a review of data that reflects: health plan quality performance, access to covered services, extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care. Measures used in this approach are largely based on Quality Assurance Reporting Requirements (QARR) – a set of measures based on The National Committee for Quality Assurance's (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), the Medicaid Encounter Data System (MEDS), Prevention Quality Indicators (PQIs)-measures developed by the Agency for Healthcare Research and Quality (AHRQ), Semi-Annual Assessment of Members (SAAM) datasets, as well as, consumer satisfaction surveys including the Consumer Assessment of Health Care Provider Systems (CAHPS®) Survey – a survey instrument that asks health plan members about experiences with access to care, health care providers and health plans.[5] In addition to national measures obtained from these sources, the Department's evaluation includes State-specific measures. State specific sources of data include the Department's Statewide Planning and Research Cooperative System (SPARCS), data reporting from New York Medicaid Choice (NYMC), the State's contracted Managed Care enrollment broker, surveys conducted by its External Quality Review agent, IPRO, and the results of quality improvement initiatives.

1.4.2.1. External Quality Review Surveys and Technical Reports

IPRO, New York State's External Quality Review Organization, conducts multiple surveys of each MCO and prepares a Plan-Specific Report for each. In accordance with federal requirements, these reports are completed every three years. Thus far the reports have been created for the mainstream and HIV/SNP plans with MLTC plans forthcoming. The reports include information on trends in plan enrollment, provider network characteristics, QARR performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies and other on-site survey findings, focused clinical study findings and financial data. Every year, the reports are updated for a subset of this information focusing on strengths and weaknesses.

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[5] The results of the 2013 Survey (Child CAHPS) can be found at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/docs/c_statewide_2013.pdf*** . The results of the 2012 Survey (Adult CAHPS) can be found at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm*** The 2013 Plan-level surveys are available at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/index.htm*** .

The most recent reports published in May 2013 reflect 2012 data. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment and disenrollment data, provider network description, encounter data summaries, quality/satisfaction points and incentive, appeals summaries and financial ratios.[6]

1.4.2.2. Monitoring of Provider Networks

On a quarterly basis, MCOs must also submit updated information on their contracted provider network to the Department. As part of these quarterly reports, MCOs provide information on the number of Medicaid enrollees empanelled to each network Primary Care Physician (PCP). In addition, any material change in network composition must be reported to the State 45 days prior to the change.

Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel size, and provider turnover.

1.4.2.3. Performance Improvement Projects (PIPs)

The Department requires MMC and MLTC plans to conduct one Performance Improvement Project each year and encourages plans to participate in collaborative quality improvement initiatives with other plans.

1.4.3. Budget Neutrality

The Special Terms and Conditions that govern the Partnership Plan Demonstration require that it be budget neutral, that is, it must cost no more than the cost would have been without the changes made as part of the Partnership Plan Demonstration. The formula for determining budget neutrality consists of two components: "Without Waiver" expenditures and "With Waiver" expenditures. Both components include expenditures for six categories of eligible populations:

- TANF children under the age of 1 to age 20,
- TANF adults ages 21 to 64,
- FHPlus adults with children,
- Family Planning Benefit Program participants,
- MLTC adult age 18 to 64 duals, and
- MLTC adult age 65+ duals.

"With Waiver" expenditures consist primarily of medical costs for individuals eligible under the waiver, but also include additional Partnership Plan population groups (Safety Net adults and FHPlus Adults without children) and programs (Home and Community

[6] These reports are available on the New York State Department of Health public website at ***http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports***

Based Services (HCBS) Expansion, Indigent Care Pool Direct Expenditures, and Designated State Health Programs). The additional populations and programs were authorized by CMS with the provision that they be paid for with savings accrued from other Partnership Plan initiatives. The figures for budget neutrality presented in this report already account for the costs of enrolling these additional populations and operating these additional programs. Figures presented reflect net savings. [See Attachment 5, New York State Partnership Plan Projected 1115 Waiver Budget Neutrality Impact through December 2013.]

2.0 MEDICAID MANAGED CARE PROGRAM

The Medicaid Managed Care (MMC) component of the Partnership Plan Demonstration provides comprehensive health care services (including all benefits available through the Medicaid State Plan) to low income uninsured individuals. It offers enrollees the opportunity to select a managed care organization (MCO) whose focus is on preventive health care. The MCO partners with the enrollee's primary care provider to provide primary care case management (PCCM) for the purpose of better coordinating patient care, helping enrollees navigate the medical delivery system and attending to the enrollee's overall health and well-being. The State's original MMC program has enrolled three distinct populations into MCOs as part of the Demonstration:

- Temporary Assistance for Needy Families (TANF) children under age 1 to age 20;
- TANF adults age 21 through 64; and
- Safety Net (SN) adults

2.1. Accomplishments: Coverage and Access

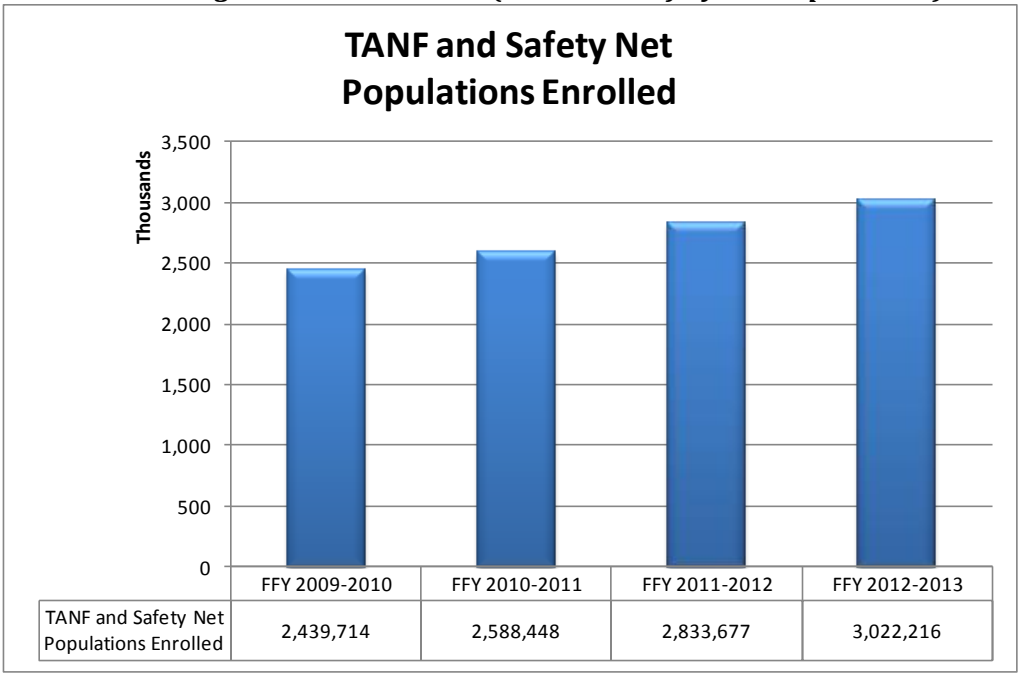
The Medicaid Managed Care (MMC) program accomplishments in the area of coverage and access include increased enrollment, expansion of mandatory enrollment, policy changes to increase access to and continuity of care and meeting standards for primary care practitioner to enrollee ratios.

2.1.1. Increased Enrollment

As of September 2013, New York had enrolled 3 million people in MMC under the Partnership Plan Demonstration.[7] From September 2010 through September 2013, enrollment in the MMC program increased by 23.9 percent, or more than 580,000 beneficiaries statewide, as illustrated in Exhibit 3: Medicaid Managed Care Enrollment (TANF and Safety Net Populations).

[7] This figure only includes individuals enrolled through the Partnership Plan Demonstration. It does not include all Medicaid beneficiaries enrolled in MCOs, such as those enrolled through Family Health Plus (discussed in the following section), the F-SHRP Demonstration, or Managed Long Term Care Plans, as discussed in Section 5.

Exhibit 3: Medicaid Managed Care Enrollment (TANF and Safety Net Populations)



	FFY 2009-2010	FFY 2010-2011	FFY 2011-2012	FFY 2012-2013
TANF and Safety Net Populations Enrolled	2,439,714	2,588,448	2,833,677	3,022,216

2.1.2. Expansion of Mandatory Enrollment

The State's goal of geographic expansion of mandatory MMC to all counties of the state for TANF and SN populations was accomplished in November 2012.

In 2013, the state legislature eliminated all previous exclusions or exemptions from mandatory enrollment into MMC. The Commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits were established, and required Federal approvals were obtained. The State is in the process of establishing and obtaining required Federal approvals for two new types of managed care arrangements within the Medicaid program to address the unique needs of previously excluded populations: Developmental Disability Individual Support and Care Coordination Organizations (DISCOs) for people with developmental disabilities and Health and Recovery Plans (HARPs) for people with behavioral health needs, such as severe and persistent mental illness and substance abuse disorders.

2.1.3. Policy Changes to Increase Access and Continuity of Care

With the approval of CMS, the Department has implemented a number of policy changes to improve quality and efficiency.

- **Eliminated exemption for "look-alike" populations.** In October 2012, the exemption for "look-alike" populations, i.e., individuals with characteristics and needs similar to those receiving services through certain 1915(c) waivers and those

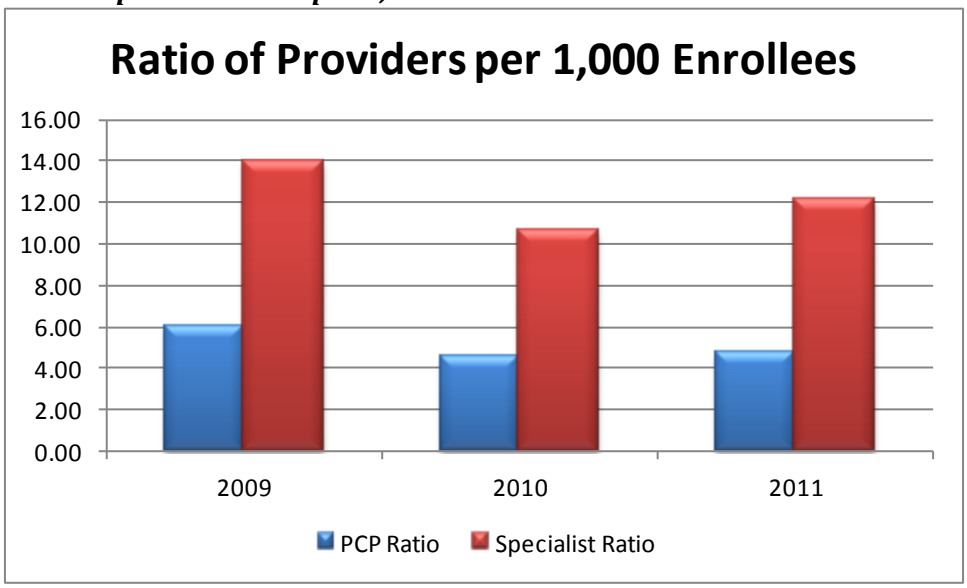
in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) was eliminated.

- **Enrollment of individuals in foster care.** CMS authorized for MMMC enrollment of individuals in foster care who are placed in the community directly by the local department of social services (LDSS). (This does not include: individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution.)
- **Enrollment of individuals in the MBI-WPD program.** CMS authorized managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

2.1.4. Meeting Standards for Primary Care Physician to Enrollee Ratios

The State's MMC program exceeds the standard of one primary care practitioner (PCP) for every 1,500 enrollees. The PCP to 1,000 enrollee ratio increased from 4.54 in 2010 to 4.79 in 2011 while the specialty physician ratio per 1,000 enrollees increased from 10.60 to 12.16 in the same period, as shown in Exhibit 4: PCP and Specialist Ratio per 1,000 Enrollees.

Exhibit 4: PCP and Specialist Ratio per 1,000 Enrollees



The total participation level of PCPs and specialty care physicians (SCPs) in Medicaid Managed Care is nearly twice the number that participated in the Medicaid Fee-For-Service (FFS) program.[8]

[8] Physician participation in Medicaid managed care taken from internal reports generated by the Department of Health, Office of Insurance Program, Division of Health Plan Contracting and Oversight for the years 2009 through 2011.

The number of PCPs between 2009 and 2011 remained relatively stable, at about 17,000 practitioners. The PCP to enrollee ratio dropped significantly from 6.02 per 1,000 in 2009 to 4.79 per 1,000 in 2011. This is likely explained by a large increase in Medicaid Managed Care enrollment which grew 32.2 percent, from 2.9 million in 2009 to 3.8 million in 2010 and then decreased to 3.5 million in 2011. A similar pattern occurred for specialist physicians. [9]

The Department monitors physician participation in both Medicaid MCOs and the Medicaid fee-for-service program. In recent years, the Department has taken significant steps to increase physician participation in the Medicaid program. For example:

- In 2009, the State increased physicians' fees by 80 percent over the 2007 levels.
- In August 2012, the State awarded $2 million in grants under the Doctors Across New York (DANY) Physician Loan Repayment and Practice Support program, which assists in the training and placement of physicians in rural and inner-city areas where a shortage of health care providers has been identified.[10]
- As part of its waiver amendment request, New York has requested $250 million in order to broaden the DANY's program and expand the Primary Care Service Corp, which focuses on recruiting non-physician primary care providers to underserviced areas as well as to support other key workforce recruiting and retention programs for underserved areas. In the near term, the Department believes these efforts will make a substantial contribution to closing the nearly 1,100 primary care physician gap as well as gaps in other primary care and some specialty physician occupations. [11]

2.2. Accomplishments: Quality

The MMC program accomplishments include exceeding national standards for quality outcomes, MCOS engaged in the required annual performance improvement projects, indications of enrollee satisfaction, activities to support informed choice and engage stakeholders, and an increase in the number of MCOS receiving quality incentive payments.

2.2.1. Exceeding National Standards for Quality Outcomes

New York exceeds the national standards for quality outcomes. New York has met or exceeded 89 percent of the national QARR benchmarks and 87 percent of the 2007 measures[12]. (See Attachment 1 for the New York State 2012 comparison with the national benchmarks and with the 2007 New York State measures). IPRO asked the Department to

[9] New York State Department of Health, Office of Health Insurance Programs, August 20, 2012.
[10] More information about the increase in physician reimbursement can be found at: ***http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/presentations/vendor-7_22_2009.pdf***. The press release announcing the DANY grant awards can be found at ***http://www.health.ny.gov/press/releases/2012/2012-08-30_state_health_department_award.htm***.
[11] ***http://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf***
[12] For the overall Medicaid managed care quality strategy see: http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

explain the strategy for improving the measures that did not meet or exceed the national standards. In a communication from the Department's Office of Quality and Patient Safety, February 27, 2014, it cited the multifaceted strategy the Department uses to improve quality. These include:

- Publish quality data comparing plans to encourage MCOs to use this information in the competitive marketplace;
- Produce consumer guides that use quality data comparing MCOs to support consumer choice (see Section 2.2.4. below);
- Use quality data as a basis for determining financial incentives (see Section 2.2.5. below); and,
- Working with poorly performing individual MCOs to improve quality through application of root cause analysis and the development of a corrective action plan.

Other activities that contribute to quality improvement include focused clinical studies, Performance Improvement Projects, and collaborative efforts to prevent, or improve treatment of, chronic diseases.

2.2.2. MCOs Engaged in the Required Annual Performance Improvement Projects

The Department and IPRO, the State's External Quality Review organization (EQRO), work together to engage Managed Care Plans in annual Performance Improvement Projects (PIPS). From 2009 – 2010, eighteen (18) plans participated in a PIP focused on improving the prevention of childhood obesity. From 2011- 2012 MCOs engaged in two collaborative projects. The first, Eliminating Disparities in Asthma Care, engaged five (5) health plans in Brooklyn. The second, Reducing Potentially Preventable Readmissions, engaged ten (10) health plans from across the state. An additional three (3) health plans, examined various topics: timely case management; retaining HIV/AIDS members with CD4 counts more than 200; and enhancing smoking cessation interventions. Of the ten (10) plans working to reduce readmissions, five (5) successfully met their pre-study goals; the other five (5) did not. Of the five (5) plans testing strategies to eliminate disparities in asthma care, four (4) successfully met their goals and one (1) did not. The one plan investigating timely case management was successful in meeting pre-study goals; the plan utilizing strategies to retain members was also successful; and the plan attempting to enhance smoking cessation did not meet their goals.

The PIP project for the study period 2013-2014, has two parts. Part 1, Medicaid Incentives for the Prevention of Chronic Disease, includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in four clinical areas: diabetes prevention, diabetes management, smoking cessation and hypertension management. Part 2 focuses on implementing interventions to improve care in one of the four clinical areas noted above. These projects are still in progress. A majority of health plans are working on diabetes management. All MCOs are participating in Part 1, while eighteen MCOs are participating in Part 2.

2.2.3. Indications of Enrollee Satisfaction

In general, Medicaid beneficiaries enrolled in managed care report satisfaction with their care and experiences. A comparison of the satisfaction ratings from the CAHPS® 4.0 surveys of adults conducted in 2009, 2011, and again in 2013 suggests a slight trend toward increasing enrollee satisfaction with Medicaid Managed Care plans, see Exhibit 5: Comparison of 2009, 2011, and 2013 MMC Satisfaction Ratings.

Exhibit 5: Comparison of 2009, 2011, and 2013 MMC Satisfaction Ratings

QARR 2012 Medicaid Managed Care Satisfaction Ratings, 2009, 2011, and 2013			
Measure of Satisfaction	**2009 Ratings**	**2011 Ratings***	**2013 Ratings** (Preliminary)**
Getting Needed Care	74	75	78
Care Coordination	74	68	78
Customer Service	80	81	82
Getting Needed Counseling or Treatment	66	71	70
Rating of Overall Healthcare	65	67	71
Getting Care Quickly	77	76	78
Rating of Treatment or Counseling	57	59	61
Rating of Health Plan	69	71	76
Wellness Discussion	52	55	71

2012 New York State Managed Care Plan Performance, p.110,* ***http://www.health.ny.gov/publications/3346_2012.pdf* for 2009 and 2011 ratings.

**Preliminary 2013 satisfaction ratings are from the 2013 CAHPS® 4.0 survey of adult MMC enrollees. This data was received via communication with Office of Quality and Patient Safety, February 27, 2014. This data is scheduled to be published during the second quarter of 2014.

2.2.4. Activities to Support Informed Choice and Engage Stakeholders

A *Medicaid Managed Care Regional Consumer Guide* has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at ***http://www.health.ny.gov/health_care/managed_care/consumer_guides/***

To support informed choice for the consumer, the state has contracted with facilitated enrollment service contractors to provide health insurance information to interested individuals and afford the opportunity for interested individuals to apply for health care coverage. The Department contracts with facilitated enrollers in a variety of setting which includes MCOs, health care providers, community-based organizations, and other entities. Local departments of social services, which are ultimately responsible for determining Medicaid eligibility for people living in their jurisdictions, monitor facilitated enrollment service contractors by to ensure that choice counseling activities are provided to those seeking information and to minimize adverse risk selection.

The Department has established processes and forums for stakeholder engagement. It has established a Managed Care Operational Issues Workgroup which provides an open forum

for the discussion and clarification of operational issues related to Medicaid Managed Care.[13]

A Medicaid Managed Care Advisory Review Panel (MMCARP) appointed by the Governor and the New York State legislature generally meets on a quarterly basis. This Panel was established to assess and evaluate multiple facets of the MMC Program, including provider participation and capacity, enrollment targets, phase-in of mandatory enrollment, the impact of marketing, enrollment and education strategies, and the cost implications of exclusions and exemptions.

The Department also reports to stakeholders through webinars, conference calls, and surveys.

2.2.5. Increase in the Percentage of MCOs Receiving Quality Incentive Payments

In 2002, the Department began rewarding MMC plans that have superior performance by adding up to an additional 3.0 percent to plan per member per month (PMPM) premiums. This Quality Incentive (QI) program uses a standardized algorithm to awards points to plans for high quality in the categories of: Effectiveness of Care, Access and Availability and Use of Services. Points are deducted for any Statements of Deficiency (SOD) issued for lack of compliance with managed care requirements. Assessment of quality and satisfaction are derived from HEDIS® measures in NYS's QARR, satisfaction data from CAHPS®, and from Prevention Quality Indicators (PQIs).[14]

The following table, from the Department's 2012 Quality Strategy Report, provides a summary of the number of plans that received the maximum incentive percentage, a partial incentive, and no incentive, as well as the expenditures associated with the awards.

Number of Plans	QI 2007	QI 2008	QI 2009	QI 2010	QI 2011	QI 2012
Full Award (3% PMPM)	2	3	1	1	1	2
Partial Award (any tier between full and none)	12	17	13	13	11	10
No Award (0%	11	3	6	4	6	6

[13] Minutes of the Managed Care Operational Issues Workgroup can be found at: ***http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_and_man_care_workshop.htm***

[14] ***https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map;jsessionid=D1521FA4C421803E144AD3F5739A9E64***

PMPM)						
Dollars (million)	**$62.3**	**$76.7**	**$49.5**		**$159.5**	**$181**

Quality Strategy for the New York State Medicaid Managed Care Program 2012, Department of Health, OQPS, November 30, 2012; p.15.

The percentage of New York's Medicaid Managed Care plans receiving a quality incentive payment increased from 56.0 percent in 2007 to 66.7 percent in 2012.[15]

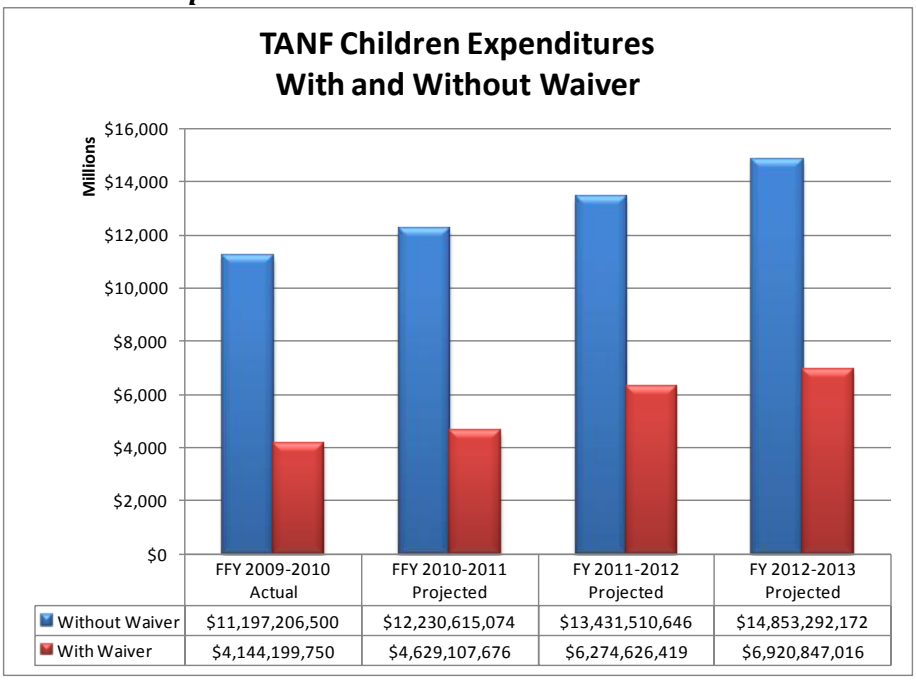
To collect the information underlying the QI program as well as other ratings of performance, the Department conducts multiple surveys a year per MMC plan. An Access and Availability survey is conducted once per year, a Provider Directory survey is conducted twice per year, a Member Services survey is conducted quarterly and a Primary Care Ratio Access Validation survey is conducted quarterly. The Access and Availability and Provider Directory surveys are tied to the QI program algorithm.

2.3. Accomplishments: Cost

From a cost effectiveness standpoint, the MMC program has been highly successful. Accomplishments include projected savings for both TANF children and TANF Adults.

For TANF children, expenditures without the waiver would have been 235 percent greater. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded $29.7 billion in projected savings, as illustrated in Exhibit 6: TANF Children Expenditures.

Exhibit 6: TANF Children Expenditures

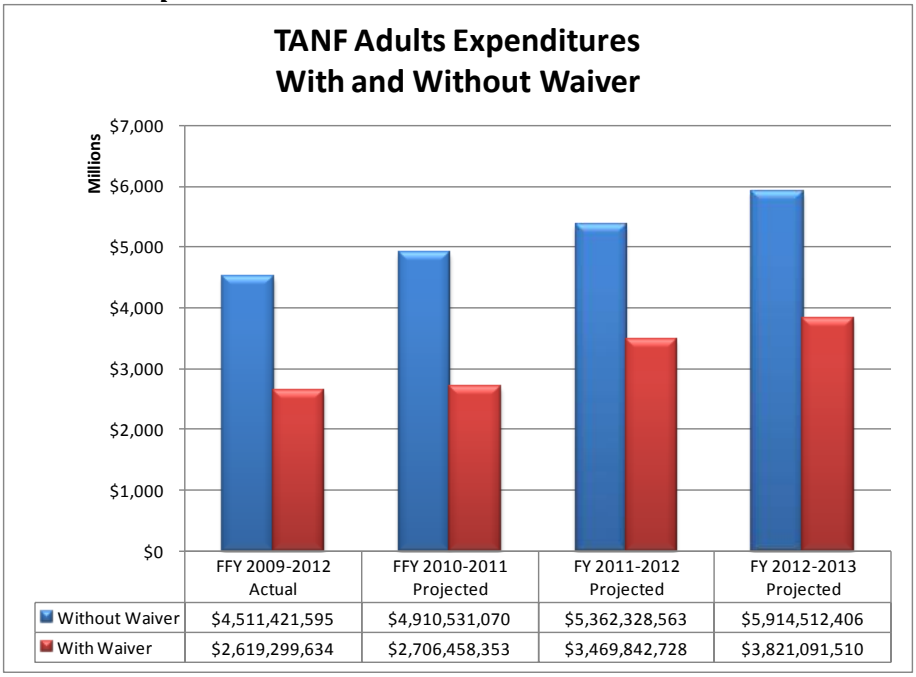


	FFY 2009-2010 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected	FY 2012-2013 Projected
Without Waiver	$11,197,206,500	$12,230,615,074	$13,431,510,646	$14,853,292,172
With Waiver	$4,144,199,750	$4,629,107,676	$6,274,626,419	$6,920,847,016

[15] ***https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf***

For TANF adults, expenditures without the waiver would have been nearly 164 percent greater than with the waiver. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded nearly $8.1 billion in projected savings for the TANF adult population, as illustrated in Exhibit 7: TANF Adults Expenditures.

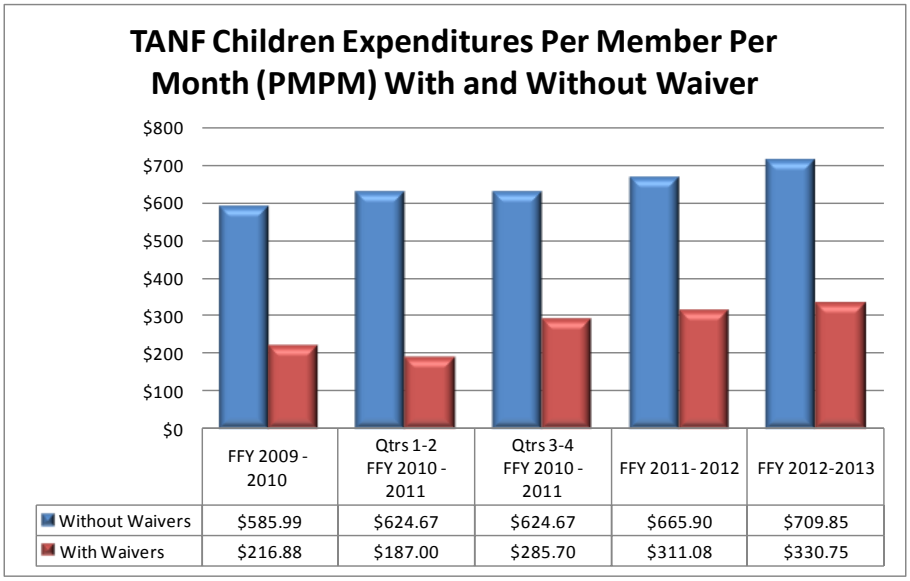
Exhibit 7: TANF Adults Expenditures



	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected	FY 2012-2013 Projected
Without Waiver	$4,511,421,595	$4,910,531,070	$5,362,328,563	$5,914,512,406
With Waiver	$2,619,299,634	$2,706,458,353	$3,469,842,728	$3,821,091,510

Per Member Per Month (PMPM) payments for TANF children without the waiver would have been a projected 215 percent greater than with the waiver in FFY 2012-0213, as illustrated in Exhibit 8: TANF Children PMPM.

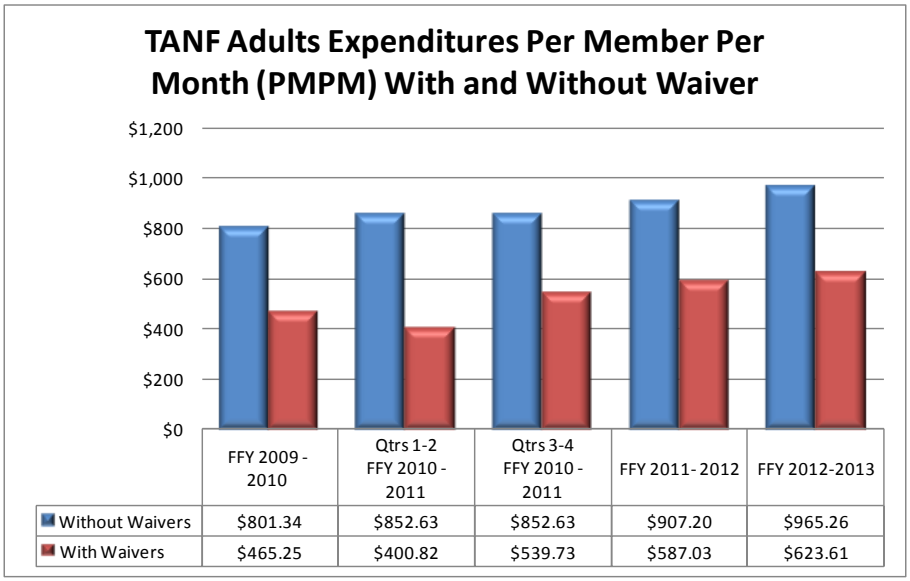
Exhibit 8: TANF Children PMPM



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$585.99	$624.67	$624.67	$665.90	$709.85
With Waivers	$216.88	$187.00	$285.70	$311.08	$330.75

Similarly, for TANF adults the PMPM payments would be a projected 155 percent higher without the Partnership Plan, as illustrated in Exhibit 9: TANF Adults PMPM.

Exhibit 9: TANF Adults PMPM



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$801.34	$852.63	$852.63	$907.20	$965.26
With Waivers	$465.25	$400.82	$539.73	$587.03	$623.61

Taking these two waiver demonstration groups (TANF children and adults) together, total projected savings for the period FFY 2009-2010 through FFY 2012-2013 are $37.8 billion.

3.0 FAMILY HEALTH PLUS

Family Health Plus (FHPlus), enacted by the State legislature in December 1999 and approved by CMS in May 2001, is a public health insurance program for adults aged 19 to 64 who have income too high to qualify for Medicaid. Due to changes under the Affordable Care Act (ACA), the FHPlus program is being phased out. Beginning January 1, 2014, individuals were asked to apply for health insurance coverage through the New York State health insurance marketplace; the State is no longer accepting applications for the program.

The primary objective of the FHPlus program is to improve access to care. It is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories. FHPlus was provided through participating MCOs and provided comprehensive coverage, including prevention, primary care, specialty care, hospitalization, prescriptions and other services. There were minimal co-payments for FHPlus services.

3.1. Transition from FHPlus to Medicaid Under ACA

Approximately 90 percent of current program enrollees will transition to Medicaid State Plan coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. This transition will occur for most program enrollees when their eligibility is renewed.

Family Health Plus adults without children were transferred to an Alternative Benefit Plan on January 1, 2014. Family Health Plus adults with children with income up to 138 percent FPL will transition to the Alternative Benefit Plan as they renew on and after April 1, 2014. Family Health Plus adults with children with incomes between 138 percent and 150 percent FPL will transition to a qualified health plan.

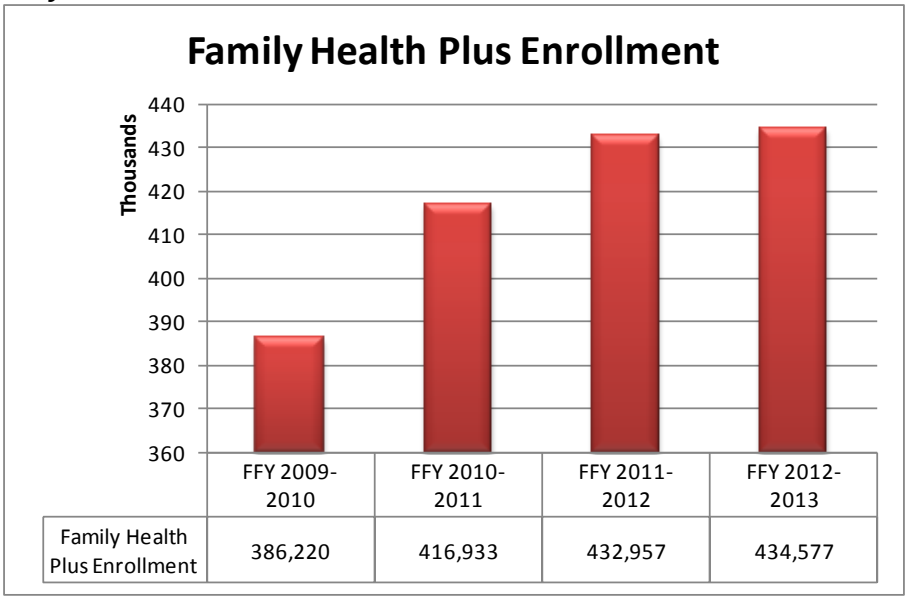
3.2. Accomplishments: Coverage and Access

The FHPlus program accomplishments in the area of coverage and access include a significant expansion of coverage, and enrollment growth in the Employer Sponsored Health Insurance Initiative (ESHI).

3.2.1. Significant Expansion of Coverage

FHPlus has resulted in a significant expansion of coverage to previously uninsured and underinsured New Yorkers. At the end of FFY 2012-2013, program enrollment was nearly 435,000. In the last four years of the program, enrollment increased more than 12.5 percent. The growth in enrollment is illustrated in Exhibit 10: Family Health Plus Enrollment.

Exhibit 10: Family Health Plus Enrollment



	FFY 2009-2010	FFY 2010-2011	FFY 2011-2012	FFY 2012-2013
Family Health Plus Enrollment	386,220	416,933	432,957	434,577

Note: Enrollment figures are for the two Demonstration populations (eligible adults with children and adults without children) for the period FFY 2009-2010 through FFY 2012-2013.

3.2.2. Enrollment Growth in the Employer Sponsored Health Insurance Initiative

To further increase coverage rates among uninsured but employed New York State residents with access to private insurance, State legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative (ESHI) through the FHPlus Premium Assistance Program (FHP-PAP). This program helps low-income workers who are eligible for FHPlus to access insurance offered by their employers. It allows the State to recognize the savings by maximizing the use of private, employer sponsored insurance coverage.

Enrollees in FHP-PAP are entitled to the services that FHPlus covers but which are not covered by ESHI plans, such as dental services and prescription drugs. These services are sometimes referred to as "wrap around benefits." The State requires that FHPlus eligible individuals who have access to ESHI enroll in FHP-PAP. Adults in this program use ESHI as their primary insurance policy. The State reimburses deductibles and co-pays to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

Enrollment in the FHPlus-PAP program has also grown fairly rapidly from 1,800 to 3,080 in the period from FFY 2009-2010 through June of FFY 2012-2013.[16]

[16] Although data about cost-effectiveness of the FHP-PAP program was not obtainable, a cost effectiveness determination was required for each applicant. The first test is to confirm that the ESHI includes the eight essential "benchmark" services. If all services were included in the ESHI plan, the application proceeds to the second test. If all benchmark services were not provided, payment of this insurance was denied and the applicant was enrolled in FHPlus and referred to a participating managed care plan. For the second test, the cost effectiveness calculation accounted for the cost of the ESHI premiums, deductibles, and co-payments. The calculator determined if the cost of the ESHI premium plus the cost of

At the end of FFY 2012-2013, there were also 1,239 unsubsidized United Federation of Teachers (UFT) members enrolled in the FHPlus Buy-In program. For child care workers who are eligible for Medicaid or FHPlus, the premium is paid by the state. The FHPlus Buy-In Program ended December 31, 2013.

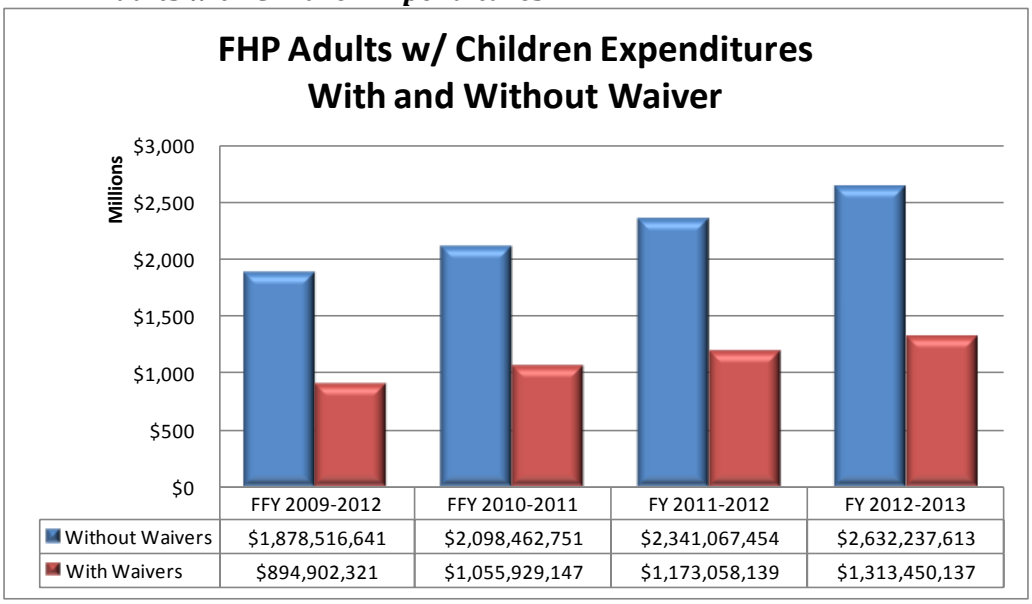
3.3. Accomplishments: Quality

The FHPlus program performed above the national average of on a majority of quality measures. A comparison of the national HEDIS® quality measures for 2012 with FHPlus QARR data for 2011 indicates that FHPlus performed above the national average for 91 percent of the quality measures (i.e., 21/23 measures).[17] Impressively, for several of these measures the FHPlus performance score was much greater than the HEDIS® national average. For example, the Breast Cancer Screening measure indicates that nationally Medicaid HMOs are only at 52 percent while FHPlus is at 72 percent. This large difference is also evident with testing for COPD, postpartum care, and ambulatory follow-up for mental illness. (See Attachment 2, FHPlus QARR/HEDIS National Benchmark 2012 Comparison.)

3.4. Accomplishments: Cost

The FHPlus program accomplishments in the area of cost are confirmed by expenditure data. In the absence of the Partnership Plan, projected expenditures for FHP Adults with Children population would have doubled, as illustrated in Exhibit 11: FHP Adults with Children Expenditures.

Exhibit 11: FHP Adults with Children Expenditures



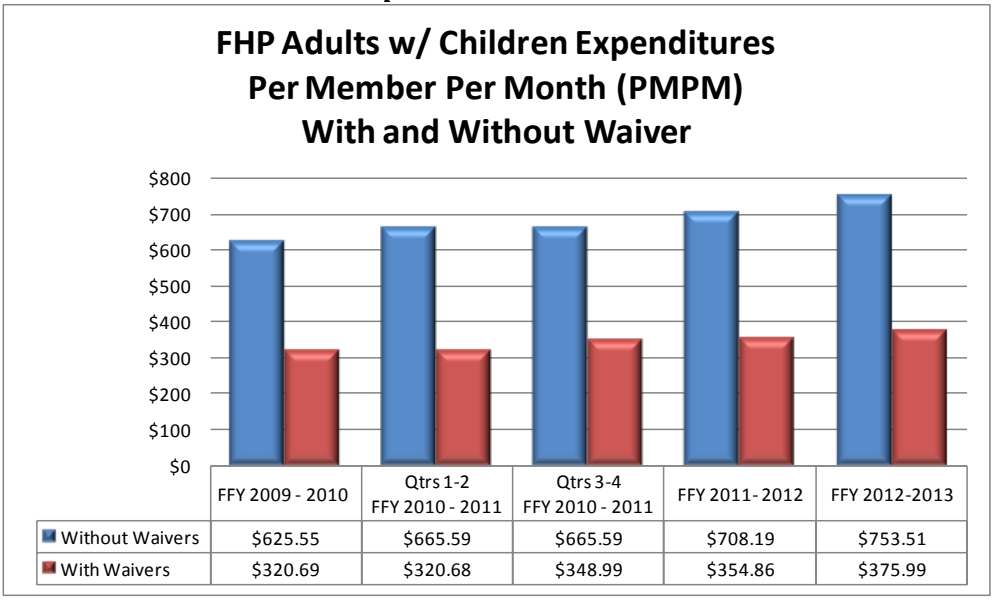
	FFY 2009-2012	FFY 2010-2011	FY 2011-2012	FY 2012-2013
Without Waivers	$1,878,516,641	$2,098,462,751	$2,341,067,454	$2,632,237,613
With Waivers	$894,902,321	$1,055,929,147	$1,173,058,139	$1,313,450,137

the Medicaid wrap-around services (optional services not included in the ESHI plan), deductibles and co-payments were less than the regional FHPlus managed care rates for adults and Medicaid managed care rates for eligible children.

[17] The HEDIS® data was taken from the NCQA *The State of Health Care Quality 2012*; specifically, the Medicaid HMO section which represents data from 2011.

Consistent with overall expenditures, PMPM payments with waiver are approximately half the amount of PMPM payments without the waiver, as illustrated in Exhibit 12: FHP Adults with Children Expenditures.

Exhibit 12: FHP Adults with Children Expenditures



	FFY 2009 - 2010	Qtrs 1-2 FFY 2010 - 2011	Qtrs 3-4 FFY 2010 - 2011	FFY 2011- 2012	FFY 2012-2013
Without Waivers	$625.55	$665.59	$665.59	$708.19	$753.51
With Waivers	$320.69	$320.68	$348.99	$354.86	$375.99

From a cost effectiveness standpoint, FHPlus has been highly successful. For the four year period FFY 2009-2010 through FFY 2012-2013, the waiver has yielded an estimated $4.5 billion in savings.

4.0 FAMILY PLANNING BENEFIT PROGRAM

The intent of the Family Planning Benefit Program (FPBP), also known as the Family Planning Expansion Program, is to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies. [18]

FPBP has been moved into the Medicaid State Plan.

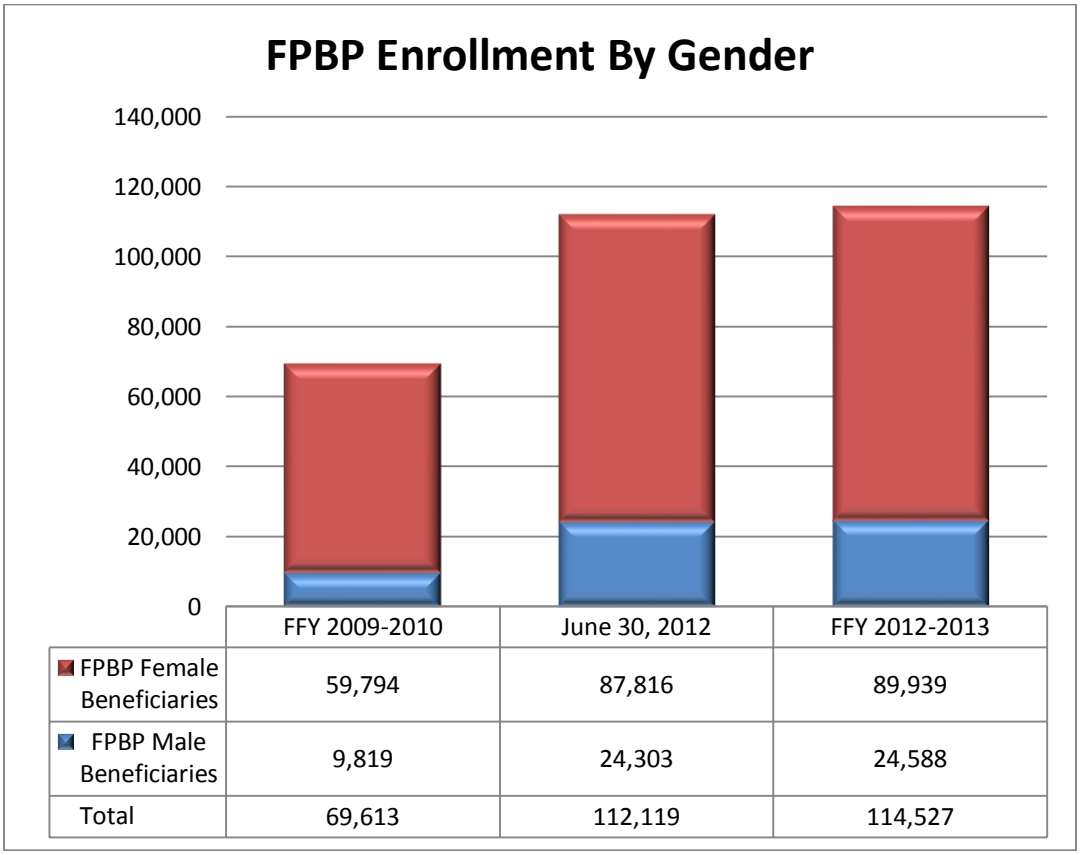
4.1. Accomplishments: Coverage and Access

FPBP accomplishments in the area of coverage and access are significant enrollment growth in program participation and a reduction in unintended pregnancies.

4.1.1. Significant Enrollment Growth

FPBP participation has grown quickly from 69,613 in 2009 to 114,527 by the end of September 2013, as illustrated in Exhibit 13: FPBP Enrollment.

Exhibit 13: FPBP Enrollment



	FFY 2009-2010	June 30, 2012	FFY 2012-2013
FPBP Female Beneficiaries	59,794	87,816	89,939
FPBP Male Beneficiaries	9,819	24,303	24,588
Total	69,613	112,119	114,527

[18] This program provides only family planning and family planning-related services to men and women with net incomes at or below 200 percent of the FPL who are not otherwise eligible for Medicaid and to women who lose Medicaid pregnancy coverage at the conclusion of 60-days postpartum. Once eligible, participants remain eligible for the program for 12 months and recertification is required.

4.1.2. Reduction in Unintended Pregnancies

The FPBP contributed to more than 5,300 averted pregnancies in 2011.[19]

4.2. Accomplishments; Quality

While there has not been an evaluation of clinical quality that has focused specifically on the FPBP beneficiary population, the State has taken steps to ensure and improve program quality by ensuring that program policies, procedures and referral lists are in place. The State has also introduced policy changes to ensure that the federal Medicaid share is claimed appropriately. For example, changes were made to procedure and billing codes in both 2008 and 2010. These changes help to ensure that only CMS-approved family planning procedures are claimed for FPBP and that the federal share is claimed appropriately.

4.3. Accomplishments: Cost

The FPBP program accomplishments in the area of cost are suggested by a significant reduction in avoided delivery costs. The program has averted more than 5,300 births in 2011. The average cost of a Medicaid delivery in New York State in 2011 was $6,800.[20]

[19] NYSDOH, Office of Health Insurance Programs, January 28, 2013.
[20] NYSDOH, Office of Health Insurance Programs, Data Mart (Claims as of December-2013).

5.0 MANAGED LONG TERM CARE (MLTC)

As part of its overall strategy to better coordinate care for high need Medicaid beneficiaries, New York has mandated that dual eligible Medicare and Medicaid recipients who are in need of home and community based care for more than 120 days enroll in a Managed Long Term Care Plan.

The program's goals are:

- Improved care coordination for Medicaid's highest risk/highest cost population.
- Improved patient safety and quality of care for consumers.
- Reduced preventable acute hospital and nursing home admissions.
- Improved satisfaction, safety and quality of life for consumers.

In August 2012, the Department received CMS approval to mandate enrollment for dual eligible recipients, 21 years of age or older. In April 2013, the state received CMS approval to mandate enrollment into a MLTC plan for dually eligible Long Term Home Health Care Program (LTHHCP) participants over age 21. The mandate only applies to counties which have a choice of plans and is currently effective, on a phase-in implementation schedule in all five boroughs of New York City, and Nassau, Suffolk or Westchester Counties. Dually eligible LTHHCP participants aged 18 to 20 and non-duals of any age may voluntarily enroll.

The initiative offers beneficiaries a choice of three (3) models of MLTC plans: 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.

In order to ensure a smooth transition of the thousands of Medicaid recipients who were previously accessing services through the State's fee-for-service programs, such as the Medicaid Personal Care Program, the Department opted to phase-in the mandate geographically. Phase I began in June 2012 in New York City[21]; Phase II began in January 2013 in Nassau, Suffolk and Westchester counties; Phase III began in September 2013 in Rockland and Orange counties; and, Phase IV began December 2013 in Albany, Erie, Onondaga, and Monroe counties. Phase V is scheduled to begin April 2014 in Columbia, Putnam, Sullivan and Ulster counties.

[21] Phase I beneficiary notifications began prior to final CMS approval.

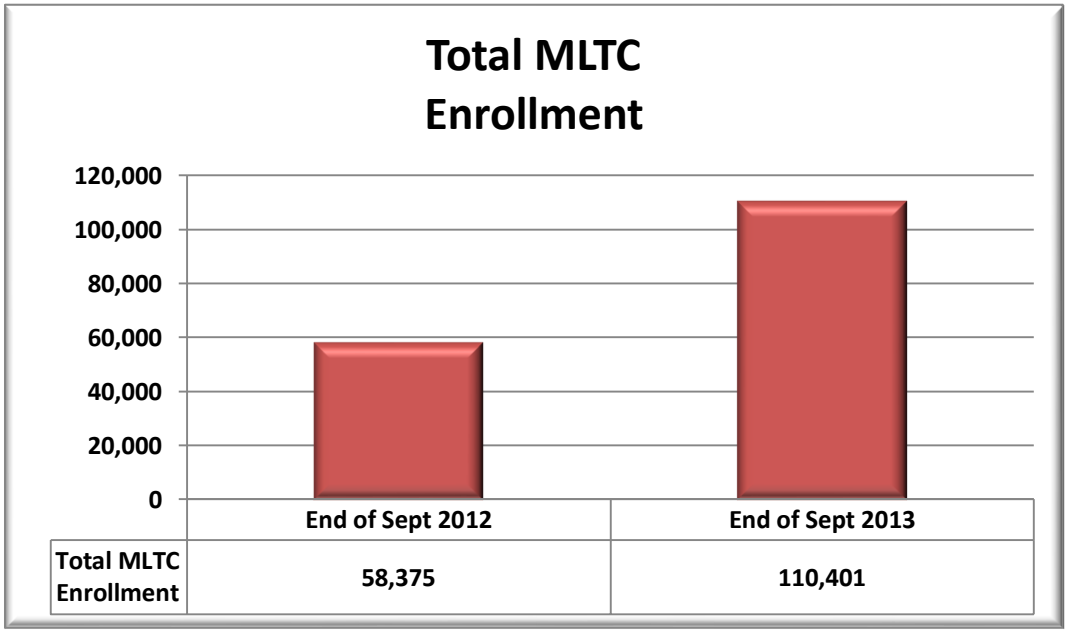
5.1. Accomplishments: Access and Coverage

Accomplishments in the areas of access and coverage include increased enrollment and the availability of information to inform choice.

5.1.1. Increased Enrollment

As of September 2013, there were 110,401 people enrolled in the State's Medicaid Managed Long Term Care program. From September 2012 through September 2013, enrollment in the MLTC program has increased by 89 percent, as illustrated in Exhibit 14: Managed Long Term Care Enrollment.

Exhibit 14: Managed Long Term Care Enrollment



5.2. Accomplishments: Quality

Accomplishments in the area of quality[22] include member satisfaction surveys being completed, continuity of care for all services provided under the plan of care transition from FFS to managed care, the introduction of a standardized assessment and activities to support informed choice and engage stakeholders.

5.2.1. Member Satisfaction Surveys Being Completed

The Department conducts an annual survey of member satisfaction. The most recent survey was distributed to a random sample of members from 25 MLTC plans. The response rate was 27 percent. The survey results are available on the Department's web

[22] For the overall Medicaid managed care quality strategy see:
http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

site and select measures are available by plan in the regional Consumer Guides[23] and will be available in the 2013 Managed Long-Term Care Report.

5.2.2. Continuity of Care in Personal Care Provider During Transition to Managed Care

To better understand member's experiences as they transition from FFS to MLTC, New York's Enrollment Broker, New York Medicaid Choice, conducted a post enrollment Outreach survey which contains 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 percent 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 percent of the respondents are receiving services from the same home attendant (personal care) agency[24].

The Department has also commissioned IPRO to conduct an additional survey focused on members' initial experiences with their new health plan. IPRO will also be analyzing measure of quality, timeliness and access to care, before and after the member joined the plan. A random sample of 1,500 newly enrolled members was selected to receive the survey. The survey was mailed in November, 2013. Survey results will be available in 2014.

5.2.3. Introduction of a Standardized Assessment

The Department has made a significant investment in standardizing needs assessments across all of its home and community-based long term care programs. As of October 2013, all MLTC plans use the Uniform Assessment System for New York (UAS-NY. The UAS-NY is a web-based, uniform data set based on the InterRAI Minimum Data Set (MDS). It provides a comprehensive assessment of an individual's health status, strengths, care needs, and preferences to guide the development of individualized long-term care service plans.

5.2.4. Activities to Support Informed Choice and Engage Stakeholders

A *Medicaid Managed Care Regional Consumer Guide* has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at ***http://www.health.ny.gov/health_care/managed_care/consumer_guides/***

To support informed choice for the consumer, the Department has contracted with Maximus, New York Medicaid Choice, to act as an Enrollment Broker in geographic areas targeted for transition to MLTC. The enrollment broker provides information to consumers related to all MLTC plans regarding provision of service and network providers both to assist informed choice and to minimize adverse risk selections by Medicaid recipients. The

[23] The Report in available on the Department's website at ***http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/*** , and select measures are reported in the Regional Consumer Guides at ***http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/***

[24] Partnership Plan Annual Report for DemonstrationYear:15(10/1/2012-9/30/2013), December 2013.

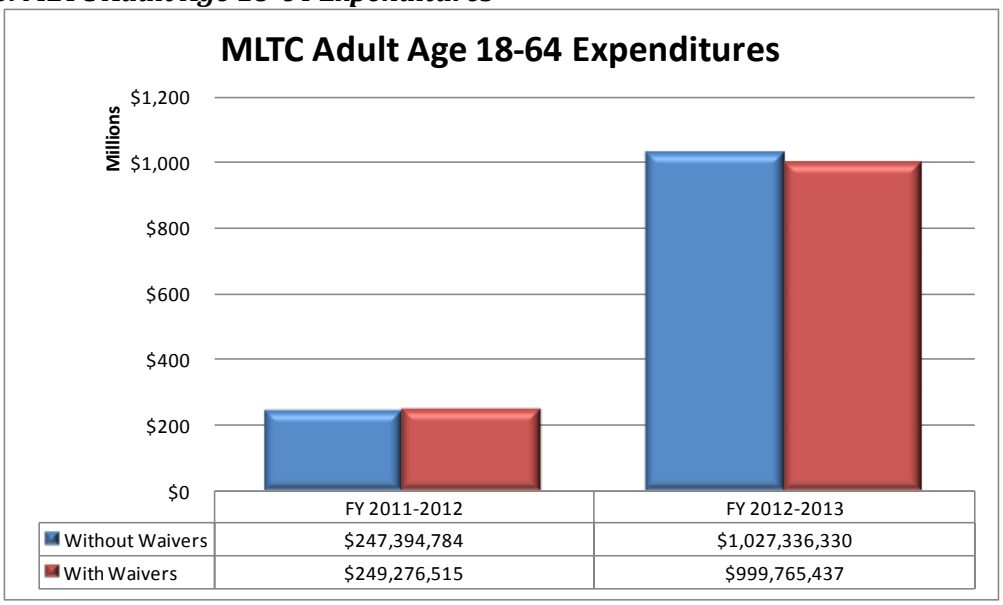
enrollment broker also provides both stakeholder and provider training throughout the state. The Department monitors choice counseling activities as well as training for stakeholders, providers and Local Department of Social Services staff to ensure accuracy of information shared.

5.3. Accomplishments: Cost

The Managed Long Term Care program meets the budget neutrality requirement. Projected expenditures for both population groups served by the program Adults Age 18-64 Duals and Adult Age 65 + duals are lower than they would have been without the Partnership Managed Long Term Care Program. As illustrated in Exhibit 15: MLTC Adult Age 18-64 Expenditures:

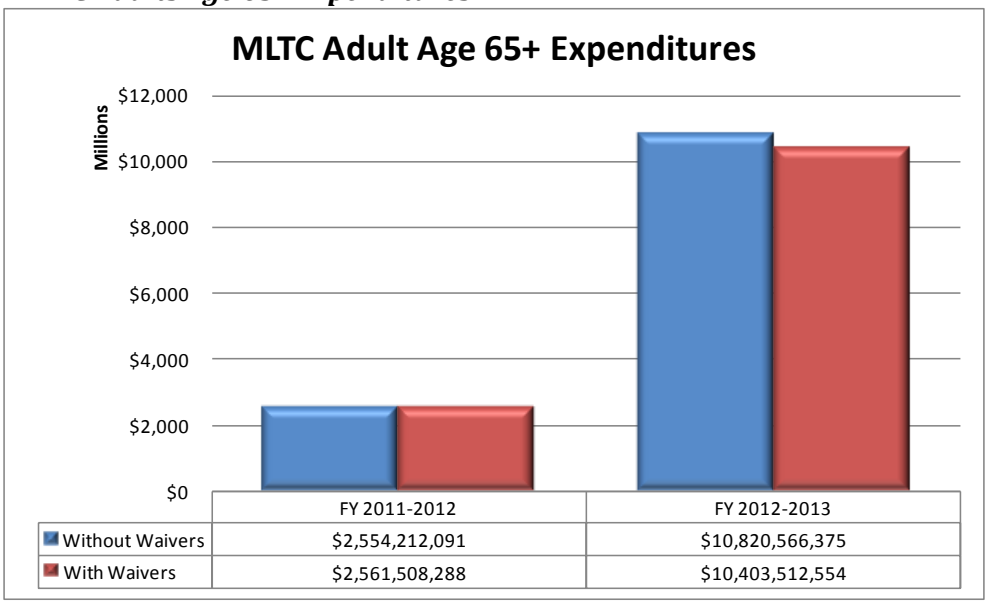
For MLTC Adults Age 18-64 Duals, expenditures without the waiver would have been 2.1 percent greater than with the waiver. For the one year period FFY 2011-2012 through FFY 2012-2013, the waiver has yielded $25.7 million in projected savings.

Exhibit 15: MLTC Adult Age 18-64 Expenditures



For the MLTC Adult population Age 65+ Duals, expenditures would have been 3.2 percent greater. For the two year period FFY 2011-2012 through FFY 2012-2013, the waiver has yielded $409.7 million in projected savings, as illustrated in Exhibit 16: MLTC Adults Age 65+ Expenditures.

Exhibit 16: MLTC Adults Age 65+ Expenditures



The difference between per member per month (PMPM) payments with the waiver and without the waiver is consistent with the analysis of program expenditures for both MLTC age groups. As illustrated in Exhibit 17: MLTC Adult Age 18-64 Expenditures PMPM and Exhibit 18: MLTC Adult Age 65+ PMPM Expenditure:

For the MLTC population Age 18-64, PMPM payments without the waiver are projected to be 2.8 percent greater than with the waiver in FFY 2012-2013. For the MLTC population Age 65+, PMPM payments without the waiver are projected to be 4.0 percent greater than with the waiver in FFY 2012-2013.

Exhibit 17: MLTC Adult Age 18-64 Expenditures PMPM

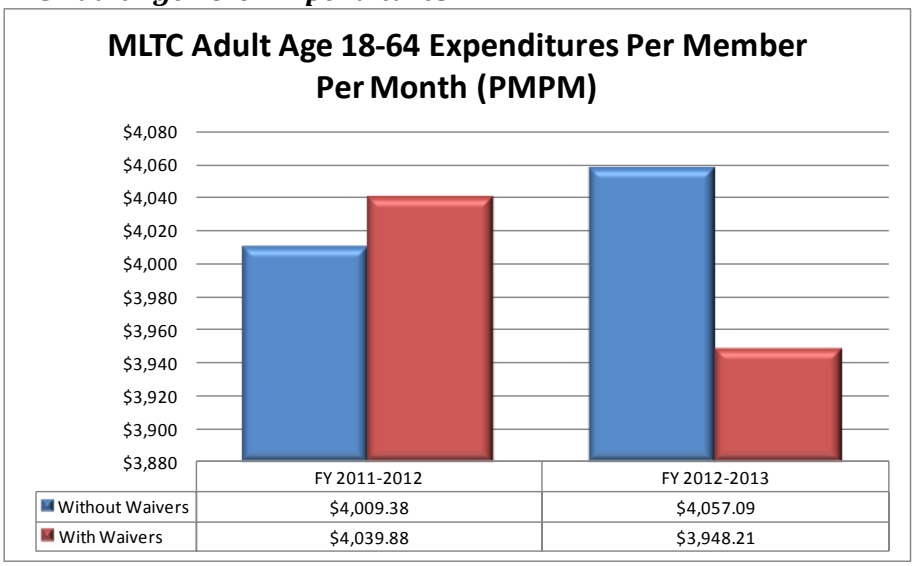
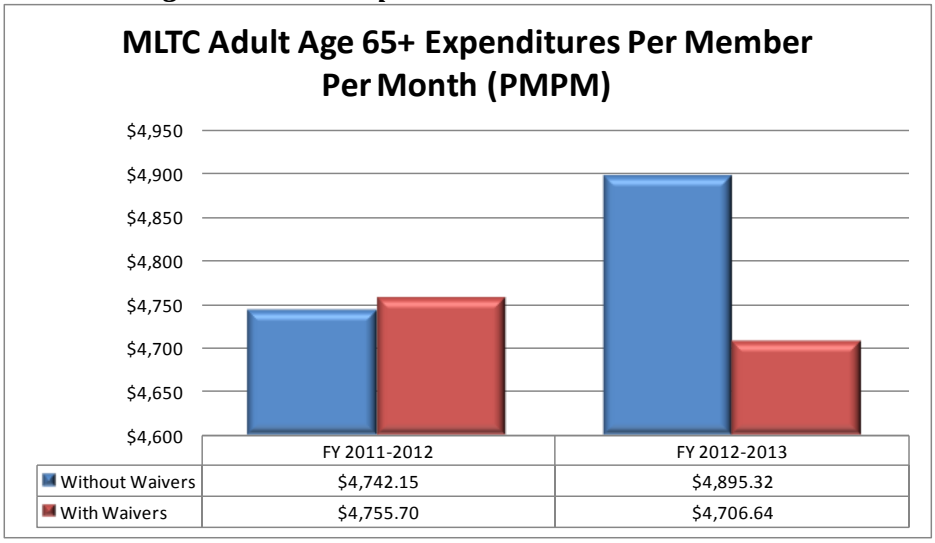


Exhibit 18: MLTC Adult Age 65+ PMPM Expenditure



Taking these two waiver demonstration groups together, total savings for the period FFY 2011-2012 through FFY 2012-2013 are projected to be $435.4 million.

6.0 OTHER NOTABLE PARTNERSHIP PLAN COMPONENTS

6.1. Home and Community-Based Services Expansion Program

The Home and Community-Based Services (HCBS) Expansion program eliminated a barrier to receiving care at home posed by eligibility rules that would otherwise lead to spousal impoverishment. The program allows special spousal budgeting provisions. [25]
This program is available in three waiver demonstrations: the Nursing Home Diversion and Transition Program, the Traumatic Brain Injury Program and the Long Term Home Health Care Program.

More than 1,400 Medicaid beneficiaries have gained access to home and community-based services as a result of the HCBS Expansion program.

For the period from April 1, 2011 through September 30, 2013 total projected program expenditures of $11,097,324.

6.2. Indigent Care Pool/Clinic Uncompensated Care Funding

Up until 2012, the Department provided state funded grants to voluntary, non- profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured through the state's Health Care Reform Act (HCRA) for the D&TC Indigent Care Pool (ICP) program. In 2012, CMS authorized Federal Financial Participation (FFP) for the state's program to address clinic uncompensated care through its ICP. In order to received ICP funds, each facility must have a comprehensive range of primary health care or mental health care services; provide at least 5 percent of their visits to uninsured individuals; and have a process to collect payments from third-party payers.

Cumulative disbursements through June 30, 2013, total $153.9 million of which $76.9 million was FFP.

6.3. Hospital-Medical Home Demonstration[26]

The Hospital-Medical Home (H-MH) Demonstration is designed to improve primary care quality, continuity and coordination in ambulatory care settings associated with primary care residency training programs. Goals include better care of chronic disease, increased preventive screenings and immunizations, increased access to care for acute conditions, better health for individual Medicaid members seen in training clinics, and improved performance on population health. A second overarching goal of the demonstration is to

[25] Under normal Medicaid eligibility rules, spouses living together at home are treated as a household of two and the basic two-person income and resource standards are applied. However, under SSA § 1924, when an institutionalized person with a spouse in the community applies for Medicaid, special spousal budgeting provisions allow the community spouse to retain a specified amount of the couple's combined income and resources. This Federal policy is intended to prevent the community spouse, who is legally responsible for the institutionalized spouse, from becoming impoverished by exhausting all of the couple's resources to help pay for institutional care.
[26] As of this writing, reports on only three quarters of the first year of the demonstration are available with many participating programs lagging in submitting reports. IPRO considers the data available to be insufficient for evaluative purposes.

prepare primary care residents for the new primary care job description: team-based, patient-centered, continuous care, with a focus on care transitions and population health.

Sixty-two New York State teaching hospitals and 119 primary care residency programs operating in 162 outpatient primary care sites are participating in this program[27]. Roughly, 1 in 3 physicians-in-training in New York State will be trained in PCMH principles and care coordination through this project, and more than half of all teaching hospitals and 25 percent of total hospitals in New York State are participating.

Hospitals submitted work plans in December 2012 for review and began their approved projects in January 2013. Hospitals are required to work on specific projects related to improving resident training, measuring health outcomes, care coordination, and improving the quality and safety of inpatient health care. In addition, participating hospitals are implementing at least two of six evidence-based Quality and Safety Improvement Projects (QSIPs). Milestones for the QSIPs can include infrastructure, redesign, implementation of evidence-based processes, and measurement and achievement of evidence-based outcomes. These QSIPs are:

- Severe Sepsis Detection and Management;
- Central Line-Associated Bloodstream Infection Prevention;
- Surgical Complications Core Processes;
- Venous Thromboembolism Prevention and Treatment;
- Neonatal Intensive Care Unit Safety and Quality; and,
- Avoidable Preterm Births.

Participating hospitals are required to achieve NCQA PPC®-PCMH™ Level 2 or Level 3 recognition, using 2011 standards, by July 2014.[28] This demonstration expires December 31, 2014.

[27] A list of participating hospitals and primary care residency programs is included as Attachment 4.
[28] The date for achieving this recognition was changed from March 2014 to July 2014.

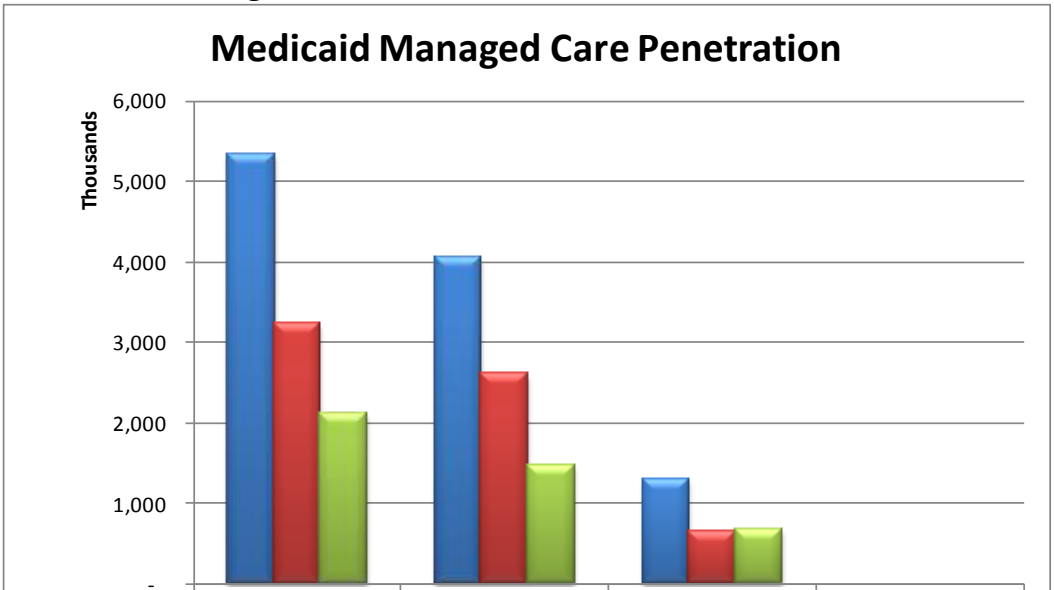
7.0 CONCLUSION AND NEXT STEPS

The Partnership Plan Demonstration has significantly expanded health care coverage to previously underinsured and uninsured populations. It has also prepared New York State to take a lead role in implementing federal health care reform initiatives supported by the ACA and to continue moving forward with compatible reforms such as expanding managed care enrollment, developing innovative ways to expand health care coverage, and improving the quality of care.

7.1. Penetration Rates

More than 4 million of the State's 5.3 million Medicaid recipients are enrolled in managed care. As of December 2013, the penetration rate of Medicaid recipients enrolled in managed care was 75.9 percent of total Medicaid enrollment statewide (80.7 percent in New York City and 68.7 percent in the rest of the State), as illustrated in Exhibit 19: Medicaid Managed Care Penetration Rates.

Exhibit 19: Medicaid Managed Care Penetration Rates



	Total Medicaid Enrollment	Managed Care	Fee for Service	Rate
Statewide	5,339,347	4,054,806	1,284,541	75.94%
NYC	3,220,083	2,598,758	651,325	80.70%
Rest of State	2,119,264	1,456,048	663,216	68.71%

The 24 percent of Medicaid enrollment still receiving care on a fee-for-service basis is comprised of populations that to this point are either not subject to mandatory enrollment or excluded from MMC. The state is addressing this issue by:

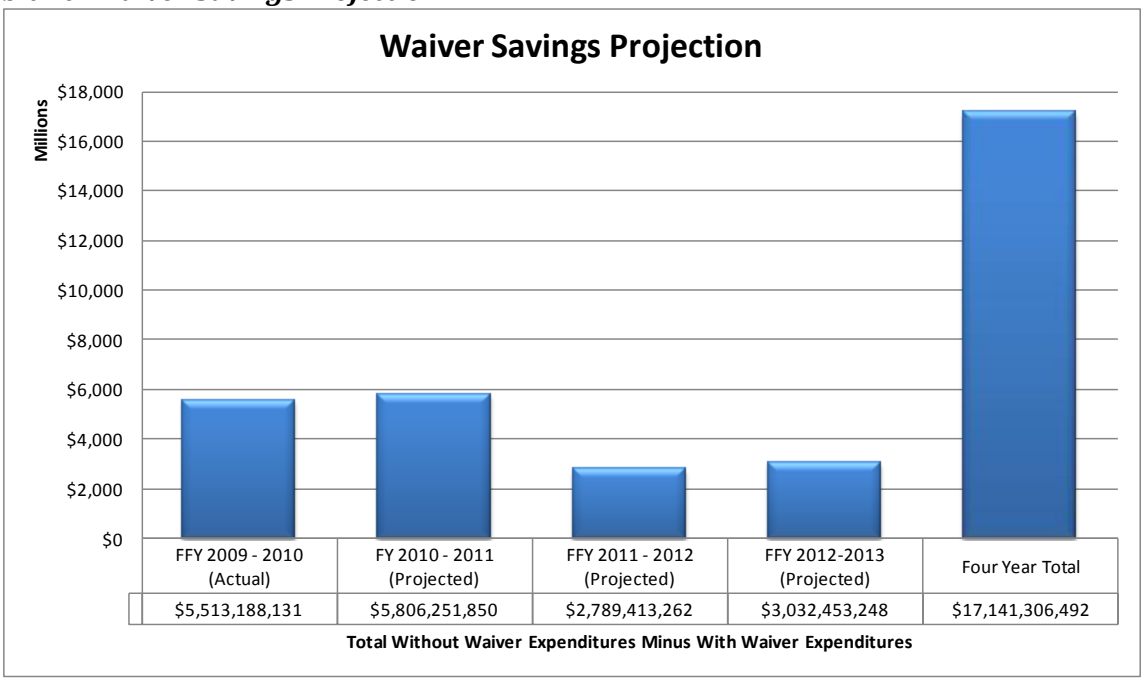
- Continuing the geographic expansion of MLTC mandatory enrollment (see Section 5.0., above);

- Continuing the implementation of the Fully Integrated Dual Advantage (FIDA) Demonstration to bring dually eligible individuals (Medicaid and Medicare) into fully-integrated managed care products.
- Continuing the implementation of the Health System Transformation for Individuals with Intellectual and Developmental Disabilities component of the Partnership Plan Demonstration (see Section 7.3.1., below); and,
- Amending the Partnership Plan to allow MCOs to include Medicaid enrollees with behavioral healthcare needs (see Section 7.3.3., below).

7.2. Cost Effectiveness

Between October 1, 2009 and September 30, 2013, the Department projects that the waiver will have saved an estimated $17.1 billion (The Department's budget neutrality impact analysis is appended as Attachment 5), as illustrated in Exhibit 20: Waiver Savings Projection, below.

Exhibit 20: Waiver Savings Projection



Review of the Department's budget neutrality analysis for the Partnership Plan indicates that the Department has been successful in producing savings for both the State and federal Medicaid programs. Implementation of the MMC mandate and the addition of FHPlus have successfully demonstrated that moving low income populations out of Fee for Service (FFS) care and into managed care models is cost effective with expenditures well below the level that would have been expected without the Partnership Plan Demonstration, as illustrated in Exhibit 21: Partnership Plan: Summary of Key Accomplishments.

Exhibit 21: Partnership Plan: Summary of Key Accomplishments

DEMONSTRATION GOALS	ACHIEVED?	KEY ACCOMPLISHMENTS
Goal 1: To expand managed care enrollment	✓	1. MMC enrollment increased by 23.9 percent between September 2010 and September 2013 2. MLTC enrollment increased by 89 percent between September 2012 and September 2013
Goal 2: To improve health care access for Medicaid beneficiaries in New York	✓	3. PCP ratio increased from 4.54 in 2010 to 4.79 in 2011 per 1,000 enrollees while specialty physicians ration per 1,000 enrollees increased from 10.6 to 12 in the same period. 4. All QARR measures of adult access to care improved between 2010 and 2012.
Goal 3: To continue to improve the quality of care	✓	5. State measures met or exceeded national measures in 2012 NCQA QARR. 6. 91 percent of the national quality benchmarks met for FHPlus.
Goal 4: Expanded Health Care Coverage	✓	7. FHPlus enrollment increased by 12.6 percent between September 2009 and September 2013.
Waiver Requirement: Budget Neutrality	✓	8. Projected Medicaid savings of approximately $17.1 billion over the last four years

Building on these key accomplishments, the State is taking further steps to improve access, quality and cost efficiency in the Medicaid Program and is working closely with CMS to obtain approval to reinvest some of the savings from the Partnership Plan and complimentary activities implemented as part of the State's Medicaid Redesign Action plan into the new initiatives described in the next section.

7.3. New Initiatives

The following initiatives are in the initial implementation phase or have yet to gain CMS approval. Therefore, more detailed analysis of program activities, performance and progress is not available at this time.

7.3.1. Health System Transformation for Individuals with Developmental Disabilities

The Health System Transformation for Individuals with Intellectual and Developmental Disabilities component of the Partnership Plan Demonstration is intended to identify goals that will improve opportunities for individuals with intellectual and developmental disabilities in the areas of employment, integrated living, and self-direction of services. The Department's Transformation Agreement[29] with CMS specifies expenditure authority beginning April 1, 2013 through March 31, 2014 and describes the following goals for this transformation including:

- Developing new service options to better meet the needs of individuals and families in a person-centered paradigm, including allowing for more self-direction of services;

[29] The Transformation Agreement can be found at ***http://www.opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment***

- Creating a specialized managed care system that recognizes the unique needs of people with disabilities, and is focused on a habilitative model of services and supports;
- Ensuring that individuals with disabilities live in the most integrated community settings;
- Increasing the number of individuals who are competitively employed; and
- Working to make funding in the system sustainable and transparent.

The Transformation Agreement also specifies a schedule of deliverables to submit to CMS that serve as milestones in the areas of self-direction, competitive employment and deinstitutionalization. This schedule is represented in the table below.

Transformation Agreement Deliverables Submitted to CMS	
April 2013	Waiver applications submission (1915(c) amendment and 1915(b) application)
	Approved protocol for Money Follows the Person
May 2013	Submit educational/training materials for participant self-direction
	Report on the baseline count of enrollees receiving supported employment (8,773) and the number of people in competitive employment (5,882)
	Draft Cost Containment Strategy submitted
June 2013	No new admissions to sheltered workshops (Directive, FAQ and other guidance issued in June)
July 2013	First Quarterly Report on Transformation Agreement deliverables 1,500 stakeholders educated on self-direction (actual number 1,844) • Assisted in the transition of 8 residents out of Finger Lakes and Taconic ICFs • Report on the baseline of workshop enrollees • Report on baseline of individual self directing
	Draft Evaluation Plan
August 2013	Draft de-institutionalization transition timeline (campus and non-campus ICFs to community settings)
	Draft accountability plan
	Draft cost containment strategy
September 2013	Draft Balancing Incentive Program Work Plan – baseline housing data, assurance of compliance with HCBS settings standards, review process for person-centered planning
	Progress Report – Practice Guidelines for CQL Personal Outcome Measures in care coordination

Transformation Agreement Deliverables Submitted to CMS	
October 2013	Draft Plan for Increasing Participation in Competitive Employment
	Second Quarterly Report on Transformation Agreement deliverables • Increased the number of new beneficiaries self-directing by 394, meeting the goal of 350 new beneficiaries self-directing their services by October 1, 2013 • Educated 1,500 additional stakeholders about self-direction • Assisted in the transition of 23 residents out of Finger Lakes and Taconic ICFs • Increase of 273 individuals engaged in competitive employment.

As of September 30, 2013, the state had met all scheduled deliverables to CMS.[30]

7.3.2. The Delivery System Reform Incentive Payment Plan

The Department is in the final stages of negotiating approval from CMS for a five year waiver amendment to the Partnership Plan for its proposed Delivery System Reform Incentive Payment Plan (DSRIP). By reinvesting some of the federal savings that have been achieved though MRT initiatives, the Department proposes to invest $7.3 billion to rebalance the delivery system as well as reduce hospitalizations and emergency department use by 25 percent over the next five years.

The Department plans to assist safety net institutions by allowing them to both downsize unneeded inpatient capacity as well as to transform service delivery systems to provide the right mix of services necessary in the communities in which they serve. In addition, the programs would help community-based providers expand and provide additional, vital services so that lower cost alternatives to inpatient care and emergency room services are available statewide. DSRIP is designed to encourage collaboration among providers in order to reduce system fragmentation.

7.3.3. Behavioral Health System Transformation

In December 2013, the Department submitted an amendment to the Partnership Plan to enable qualified MCOs to more comprehensively meet the needs of participants with behavioral health needs. The Department is proposing to integrate all Medicaid covered services for mental illness, substance use disorders, and physical health conditions. The state plans to enroll adult populations with serious and persistent mental illness and substance use disorders, in specialty lines of business within the qualified mainstream MCOs, called Health and Recovery Plans (HARPs).

The goals of this managed care service delivery model are to improve clinical and recovery outcomes for enrollees, slow the growth in costs through a reduction in unnecessary emergency and inpatient care, and increase MCO capacity to deliver community-based recovery services and supports.

[30] Transformation expenditures under the Partnership Plan are not included in budget neutrality calculations.

ATTACHMENT 1. MEDICAID MANAGED CARE (MMC) QARR/NATIONAL BENCHMARK COMPARISON OF 2012 DATA & COMPARISON OF MMC QARR 2007 AND 2012 DATA

Medicaid Managed Care QARR/National Benchmark Comparison of 2012 Data &Comparison of MMC QARR 2007 and 2012 Data

Seventeen Medicaid Managed Care (MMC) plans submitted 2012 QARR data in June 2013. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for QARR 2007 and 2012 are displayed in the following table and QARR 2012 data is also compared with the NCQA HEDIS® National benchmark measures for 2012 Medicaid HMOs in the NCQA *The State of Health Care Quality 2013*. For comparative purposes, the measures listed in the table are limited to those that are common to either both QARR 2007 and 2012 or both QARR 2012 and the HEDIS® 2012 data. For the QARR Reports, Medicaid plans submitted 2012 data in June 2013 and 2007 data in June of 2008.

New York's MMC Care 2012 average exceeded the 2007 average for 27 of 31 measures as indicated by a check mark (☑) in the fourth column. New York's 2012 average exceeded the national benchmarks for 31 of 35 measures as indicated by a check mark (☑) in the sixth column (**gray** cells indicate that national benchmarks were not available, and **yellow** cells indicate that 2007 measures were not available).

Measure	2012 NYS Medicaid Managed Care (MMC) Average	2007 NYS Medicaid Managed Care (MMC) Average	2012 MMC Measures Above the 2007 NYS Average	National HEDIS 2012 Medicaid HMO Average*	2012 MMC Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	93	88	✓	88	✓
Children and Adolescents' Access to PCPs Ages 12-24 months	97	95		96	✓
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	93	90	✓	88	✓
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	96	93	✓	90	✓
Follow-Up for ADHD Medication: Continuation Phase	63	59	✓	45	✓
Follow-Up for ADHD Medication: Initiation Phase	57	53	✓	39	✓
Adults' Access to Care Age 20-44 Yrs	84	80	✓		
Adults' Access to Care Age 45-64 Yrs	90	87	✓		
Adults' Access to Care Age 65 and over	90	88	✓		
Adult BMI Assessment (ABA)	79			68	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	79	77	✓	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	65	60	✓	44	✓
Antidepressant Medication Management-180 Day Effective Continuation Phase Treatment	37	29	✓	37	
Antidepressant Medication Management-84 Day Acute Phase Treatment	53	46	✓	53	
Drug Therapy in Rheumatoid Arthritis	78	74	✓	70	✓
Use of Imaging Studies for Low Back Pain	78	81		76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	24	27		24	
Cervical Cancer Screening	71			65	✓
Chlamydia Screening (Ages 16-20)	71	53	✓	55	✓
Chlamydia Screening (Ages 21-24)	73	60	✓	64	✓
Frequency of Ongoing Prenatal Care 81-100%	70			60	✓

Measure	2012 NYS Medicaid Managed Care (MMC) Average	2007 NYS Medicaid Managed Care (MMC) Average	2012 MMC Measures Above the 2007 NYS Average	National HEDIS 2012 Medicaid HMO Average*	2012 MMC Measures Above the National Average
Controlling High Blood Pressure (Ages 18-85)	63			56	✓
Persistence of Bete-Blocker Treatment After a Heart Attack	77			82	
Breast Cancer Screening	68	68		52	✓
Annual Monitoring for Patients on Persistent Medications-ACE inhib/ARBs	92	85	✓	86	✓
Annual Monitoring for Patients on Persistent Medications-Anticonvulsant	68	65	✓	66	✓
Annual Monitoring for Patients on Persistent Medications-Combined	90	84	✓	85	✓
Annual Monitoring for Patients on Persistent Medications-Digoxin	93	91	✓	90	✓
Annual Monitoring for Patients on Persistent Medications-Diuretics	91	84	✓	86	✓
Pharmacotherapy Management of COPD Exacerbation-Bronchodilator	88	77	✓	82	✓
Pharmacotherapy Management of COPD Exacerbation-Corticosteroid	72	50	✓	65	✓
Appropriate Testing for Pharyngitis	87	73	✓	68	✓
Postpartum Care	70			63	✓
Timeliness of Prenatal Care	88			83	✓
Use of Spirometry Testing for COPD	53	40	✓	32	✓
Appropriate Treatment for URI	93	89	✓	85	✓
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	82	81	✓	72	✓
Adolescent Well-Care Visits	59	58	✓	50	✓
Total Indicators	***38***	***31***	***27***	***35***	***31***

N/A - not applicable to the product
QARR 2013 data from Partnership Plan Annual Report (10/1/2012-9/30/2013), pp.28-30
**National benchmarks from NCQA's 2013 State of Health Care Quality report*

ATTACHMENT 2. FAMILY HEALTH PLUS 2011 QARR/HEDIS® NATIONAL BENCHMARK 2011 COMPARISON

Family Health Plus 2011 QARR/National Benchmark 2011 Comparison

The Department provided IPRO with Family Health Plus (FHPlus) data[31] disaggregated from the full Medicaid Managed Care plan QARR data. IPRO constructed the following table to represent a comparison of the national HEDIS® quality measures to the FHPlus data where these measures were in common.

As indicated in the final column of the table below, FHPlus exceeded the national quality metric for 91.3 percent of the measures (i.e., 21/23 measures).[32] New York's scores are notably higher than the national average in some areas. For example, New York's Medicaid Managed Care plans completed recommended Breast Cancer Screening for 72 percent of FHP enrollees compared to the national average of 50 percent. This large difference is also evident with testing for COPD, postpartum care, and ambulatory follow-up for mental illness. For the few measures that are not above the national metric, NYS was within five percentage points with the exception of adolescent well-care visits at a seven percentage point difference.

[31] Family Health Plus data was taken from the 2012 New York State Demographic Variation in Medicaid Managed Care,.
[32] The HEDIS data was taken from the NCQA *The State of Health Care Quality 2013*; specifically, the Medicaid HMO section which represents data from 2012.

Measure	2011 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2011 Medicaid HMO Average*	FHPlus Measures Above the National Average
Adult BMI Assessment (ABA)	70	53	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	86	65	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	75	47	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	35	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	53	51	✓
Drug Therapy in Rheumatoid Arthritis	81	69	✓
Use of Imaging Studies for Low Back Pain	78	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	29	24	✓
Cervical Cancer Screening	74	67	✓
Frequency of Ongoing Prenatal Care 81-100%	77	61	✓
Controlling High Blood Pressure (Ages 18-85)	69	57	✓
Breast Cancer Screening	72	50	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	91	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	61	65	
Annual Monitoring for Patients on Persistent Medications- Combined	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	91	90	✓
Annual Monitoring for Patients on Persistent Medications- Diuretics	89	85	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	82	80	✓
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	73	64	✓
Postpartum Care	77	64	✓
Timeliness of Prenatal Care	92	83	✓
Use of Spirometry Testing for COPD	58	32	✓
Adolescent Well-Care Visits	43	50	
Total Indicators	***23***	***23***	***21***

ATTACHMENT 3. NEW YORK STATE DEPARTMENT OF HEALTH COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS

ORGANIZATION & MANAGEMENT	
QUESTION	**CITATIONS**
1. Does the plan have an effective mechanism for input by enrollees to the board of directors?	98-1.17(a)(4)
2. Is the board of directors comprised of at least 1/3 of New York State residents and are at least 20% MCO members? Are member representatives, or in the case of a PHSP, consumer representatives from an advisory council representing the membership, given prior notice and invited to board meetings? In the case of an HIV SNP, is there at least one person with HIV infection serving as a consumer representative? Note: Article 43s with Article 44 lines of business do not need to comply with this requirement.	98-1.6(a) 98-1.11 (g) (1),(2)
3. Does the MCO have any new board members, managers of an LLC, officers, or medical director? Has the MCO notified the department of those new individuals and the names of those individuals that are leaving their positions?	98-1.5 (b)(2)(ii)
4. Does the board of directors meet to conduct business at least four times a year, once in each quarter?	98-1.6(a)
5. If the plan has a management contract: (a) Does the MCO retain its authority in key areas described in 98-1.11(i)? (b) Has the contract received Health Department approval?	98-1.11(i) 98-1.11(j) 98-1.11(k)
6. Does the MCO conduct audits or other monitoring activities of its management contractors?	98-1.11(h) MMC/FHP Contract: Sections 22.1, 22.4(b), 22.5(a),(i), Appendix R(5)
7. (a) Is there evidence that the governing authority is responsible for the establishment and oversight of the MCO's policies, management and overall operation? (b) Do board minutes reflect that the board is managing its operation?	PHL §4404(1) 98-1.11(h)

QUALITY ASSURANCE	
QUESTION	**CITATIONS**
8. Does the MCO have a comprehensive quality management program that is approved by the MCO board of directors and the Department?	98-1.12
9. Does the MCO's medical director supervise the quality and utilization management programs?	98-1.12(a) 98-1.2(bb)
10. (a) Does the MCO have an internal quality assurance committee? (b) Does the committee composition include healthcare providers and other appropriate MCO staff? (c) Is the Board kept apprised of quality management activities by the QA committee? Is there evidence that the board is actively involved in the oversight of the quality management program?	98-1.12(e) 98-1.12(f)(1) 98-1.12(i)
11. What sources and strategies does the MCO use to identify and examine actual and potential problems in health care administration?	98-1.5(b)(16) 98-1.12(a), (b), (c), (g), (h) 98-1.12(f)(2) MMC/FHP Contract Sections 10.4, 16.2, 35.7
12. Does the MCO develop and implement appropriate recommendations and corrective actions to address problems identified?	98-1.12(i), (j)
13. How does the MCO evaluate whether problem areas are resolved?	98-1.12(a) 98-1.12(f)(iv) 98-1.12(i)(1), (2), (3) 98-1.12(j)(1), (2), (3)
14. Does the MCO have a peer review committee responsible for monitoring provider performance?	98-1.12(f)(2)
15. What method is used by the MCO to determine the clinical study(ies) that should be undertaken by the MCO to improve the health of its enrollees?	98-1.12(g)
16. Has the plan integrated QARR results into their ongoing procedures?	98-1.12 (b), (i) MMC/FHP Contract Section 18.5(a)(x)
17. Does the plan have a case management program for individuals with chronic diseases and for high risk pregnant women to promote coordination of care amongst providers and other support services?	MMC/FHP Contract Sections 10.19 10.20 98-1.13(h)
18. Does each member have a primary care provider who is responsible for managing and facilitating care?	98-1.13 (d), (h) MMC/FHP Contract Sections 21.8, 21.11

QUALITY ASSURANCE	
QUESTION	**CITATIONS**
19. Has the plan developed medical record standards and are these standards disseminated to and applied to providers?	98-1.13(k), (l) MMC/FHP Contract Sections 19.1(a)(i), 20.2, 20.3
20. Does the plan take appropriate actions to ensure the confidentiality of medical records and other specific information?	PHL 4410.2 PHL 2782 MMC/FHP Contract Section 20.3 PHL 4902.1(g) PHL 4905.1, 2, 8
21. Does the MCO provide HIV testing and counseling to all pregnant women? (a) Is HIV counseling/testing provided to each prenatal enrollee with clinical recommendation for HIV testing? (b) Is HIV post-test counseling provided to all women who are HIV tested?	PHL Chapter 220
22. Does the plan have effective credentialing and recredentialing processes that are overseen by the medical director?	98-1.12(k) 98-1.12(l) MMC/FHP Contract Sections 21.4, 21.1(b) 4408-1.(r) 4406(d)-1
23. (a) Does the MCO have a process to identify, on an ongoing basis, healthcare providers that have been sanctioned by regulatory agencies or providers whose license or registration has expired or been revoked? (b) Does the process include removal of providers from the network who are unable to provide services due to final disciplinary action, sanction by regulatory agency, or due to an expired license/registration?	98-1.12(l) MMC/FHP Contract Sections 21.1(b), 21.4(b), 21.5
24. **PRENATAL Medicaid Only:** Are risk assessments conducted initially and periodically throughout the prenatal period, and is appropriate follow-up conducted?	MMC/FHP Contract Section 13.6(a)(ii), (v)
25. **PRENATAL Medicaid Only**: Are prenatal diagnostic and treatment services and postpartum services provided according to accepted standards?	MMC/FHP Contract Section 10.11 SSL 365-k.

SERVICE DELIVERY NETWORK	
QUESTION	**CITATIONS**
26. Does the Plan have a Provider Manual which is distributed to all providers?	See Provider Manual Checklist 98-1.12 (o) requires a provider manual
27. (a) Does the plan have a mechanism to monitor clinical access to PCPs 24 hours a day, 7 days a week (including for pregnant women)? (b) Medicaid Only: Does the MCO monitor appointment availability?	Appointment and Availability Study PHL 4408(1)(h) 98-1.6(f) 98-1.6(f) 98-1.13 (d) and (h) MMC/FHP Contract Section 18.5(a)(ix)
28. (a) Does the MCO allow each member to choose a PCP? (b) If the member does not select a PCP, does the plan assign a PCP? (c) Does the MCO allow member to change PCPs?	PHL 4403(5)(a)(i) (ii) 98-1.13(d) MMC/FHP Contract Sections 13.6 21.8(a),(b),(c) 21.9 21.10(c) 21.14(d) and (e) 21.15(c)
29. Does the Plan have contracts for all providers that are listed on the HPN?	PHL 4402(2)(a) PHL 4403(5) 98-1.2(aa) 98-1.5(b)(6) 98-1.13 (a) 98-1.18(a) MMC/FHP Contract: Sections 21.1, 22.1, 22.3, 22.4
30. (a) Does the Plan have a process to update the provider directory? (b) Does the MCO notify enrollees and providers of changes to the directory?	PHL 4403(5)(a)(b) PHL 4408(1)(r) 98-1.16(i) MMC/FHP Contract Section 13.1
31. Does the plan have an internal process to identify capacity problems and augment the network as needed?	PHL 4403(5)(a)(b) 98-1.6 (f) 98-1.13 (h) MMC/FHP Contract Section 21.1
32. (a) Does the MCO notify DOH appropriately upon large contract assignments, terminations or non-renewals? (b) Are contracts that were assigned to the MCO through a purchase or acquisition updated?	98-1.13(c) MMC/FHP Contract Section 22.12
33. Does the MCO implement procedures to address health care professional (provider) terminations and due process?	PHL 4406-d(2) PHL 4406-d(5)

MEMBER SERVICES/ACCESS TO SERVICES	
QUESTION	**CITATIONS**
34. How does the MCO provide care to members with life threatening or degenerative and disabling conditions needing access to specialty care centers?	PHL 4403(6)(d) MMC/FHP Contract Sections 10.19, 10.20, 15.9, 21.14(b)
35. How does the plan provide access to specialty care outside of the plan's contracted network, as needed?	PHL 4403(6)(a) 98-1.13(a) MMC/FHP Contract Section 21.2
36. Does the MCO have procedures in place to allow a specialist to act as the PCP for enrollees with a life-threatening condition or disease or a degenerative and disabling condition or disease which requires specialized medical care?	PHL 4403(6)(c)
37. a) Does the plan have policies and procedures to allow transitional care to new members upon joining the MCO? **<u>Medicaid Only:</u>** b) What does the plan do to promote continuity of care for new enrollees who have a life threatening disease or condition or a disabling degenerative condition, specifically as it relates to home health care and private duty nursing?	PHL 4403(6)(f) MMC/FHP Contract Section 15.6
38. Does the plan have policies and procedures to address continuity of care when a provider leaves a network?	PHL 4403(6)(e)(1) PHL 4408(4) 98-1.2(oo)
39. Does the MCO have a process for the resolution of requests for services to be provided by out-of-network providers for medically necessary services not available in network?	98-1.13(a), (b), (i)
40. Is the plan issuing member handbooks and policies and procedures to address all requirements prescribed in regulation and law?	PHL 4408 98-1.14
41. Does the plan have a mechanism to provide health and childbirth education to prenatal enrollees?	MMC/FHP Contract Section 10.11 SSL 365-k.
42. Does the MCO have a toll-free telephone number to accept oral complaints on a 24-hour basis?	PHL 4408-a(3)(d)
43. Does the MCO have an acceptable toll-free telephone number which connects callers to UR personnel?	PHL 4902.1(f)
44. Is the complaint process accessible and usable to the non-English speaking, or by persons with mobility, auditory, visual, and cognitive impairments?	PHL 4408-a(2)(c) PHL 4403(5)(b)(ii) 98-1.16(k) MMC/FHP Contract Sections 12.2, 12.3, Appendix F.2(2)(a)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
45. Are there procedures for enrollee filing of a complaint or grievance?	PHL 4408-a PHL 4403 (1) (g) PHL 4403(5) (b)(iii) 98-1.14 (c), (d), (e) 98-1.16(k) MMC/FHP Contract App F.2 (1), (2), and (6)-(9) Section 12.2, 12.3
46. Are the MCO's grievance, complaint and appeal notifications accessible to and usable by persons with auditory, visual, and cognitive impairments and by persons who speak a language other than English?	PHL 4403.5(b)(ii) 98-1.16(k) MMC/FHP Contract Appendix F F.1 (5)(a) F.2 (5)(a) Appendix J (IV) (B4)
47. **Medicaid Only:** a) Does the MCO handle service or referral requests and claim submissions for contracted benefits consistent with the MMC/FHP contract? b) Are qualified personnel reviewing requests for benefits/referrals and claims?	MMC/FHP Contract Section 14.1, 14.2(a), (b) Appendix F F.1(2)(a)(iii) F.1(6) F.2 (2)(f) F.2 (3)(a)(vii)
48. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	Medicaid Advantage Contract Appendix F F.1 (2)(c)
49. **Commercial /CHP Only:** Is written notice of grievance procedure provided to the enrollee when a request for referral or service is denied or claim is denied in whole or in part, because the MCO determines the service is not covered?	PHL 4408-a (2)(a)& (b) PHL 4408-a(3) (a),(b), & (d)
50. Does the plan have designated personnel to accept review and make determinations on all complaints/grievances and as applicable, Action appeals?	4408a-(3)(d) 4408-a (5) 4408-a(10) MMC/FHP Contract Appendix F F.1(2)(a)(iii) F.2 (2)(b) F.2(3)(a)(vii) F.2 (6)(a)(iii) and (iv) F.2 (9)(a)(iii)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
51. **Medicaid Only:** Does the enrollee have the ability to file standard Action appeals?	MMC/FHP Contract, Appendix F F.1 (d)(v) F.2(3)(a)(i), (ii), (iii) and (iv) F.2 (4) F.2 (5) F.2(10)
52. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
53. Are grievances and complaints, other than immediately resolved oral complaints, acknowledged within 15 business days? b) Are appeals of the MCO's grievance and complaint determinations acknowledged within 15 business days? c) Medicaid Only: Are Action appeals acknowledged within 15 calendar days?	PHL 4408-a(4) PHL 4408-a(3)(c) PHL4408-a(9) 98-1.14(e) MMC/FHP Contract Appendix F F.2 (3)(a)(iii) F.2 (6)(a)(ii) F.2 (9)(a)(ii)
54. Does the MCO review grievances and investigate complaints in accordance with statute and, if applicable, the MMC/FHP Contract? b) Medicaid Only; Does the MCO review Action Appeals in accordance with statute and the MMC/FHP Contract?	PHL 4408-a(1) PHL 4408-a(2)(b) PHL 4408-a(4) PHL 4408-a(6) PHL 4408-a(13) 98-1.14(c), (e) MMC/FHP Contract App F.2 (2), (3), (4), (5), (6) and (7)
55. **Medicaid Only**: Does the MCO extend reviews of referral/ benefit requests, claims and Action appeals in accordance with the MMC/FHP Contract?	MMC/FHP Contract App F.1 (3)(c)(i) and (ii) F.1 (3)(d) F.2(4)(a)(iii) F.2(10)(vii)
56. Does the MCO issue appropriate resolution notices to the enrollee, or their designee, for complaints and grievances, and, as applicable, Action appeals?	PHL 4408-a(6) PHL 4408-a(7) 98-1.14(e) MMC/FHP Contract App F.2 (5)(a)(iii) F.2 (8)
57. Does the enrollee have the ability to file an appeal of the MCO's grievance or complaint determination?	PHL 4408-a (8), (9) 98-1.14(e) MMC/FHP Contract Appendix F.2 (9)

COMPLAINTS/GRIEVANCES	
QUESTION	**CITATIONS**
58. Are grievance and complaint appeal determinations issued in accordance with all requirements?	PHL 4408-a(12) MMC/FHP Contract App F.2 (9)(a)(vi)
59. Is there a complete file for each complaint/ grievance, appeal and as applicable Action appeal?	PHL 4408-a(14) 98-1.14(d) MMC/FHP Contract App F.2 (10)
60. Does the MCO have procedures in place to address provider complaint/grievances?	PHL 4406-c(3),(4) PHL 4406-d PHL 4408-a(1) MMC/FHP Contract Section 22.7(a)(ii) and (iii)
61. Does the MCO report incidents of probable health care provider professional misconduct to appropriate professional disciplinary agencies?	PHL 4405-b MMC/FHP Contract Section 18.8
62. Does the MCO report complaints regarding fraud and abuse to DOH?	98-1.21(d) MMC/FHP Contract Section 18.5(a)(vi)
63. **Medicaid Only:** Are accurate reports on Medicaid complaints and Action Appeals sent to SDOH on a quarterly basis?	PHL 4408-a (14) 98-1.16(h) MMC/FHP Contract Section 18.5(a)(vi) App F.2 (7)(a)(i)
64. Does the plan trend complaints/grievances to identify administrative problems and issues regarding the provision of health care services?	PHL4403(5)(b) (iii) PHL 4408-a(14) 98-1.12 (g), (h),(i), and (j)
65. Does the MCO monitor complaints, grievances, and as applicable, Action appeals, related to accessibility issues for enrollees, including persons with disabilities? b) Does the MCO routinely identify enrollee special needs, and respond to complaints regarding accessibility in a manner consistent with identified needs?	PHL 4403(5)(b)(i) 98-1.12 (g), (h),(i), and (j) MMC/FHP Contract Appendix J (IV) (B4)

UTILIZATION REVIEW (with MMC/FHP Actions)	
QUESTION	**CITATIONS**
66. Does the MCO have written Utilization Review procedures that are compliant with statute, regulation, and, as applicable, the MMC/FHP contract?	PHL 4902 PHL 4903 PHL 4904 PHL 4905 PHL 4910 PHL 4900(9) 98-2.3(a) 98-1.13(n) 98-2.9 MMC/FHP Contract Section 14.1, 14.2(a),(b) and Appendix F
67. Are notices of initial UR adverse determinations issued in accordance with all requirements?	PHL 4903(5) PHL 4902(1)(e) MMC/FHP Contract App F.1 (2)(a)(iv) F.1 (5)(a)(iii) F.2(3)(a)(iv)
68. Are notices of UR final adverse determinations issued in accordance with all requirements?	98-2.9(e) 98-2.9(h) PHL 4904(5) PHL 4904(3) MMC/FHP Contract App F.2(4)(a)(v) F.2(5)(a) F.2 (5)(a)(iii)
69. Are requests for pre-authorization or continuation/ extension of services reviewed in accordance with statute and, as applicable, the MMC/FHP contract?	PHL 4903(2) PHL 4903(3) PHL 4903(7) MMC/FHP Contract App F.1(1), (2) F.1 (3)(a), (b)
70. Is retrospective utilization review done in accordance with statute, and as applicable, the MMC/FHP contract?	PHL 4903(4) PHL 4903(7) PHL 4905(5) 98-1.13(n) MMC/FHP Contract App F.1(4)(b), (c) F.1(6)(b)
71. Does the plan have qualified personnel who perform utilization review?	4900.2 (a) 4903.1 4904.4
72. **Medicaid Only:** Does the MCO identify and review initial requests for authorization of services requiring expedited review in accordance with the MMC/FHP contract?	MMC/FHP Contract App F.1(2)(a)(i)
73. When more information is needed to render a determination, does the MCO request necessary information prior to making an adverse determination or upholding an appeal?	4903.5(c) 4905.11 4408-a(3)(c)

UTILIZATION REVIEW (with MMC/FHP Actions)	
QUESTION	**CITATIONS**
	98-2.9(b) MMC/FHP Contract App F.1 (2)(a) [42CFR 438.210 (b)(2)(ii)] F.1 (3)(c)(ii) F.2(4)(a)(iii)(B) F.2(10)
74. Does the MCO notify enrollees and providers when services are authorized?	4903.2 4903.3 MMC/FHP Contract App F.1(2)(iv)
75. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	MA Advantage Contract App F.1 (2)(c)
76. Do providers have the ability to request timely reconsideration of a UR adverse determination of a service they recommended?	4903.6 4903.5
77. Does the enrollee have the ability to file standard appeals of adverse determinations?	4904.3 4903.5 MMC/FHP Contract App F.2(3)(a)(i), (ii), (iii) and (iv) F.2(10)
78. Does the enrollee and/or the enrollee=s health care provider have the opportunity to engage in an expedited appeal?	4904.2 (a) and (b) 4903.5(b) 98-2.9 (e)(f) 98-1.14 (c) MMC/FHP Contract App F.2(3), (4), (10)
79. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
80. Does the MCO adequately cover emergency services?	4902.1(c),(h) 4903.4 4903.5 4904.1 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(2)
81. Does the MCO adequately cover the provision of post-stabilization care and inpatient admissions resulting from an ER visit? b) How does the MCO facilitate the transfer of patients from non-participating to participating hospitals after stabilization?	4902.1(d) 4902.1(h) 4903.3 4903.6 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(3), (4)

MANAGEMENT INFORMATION SYSTEMS	
QUESTION	**CITATIONS**
82. Does the MCO have the system capacity to produce and submit all required reports?	364-j(8)(d) 98-1.17(a)(2)
83. Does the plan produce mgmt. reports which summarize denials in order to monitor utilization review activities?	98-1.6(f) 98-1.8(a)
84. How does the plan track pended claims to ensure timely resolution?	98-1.6(c) 98-1.8(a) NYS INS Law 3224-a
85. Does the plan's information systems, or those used by delegated entities, integrate the utilization management and claims adjudication systems to promote accurate processing.	98-1.6(c) 98-1.8(a)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
Note-- This entire section applies to: • *Commercial MCOs with Medicaid product and over 10,000 enrollees* • *Medicaid only plans with over 10,000 enrollees* • *Commercial only MCOs with over 60,000 enrollees (certain exceptions noted).* ***As indicated, only select questions apply to Medicaid Only plans with less than 10,000 enrollees***	
86. Does the MCO have a separate and distinct full time Special Investigation Unit (SIU) distinct from any other MCO unit or function?	98-1.21(b)(1)
87. Does the MCO have a designated officer or director position? who has responsibility for carrying out the provisions of the FAPP who reports directly to senior management? (b) **For Medicaid Only plans with less than 10,000 enrollees:** Does the MCO have a designated compliance officer and compliance committee that are accountable to senior management?	98-1.21(a) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
88. Does the MCO dedicate resources to support the functions of the SIU and the implementation of the FAPP?	98-1.21(b)(2)
89. **For all applicable MCOs, including Medicaid Only with less than 10,000 enrollees:** Do relationships exist between: • the Fraud & Abuse Director and the SIU; • the Fraud & Abuse Director and the SIU and law enforcement agencies; and • Staff in other units of the MCO, such as claims, UR, quality, etc, and the SIU?	98-1.21(b)(4) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
90. Is there a process for case referrals to the SIU, DOH and other law enforcement agencies?	98-1.21(b)(6)
91. How does the MCO prevent, detect, and conduct case investigations of fraud or abuse?	98-1.21(b)(5)
92. **For applicable MCOs, including Medicaid only MCOs with less than 10,000 enrollees:** How has the MCO Improved performance or modified processes as a result of fraud and abuse investigations?	98-1.21(b)(11) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
93. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees**: (a) Does the plan have written policies, procedures and standards of conduct that are distributed to all affected employees and appropriate delegated entities? (b) Do they reflect the MCO's commitment to comply with all applicable federal and state standards and identify and address specified areas of risk and vulnerability? (c) Does the plan conduct internal audits to ensure compliance with standards of conduct?	98-1.21(a) 98-1,21(b)(7), (11)&(12) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608) Section 1902(a) of the Social Security Act
94. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees:** Does the MCO have provisions for in-service training programs for investigative, claims, quality, UM and other personnel with periodic	98-1.21(b)(9) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
refreshers?	
95. Does the MCO have a Fraud and Abuse Awareness program?	98-1.21(b)(13)
96. Does the MCO have a fraud and abuse detection manual that is available to its employees?	98-1.21(b)(14) Section 1902(a) of the Social Security Act
97. If the MCO accepts paper claim forms, other than standardized federal claim forms such as the HCFA1500, do such forms include appropriate c warning statement against fraudulent acts?	98-1.22(a), (b)
98. Has the plan submitted to the State information about certain business transactions within wholly owned suppliers or any subcontractors?	MMC/FHP Section 18.6 (c) , 18.10(c) (42 CFR 455.105)
99. (a) Is the plan prepared to disclose to the State the identity of any person who has ownership or control interest in the MCO or is an agent or managing employee of the plan and has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or Title XX? (b) Has the plan required its providers to disclose health care related criminal conviction information from all parties affiliated with the provider? (c) Has the plan refused to enter into or renew an agreement with the provider or with parties affiliated with the provider because of criminal convictions related to the Medicare, Medicaid or Title XX programs?	(a) MMC/FHP Section 18.12(a) & (b) (42 CFR 455.106) (b)MMC/FHP Section 18.12(a), (b) & (c) (42 CFR 455.106) (c) Section 18.12(c). (42 CFR 455. 106(c)
100. Does the plan report to the State and HHS-OIG any adverse actions taken against providers for program integrity reasons, such as providers denied MCO participation?	MMC/FHP Section 18.8(c) (42 CFR 1002.3(b) and CMS 2010 Best Practice Bulletin)
101. Has the plan implemented a service verification process?	MMC/FHP Section 23.3 (42 CFR 455.20)
102. (a)Does the plan capture information on any employee that is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations. The information shall be checked against the exclusionary lists (including List of Excluded Individuals and Entities (LEIE), Medicare Exclusion Database (MED), Excluded Parties List System (EPLS), Social Security Administration Death Master File and the National Plan Provider Enumeration System (NPPES) (b) Does the plan check new providers, re-enrolled providers against the excluded provider lists, which includes updates from the LEIE, MED, EPLS, Social Security Administration Death Master File and the NPPES? (c) Does the MCO also conduct monthly verifications on all participating	MMC/FHP Section 18.9(a) &(b) (42 CFR 455.101 and 455.436)

FRAUD AND ABUSE	
QUESTION	**CITATIONS**
providers? (d) Does the plan require all network providers to monitor staff and managing employees against the exclusionary lists and report any exclusions to the MCO on a monthly basis?	
103. (a) Does the plan collect all required ownership and control disclosure information from persons with an ownership or control interest of 5 % or more in the MCO or any subcontractor, or who are managing employees of the plan? (b) Do the reporting individuals in (a) above disclose if they are related to another disclosing entity (MCO, provider, subcontractor) or owner as a spouse, parent, child or sibling? (c) Does the plan collect updated disclosure from disclosing entities, regarding persons with an ownership and control interest, or who are managing employees of the disclosing entity, at intervals within contract periods and or contract renewals and prepared to submit the information to the Sate or CMS within 35 days of a written request? . **NOTE:** All parts of question 104 apply to providers as well. A disclosing entity includes all providers with the exception of an individual provider or group of health care practitioners. Therefore See 42 CFR 455.101.	(a) MMC/FHP Section 18.10(a) 42 CFR 455.104 (b) and (c) MMC/FHP Section 18.6(b) 42 CFR 455.104

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ATTACHMENT 4. HOSPITALS AND PRIMARY CARE RESIDENCY PROGRAMS PARTICIPATING IN THE HOSPITAL-MEDICAL HOME DEMONSTRATION

Hospitals and Residencies Participating in the Hospital Medical Home Demonstration

ALBANY MEDICAL CENTER HOSPITAL	INTERNAL MEDICINE
ALBANY MEDICAL CENTER HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
ALBANY MEDICAL CENTER HOSPITAL	PEDIATRICS
BELLEVUE HOSPITAL CENTER	INTERNAL MEDICINE
BELLEVUE HOSPITAL CENTER	PEDIATRICS
BETH ISRAEL MEDICAL CENTER - PETRIE CAMPUS	INTERNAL MEDICINE
BETH ISRAEL MEDICAL CENTER - PETRIE CAMPUS	FAMILY MEDICINE
BRONX-LEBANON HOSPITAL CENTER	INTERNAL MEDICINE
BRONX-LEBANON HOSPITAL CENTER	FAMILY MEDICINE
BRONX-LEBANON HOSPITAL CENTER	PEDIATRICS
BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
BROOKHAVEN MEMORIAL HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	INTERNAL MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	FAMILY MEDICINE
BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	PEDIATRICS
CITY HOSPITAL CENTER AT ELMHURST	INTERNAL MEDICINE
CITY HOSPITAL CENTER AT ELMHURST	PEDIATRICS
CONEY ISLAND HOSPITAL	INTERNAL MEDICINE
CONEY ISLAND HOSPITAL	PEDIATRICS
ELLIS HOSPITAL	FAMILY MEDICINE
ERIE COUNTY MEDICAL CENTER	INTERNAL MEDICINE
ERIE COUNTY MEDICAL CENTER	FAMILY MEDICINE
FLUSHING HOSPITAL MEDICAL CENTER	INTERNAL MEDICINE
FLUSHING HOSPITAL MEDICAL CENTER	PEDIATRICS
GLEN COVE HOSPITAL	FAMILY MEDICINE
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
GOOD SAMARITAN HOSPITAL MEDICAL CENTER	PEDIATRICS
HARLEM HOSPITAL CENTER	INTERNAL MEDICINE
HARLEM HOSPITAL CENTER	PEDIATRICS
HIGHLAND HOSPITAL	FAMILY MEDICINE
INTERFAITH MEDICAL CENTER	INTERNAL MEDICINE
JACOBI MEDICAL CENTER	INTERNAL MEDICINE
JACOBI MEDICAL CENTER	PEDIATRICS
JAMAICA HOSPITAL MEDICAL CENTER	FAMILY MEDICINE
JAMAICA HOSPITAL MEDICAL CENTER	INTERNAL MEDICINE

KALEIDA HEALTH - BUFFALO GENERAL MEDICAL CENTER	FAMILY MEDICINE
KALEIDA HEALTH - BUFFALO GENERAL MEDICAL CENTER	INTERNAL MEDICINE
KALEIDA HEALTH - MILLARD FILLMORE SUBURBAN HOSPITAL	FAMILY MEDICINE
KALEIDA HEALTH - WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO	PEDIATRICS
KALEIDA HEALTH - WOMEN AND CHILDREN'S HOSPITAL OF BUFFALO	INTERNAL MEDICINE-PEDIATRICS
KINGS COUNTY HOSPITAL CENTER	INTERNAL MEDICINE
KINGS COUNTY HOSPITAL CENTER	PEDIATRICS
KINGS COUNTY HOSPITAL CENTER	FAMILY MEDICINE
KINGSBROOK JEWISH MEDICAL CENTER	INTERNAL MEDICINE
KINGSTON HOSPITAL	FAMILY MEDICINE
KINGSTON HOSPITAL/INSTITUTE FOR FAMILY HEALTH	FAMILY MEDICINE
LINCOLN MEDICAL & MENTAL HEALTH CENTER	INTERNAL MEDICINE
LINCOLN MEDICAL & MENTAL HEALTH CENTER	PEDIATRICS
LUTHERAN MEDICAL CENTER	FAMILY MEDICINE
LUTHERAN MEDICAL CENTER	INTERNAL MEDICINE
MAIMONIDES MEDICAL CENTER	INTERNAL MEDICINE
MERCY HOSPITAL OF BUFFALO	INTERNAL MEDICINE
METROPOLITAN HOSPITAL CENTER	INTERNAL MEDICINE
METROPOLITAN HOSPITAL CENTER	PEDIATRICS
MONTEFIORE MEDICAL CENTER	FAMILY MEDICINE
MONTEFIORE MEDICAL CENTER	INTERNAL MEDICINE
MONTEFIORE MEDICAL CENTER	PEDIATRICS
MOUNT VERNON HOSPITAL	INTERNAL MEDICINE
NASSAU UNIVERSITY MEDICAL CENTER	PEDIATRICS
NASSAU UNIVERSITY MEDICAL CENTER	INTERNAL MEDICINE
NASSAU UNIVERSITY MEDICAL CENTER	PEDIATRICS
NEW YORK METHODIST HOSPITAL	INTERNAL MEDICINE
NEW YORK METHODIST HOSPITAL	PEDIATRICS
NIAGARA FALLS MEMORIAL MEDICAL CENTER	FAMILY MEDICINE
NORTH CENTRAL BRONX HOSPITAL	INTERNAL MEDICINE
NORTH SHORE UNIVERSITY HOSPITAL	INTERNAL MEDICINE
PECONIC BAY MEDICAL CENTER	FAMILY MEDICINE
PHELPS MEMORIAL HOSPITAL ASSOCIATION	FAMILY MEDICINE
QUEENS HOSPITAL CENTER	INTERNAL MEDICINE
RICHMOND UNIVERSITY MEDICAL CENTER	INTERNAL MEDICINE
RICHMOND UNIVERSITY MEDICAL CENTER	PEDIATRICS
ROCHESTER GENERAL HOSPITAL	INTERNAL MEDICINE
ROCHESTER GENERAL HOSPITAL	PEDIATRICS
SAMARITAN MEDICAL CENTER	INTERNAL MEDICINE
SAMARITAN MEDICAL CENTER	FAMILY MEDICINE
SISTERS OF CHARITY HOSPITAL	INTERNAL MEDICINE
SISTERS OF CHARITY HOSPITAL	FAMILY MEDICINE

SOUND SHORE MEDICAL CENTER OF WESTCHESTER	INTERNAL MEDICINE
SOUND SHORE MEDICAL CENTER OF WESTCHESTER	PEDIATRICS
SOUTH NASSAU COMMUNITIES HOSPITAL	FAMILY MEDICINE
ST BARNABAS HOSPITAL	INTERNAL MEDICINE
ST BARNABAS HOSPITAL	FAMILY MEDICINE
ST BARNABAS HOSPITAL	PEDIATRICS
ST JOSEPH'S HOSPITAL HEALTH CENTER	FAMILY MEDICINE
ST. JOSEPH'S MEDICAL CENTER	FAMILY MEDICINE
ST. LUKE'S - ROOSEVELT HOSPITAL CENTER	INTERNAL MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	INTERNAL MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	FAMILY MEDICINE
STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER	PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	FAMILY MEDICINE
STONY BROOK UNIVERSITY HOSPITAL	PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
STONY BROOK UNIVERSITY HOSPITAL	INTERNAL MEDICINE
STRONG MEMORIAL HOSPITAL	INTERNAL MEDICINE
STRONG MEMORIAL HOSPITAL	PEDIATRICS
STRONG MEMORIAL HOSPITAL	INTERNAL MEDICINE-PEDIATRICS
THE MOUNT SINAI MEDICAL CENTER	INTERNAL MEDICINE
THE MOUNT SINAI MEDICAL CENTER	PEDIATRICS
THE MOUNT SINAI MEDICAL CENTER	FAMILY MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	INTERNAL MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	FAMILY MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	PEDIATRICS
THE NEW YORK AND PRESBYTERIAN HOSPITAL	INTERNAL MEDICINE
THE NEW YORK AND PRESBYTERIAN HOSPITAL	PEDIATRICS
THE NEW YORK HOSPITAL MEDICAL CENTER OF QUEENS	INTERNAL MEDICINE
THE NEW YORK HOSPITAL MEDICAL CENTER OF QUEENS	PEDIATRICS
UNITY HOSPITAL	INTERNAL MEDICINE
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	PEDIATRICS
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	PEDIATRICS
WESTCHESTER MEDICAL CENTER	INTERNAL MEDICINE
WESTCHESTER MEDICAL CENTER	PEDIATRICS
WINTHROP-UNIVERSITY HOSPITAL	PEDIATRICS
WOODHULL MEDICAL & MENTAL HEALTH CENTER	INTERNAL MEDICINE
WOODHULL MEDICAL & MENTAL HEALTH CENTER	PEDIATRICS
WYCKOFF HEIGHTS MEDICAL CENTER	INTERNAL MEDICINE
WYCKOFF HEIGHTS MEDICAL CENTER	PEDIATRICS

ATTACHMENT 5. NEW YORK STATE PARTNERSHIP PLAN PROJECTED 1115 WAIVER BUDGET NEUTRALITY IMPACT THROUGH DECEMBER 2013

Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Medicaid Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver must not be more than the cost that would have occurred without the waiver.

The neutrality formula consists of two components: "Without Waiver" expenditures and "With Waiver" expenditures. Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) multiplied by the trended Per Member Per Month allowance approved by CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

The six agreed upon MEGs for the purposes of establishing Without Waiver expenditures are as follows:

- TANF children under the age of 1 to 20,
- TANF adults ages 21 to 64,
- FHPlus adults with children,
- Family Planning Benefit Program participants,
- MLTC adult age 18 to 64 duals, and
- MLTC adult age 65+ duals.

With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future medical costs.

Expenditures for the six agreed upon MEGs are included in the With Waiver calculations as well as expenditures for Safety Net adults, FHPlus without children, Home and Community Based Services (HCBS) Expansion, Indigent Care Pool Direct Expenditures, and Designated State Health Programs.

Therefore, the savings achieved for the Without Waiver MEGs are used to expand access and quality as well as service volume for With Waiver populations, programs and initiatives. After all the With Waiver expenditures are subtracted from the Without Waiver estimated costs do we achieve the net savings for the waiver as a whole (see below).

Between October 2009 and September 2013, the Department projects that the waiver will have saved $17,141,306,492. After subtracting the With Waiver expenditures from the Without Waiver calculation of expenditures, the Partnership Plan yields $17.1 billion in projected savings, and pays for five more programs than are included in the Without Waiver populations. (The Department's budget neutrality impact analysis is at the end of this attachment.)

Review of the budget neutrality analysis for the Partnership Plan indicates that the Department has been successful in producing savings for both the State and federal Medicaid programs. Implementation of the MMC mandate and addition of FHPlus have successfully demonstrated that moving low income populations out of FFS care and into managed care models is cost effective with expenditures well below the level that would have been expected had the Partnership Plan Demonstration not occurred.

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	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	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/06 - 12/31/13) Projected	DY 1 - 16
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$10,048,004,954	$11,197,206,500	$6,105,699,488	$6,124,915,586	$13,431,510,646	$14,853,292,172	$7,950,225,796	$87,438,675,151	
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,511,421,595	$2,467,348,368	$2,443,182,702	$5,362,328,563	$5,914,512,406	$3,159,849,805	$33,978,117,234	
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,746,457,301	$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$14,927,293,206	
Demonstration Group 8 - Family Planning Expansion							$0	$10,702,271	$1,856,551	$0	$12,558,822	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$247,394,784	$1,027,336,330	$260,284,563	$1,535,015,677	
Demonstration Group 11 - MLTC Adult Age 65+ Duals								$2,554,212,091	$10,820,566,375	$2,796,750,566	$16,171,529,032	
W/O Waiver Total	**$144,639,878,523**	**$13,378,994,890**	**$14,117,434,787**	**$15,651,219,786**	**$17,587,144,736**	**$9,616,095,275**	**$9,623,513,619**	**$23,947,215,809**	**$35,249,801,447**	**$14,891,768,772**	**$154,063,189,121**	**$298,703,067,644**

Budget Neutrality Cap (With Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	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	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/09 - 12/31/13) Projected	DY 1 - 16
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$4,828,196,168	$4,144,199,750	$1,827,792,863	$2,801,314,813	$6,274,626,419	$6,920,847,016	$3,682,227,594	$38,898,045,563	
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,619,299,634	$1,159,889,284	$1,546,569,069	$3,469,842,728	$3,821,091,510	$2,038,979,725	$21,494,890,982	
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,024,374,518	$1,864,361,807	$2,829,518,468	$6,893,620,899	$8,184,495,364	$2,210,213,971	$36,055,996,465	
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$963,020,020	$502,539,894	$553,389,253	$1,173,058,139	$1,313,450,137	$360,124,780	$7,458,988,303	
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$313,222,949	$155,882,395	$173,575,211	$352,894,110	$401,041,648	$110,970,648	$3,073,837,039	
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$9,839,735	$4,164,485	$5,460,394	$11,576,340	$2,045,425	$0	$65,294,983	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$249,276,515	$999,765,437	$249,927,129	$1,498,969,081	
Demonstration Group 11 - MLTC Adult Age 65+ Duals								$2,561,508,288	$10,403,512,554	$2,629,869,736	$15,594,890,578	
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	$14,650,000	$13,700,000	$3,400,000	$34,350,000	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)							$0	$133,400,000	$133,300,000	$33,300,000	$300,000,000	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)							$0	$5,000,000	$6,700,000	$1,600,000	$13,300,000	
Demonstration Population 5: Designated State Health Programs (Various)											$0	
With Waiver Total	**$123,931,127,812**	**$10,499,291,132**	**$11,309,400,341**	**$12,518,840,868**	**$12,073,956,605**	**$5,514,630,728**	**$7,918,726,316**	**$21,157,802,546**	**$32,217,348,199**	**$11,324,938,360**	**$124,534,935,096**	**$248,466,062,908**
Expenditures (Over)/Under Cap	**$20,708,750,711**	**$2,879,703,758**	**$2,808,034,446**	**$3,132,378,918**	**$5,513,188,131**	**$4,101,464,547**	**$1,704,787,303**	**$2,789,413,262**	**$3,032,453,248**	**$3,566,830,412**	**$29,528,254,026**	**$50,237,004,737**

ATTACHMENT 6. TECHNICAL NOTES AND REFERENCE MATERIALS

In preparing this interim report, IPRO reviewed a wide range of documents including Partnership Plan and CMS 273 Quarterly and Annual Reports, Special Terms and Conditions, Contract Surveillance Tools and reports, and consulted with the Department's senior managers and staff as follows:

- Partnership Plan Medicaid Section 1115 Annual Reports for Federal Fiscal Year (FFY) 2008-2009, FFY 2009-2010, FFY 2010-2011, FFY 2011-2012, and FFY 2012-2013.
- Partnership Plan Medicaid Section 1115 Quarterly Reports for FFY 2012-2013.
- Application for Extension, New York State Medicaid Section 1115 Demonstration, December 31, 2013.
- Special Terms and Conditions for the Partnership Plan Medicaid Section 1115 Demonstration effective April 2013.
- Medicaid Managed Care and Family Health Plus MCO Contract Surveillance Tool, Revised October 2007; New York State, Office of Health Insurance Programs (OHIP), Division of Managed Care and Program Evaluation.
- Quality Strategy for the New York State Medicaid Managed Care Program 2012, November 30, 2012.
- Primary Care/Specialty Care Participation Rate Report, New York State Department of Health , Division of Health Plan Contracting and Oversight, Calendar Years 2009, 2010, and 2011.
- Managed Care Plan Performance: A Report on the Quality, Access to Care, and Consumer Satisfaction (QARR); New York State Department of Health, 2008, 2009, 2010, 2011 and 2012.
- Demographic Variation in Medicaid Managed Care, New York State Department of Health, 2011 and 2012.
- Managed Care Access and Utilization Report, New York State Department of Health, 2009, 2010, 2011, and 2012.
- CAHPS® 4.0 Adult Medicaid Survey, Medicaid Managed Care Program, New York State Department of Health, April 2010
- New York State Medicaid Redesign Team Waiver Amendment, New York State Department of Health, December 2013.
- Partnership Plan Evaluation, Program Evaluation of Medicaid Section 1115 Waiver Program – Final Report, Delmarva Foundation, January 2010.
- Managed Long Term Care Plan Member Satisfaction Survey Report, IPRO, September 2011.
- The State of Health Quality, 2012; National Committee for Quality Assurance, 2012.
- The State of Health Quality, 2013; National Committee for Quality Assurance, 2013.

IPRO reviewed the following websites:

http://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf

http://www.health.ny.gov/health_care/managed_care/appextension/

http://www.health.ny.gov/health_care/medicaid/redesign/

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm

http://www.health.ny.gov/health_care/managed_care/consumer_guides/

http://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm

http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2012/

http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/

http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm

http://www.health.ny.gov/health_care/managed_care/reports/docs/2011_pip_abstract_compendium.pdf

http://www.ncqa.org/tabid/836/Default.aspx

https://hospitalmedicalhome.ipro.org/

http://www.opwdd.ny.gov/transformation-agreement/04012013_partnership_plan_stcs_attachment

IPRO consulted with mangers and staff in the following Offices of the Department:

- Office of Health Insurance Programs
  - Executive Office
  - Division of Program Development & Management
  - Division of Health Plan Contracting & Oversight
  - Division of Long Term Care
- Office of Audit, Fiscal and Program Planning
- Office of Quality and Patient Safety

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
Extension Application Through 12/31/2019

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	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	Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 16	DY 17 (1/1/15 - 12/31/15) Projected	DY 18 (1/1/16 - 12/31/16) Projected	DY 19 (1/1/17 - 12/31/17) Projected	DY 20 (1/1/18 - 12/31/18) Projected	DY 21 (1/1/19 - 12/31/19) Projected	Current Extension Period (1/1/15 - 12/31/19) Projected	DY 1 - DY 21
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$10,048,004,954	$11,210,460,422	$6,105,699,488	$6,124,915,586	$13,431,555,927	$14,853,389,777	$3,975,139,194	$3,975,139,194	$12,414,265,562	**$99,866,390,111**		$17,645,613,012	$18,810,799,030	$20,053,186,973	$21,377,810,257	$22,789,715,193	**$100,677,124,465**	
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,517,252,946	$2,467,348,368	$2,443,182,702	$5,362,266,874	$5,914,379,682	$1,579,889,213	$1,579,889,213	$4,990,746,528	**$38,974,429,320**		$7,082,358,885	$7,535,714,793	$8,018,707,843	$8,532,678,478	$9,079,745,922	**$40,249,205,919**	
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,746,457,301	$1,874,936,618	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042			**$14,923,713,183**							**$0**	
Demonstration Group 8 - Family Planning Expansion							$5,140,241	$10,702,271	$1,856,551				**$17,699,062**							**$0**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$247,394,784	$1,027,336,330	$260,284,563	$260,284,563	$874,995,982	**$2,670,296,222**		$1,310,232,680	$1,364,802,292	$1,383,228,677	$1,400,567,568	$1,417,233,942	**$6,876,065,159**	
Demonstration Group 11 - MLTC age 65+ Duals								$2,554,212,091	$10,820,566,375	$2,796,750,566	$2,796,750,566	$9,564,835,392	**$28,533,114,990**		$14,710,915,500	$15,702,703,366	$16,234,869,317	$16,769,495,565	$17,311,153,074	**$80,729,136,821**	
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$6,740,030,752	**$6,740,030,752**		$5,217,606,005	$5,221,378,989	$5,231,860,540	$5,552,853,881	$5,892,047,876	**$27,115,747,291**	
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$2,917,455,149	**$2,917,455,149**		$8,690,188,441	$9,629,135,131	$10,591,938,428	$11,241,791,703	$11,928,492,328	**$52,081,546,031**	
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$297,127,032	**$297,127,032**		$115,287,674	$96,117,801	$77,899,577	$82,079,354	$86,505,001	**$457,889,407**	
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$196,481,343	**$196,481,343**		$581,017,822	$639,235,895	$698,311,674	$735,780,264	$775,452,890	**$3,429,798,545**	
Demonstration Group 7 – Non Duals 18-64												$260,463,274	**$260,463,274**		$373,622,309	$399,781,370	$425,974,437	$451,106,815	$477,722,059	**$2,128,206,991**	
Demonstration Group 8 – Non Duals 65+												$67,786,019	**$67,786,019**		$95,105,016	$99,552,526	$103,795,256	$107,531,930	$111,403,116	**$517,387,843**	
W/O Waiver Total	**$144,639,878,523**	**$13,378,994,889**	**$14,117,434,787**	**$15,651,219,785**	**$17,602,649,986**	**$9,616,095,275**	**$9,628,653,860**	**$23,947,199,400**	**$35,249,766,328**	**$9,336,721,578**	**$8,612,063,536**	**$38,324,187,033**	**$195,464,986,458**	**$340,104,864,981**	**$55,821,947,343**	**$59,499,221,192**	**$62,819,772,721**	**$66,251,695,815**	**$69,869,471,399**	**$314,262,108,471**	**$654,366,973,452**

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
Extension Application Through 12/31/2019

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	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	Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 16	DY 17 (1/1/15 - 12/31/15) Projected	DY 18 (1/1/16 - 12/31/16) Projected	DY 19 (1/1/17 - 12/31/17) Projected	DY 20 (1/1/18 - 12/31/18) Projected	DY 21 (1/1/19 - 12/31/19) Projected	Current Extension Period (1/1/15 - 12/31/19) Projected	DY 1 - DY 21
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$4,828,196,168	$4,492,088,177	$1,827,792,863	$2,801,314,813	$6,274,647,760	$6,920,891,478	$1,841,829,404	$1,840,421,312	$5,730,328,833	**$44,976,351,747**		$7,739,333,331	$8,241,746,621	$8,785,674,939	$9,314,977,910	$9,314,977,910	**$43,396,710,710**	
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,712,728,726	$1,159,889,284	$1,546,569,069	$3,469,798,151	$3,820,998,638	$1,019,514,707	$1,019,416,724	$3,245,361,788	**$24,833,496,118**		$4,324,485,509	$4,612,796,415	$4,939,764,053	$5,192,548,565	$5,192,548,565	**$24,262,143,108**	
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,224,557,751	$1,864,361,807	$2,829,518,468	$6,893,620,899	$8,184,495,364	$2,210,213,971			**$36,256,179,698**							**$0**	
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$965,325,522	$502,539,894	$553,389,253	$1,173,058,139	$1,313,450,137	$360,124,780			**$7,461,293,807**							**$0**	
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$316,237,864	$155,882,395	$173,575,211	$352,894,110	$401,041,648	$110,970,648			**$3,076,851,953**							**$0**	
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$11,835,960	$4,164,485	$6,573,308	$13,934,296	$2,462,132				**$71,178,785**							**$0**	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$924,777	$2,774,331	**$15,721,209**		$3,699,108	$3,699,108	$3,699,108	$3,699,108	$3,699,108	**$18,495,540**	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals								$249,276,515	$999,765,437	$249,927,129	$249,927,129	$846,152,416	**$2,595,048,626**		$1,324,113,805	$1,388,540,836	$1,422,903,191	$1,480,841,723	$1,480,841,723	**$7,097,241,277**	
Demonstration Group 11 - MLTC age 65+ Duals								$2,561,508,288	$10,403,512,554	$2,629,869,736	$2,629,869,736	$9,056,595,115	**$27,281,355,428**		$14,255,287,545	$15,118,044,459	$15,619,482,984	$16,358,745,504	$16,358,745,504	**$77,710,305,996**	
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$5,800,497,292	**$5,800,497,292**		$3,951,999,754	$3,956,791,450	$3,816,034,808	$3,816,034,808	$3,816,034,808	**$19,356,895,626**	
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$2,054,061,282	**$2,054,061,282**		$6,053,693,623	$6,636,646,162	$7,224,046,405	$7,224,046,405	$7,224,046,405	**$34,362,479,001**	
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$333,662,997	**$333,662,997**		$190,609,691	$194,209,851	$188,661,308	$188,661,308	$188,661,308	**$950,803,465**	
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.												$150,888,689	**$150,888,689**		$444,696,514	$487,519,454	$530,669,118	$530,669,118	$530,669,118	**$2,524,223,321**	
Demonstration Group 7 – Non Duals 18-64												$221,887,579	**$221,887,579**		$321,593,199	$347,683,789	$374,311,551	$374,311,551	$374,311,551	**$1,792,211,640**	
Demonstration Group 8 – Non Duals 65+												$59,275,663	**$59,275,663**		$85,894,211	$92,861,786	$99,996,824	$99,996,824	$99,996,824	**$478,746,469**	
Designated State Health Programs (Existing F-SHRP)													**$0**		$637,100,000	$637,100,000	$637,100,000	$637,100,000	$637,100,000	**$3,185,500,000**	
Designated State Health Programs (New F-SHRP)													**$0**		$431,800,000	$431,800,000	$431,800,000	$431,800,000	$431,800,000	**$2,159,000,000**	
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**							**$0**	
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	$45,791,667	**$74,850,000**							**$0**	
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**							**$0**	
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**							**$0**	

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
Extension Application Through 12/31/2019

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	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	Extension Period (10/1/06 - 12/31/14) Projected	DY 1 - DY 16	DY 17 (1/1/15 - 12/31/15) Projected	DY 18 (1/1/16 - 12/31/16) Projected	DY 19 (1/1/17 - 12/31/17) Projected	DY 20 (1/1/18 - 12/31/18) Projected	DY 21 (1/1/19 - 12/31/19) Projected	Current Extension Period (1/1/15 - 12/31/19) Projected	DY 1 - DY 21
Demonstration Population 5: Designated State Health Programs (Various)										$100,000,000	$100,000,000	$300,000,000	**$500,000,000**		$421,400,000	$421,400,000	$421,400,000	$421,400,000	$421,400,000	**$2,107,000,000**	
DSHP DD													**$0**		$750,000,000	$750,000,000	$750,000,000	$750,000,000	$750,000,000	**$3,750,000,000**	
DSHP: Orderly Close out of Demo Group 6											$363,417,732	$635,987,007	**$999,404,739**							**$0**	
DSHP: APTC Wrap											$7,000,800	$84,009,600	**$91,010,400**		$183,170,000	$184,800,000	$184,800,000	$184,800,000	$184,800,000	**$922,370,000**	
DSHP For DSRIP												$376,000,000	**$376,000,000**		$690,800,000	$953,050,000	$935,650,000	$687,100,000	$357,400,000	**$3,624,000,000**	
DSRIP												$240,000,000	**$240,000,000**		$2,015,500,000	$2,141,500,000	$3,401,200,000	$3,023,300,000	$2,015,500,000	**$12,597,000,000**	
IAAF												$1,000,000,000	**$1,000,000,000**		$0	$0	$0	$0	$0	**$0**	
1915i													**$0**		$200,000,000	$491,800,000	$400,000,000	$200,000,000	$0	**$1,291,800,000**	
With Waiver Total	**$123,931,127,812**	**$10,499,291,132**	**$11,309,400,341**	**$12,518,840,867**	**$12,722,773,999**	**$5,514,630,728**	**$7,919,839,230**	**$21,122,103,933**	**$32,179,033,163**	**$8,555,529,317**	**$6,239,732,376**	**$30,235,490,924**	**$158,816,666,011**	**$282,747,793,823**	**$44,025,176,289**	**$47,091,989,931**	**$50,167,194,289**	**$50,920,032,822**	**$49,382,532,822**	**$241,586,926,154**	**$241,586,926,154**
Expenditures (Over)/Under Cap	**$20,708,750,711**	**$2,879,703,758**	**$2,808,034,445**	**$3,132,378,919**	**$4,879,875,987**	**$4,101,464,547**	**$1,708,814,629**	**$2,825,095,467**	**$3,070,733,165**	**$781,192,261**	**$2,372,331,160**	**$8,088,696,109**	**$36,648,320,447**	**$57,357,071,157**	**$11,796,771,054**	**$12,407,231,261**	**$12,652,578,432**	**$15,331,662,993**	**$20,486,938,577**	**$72,675,182,317**	**$412,780,047,298**

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2014
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Transformation Agreement

April 1, 2014

Quarterly Update and Annual Progress Report

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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.

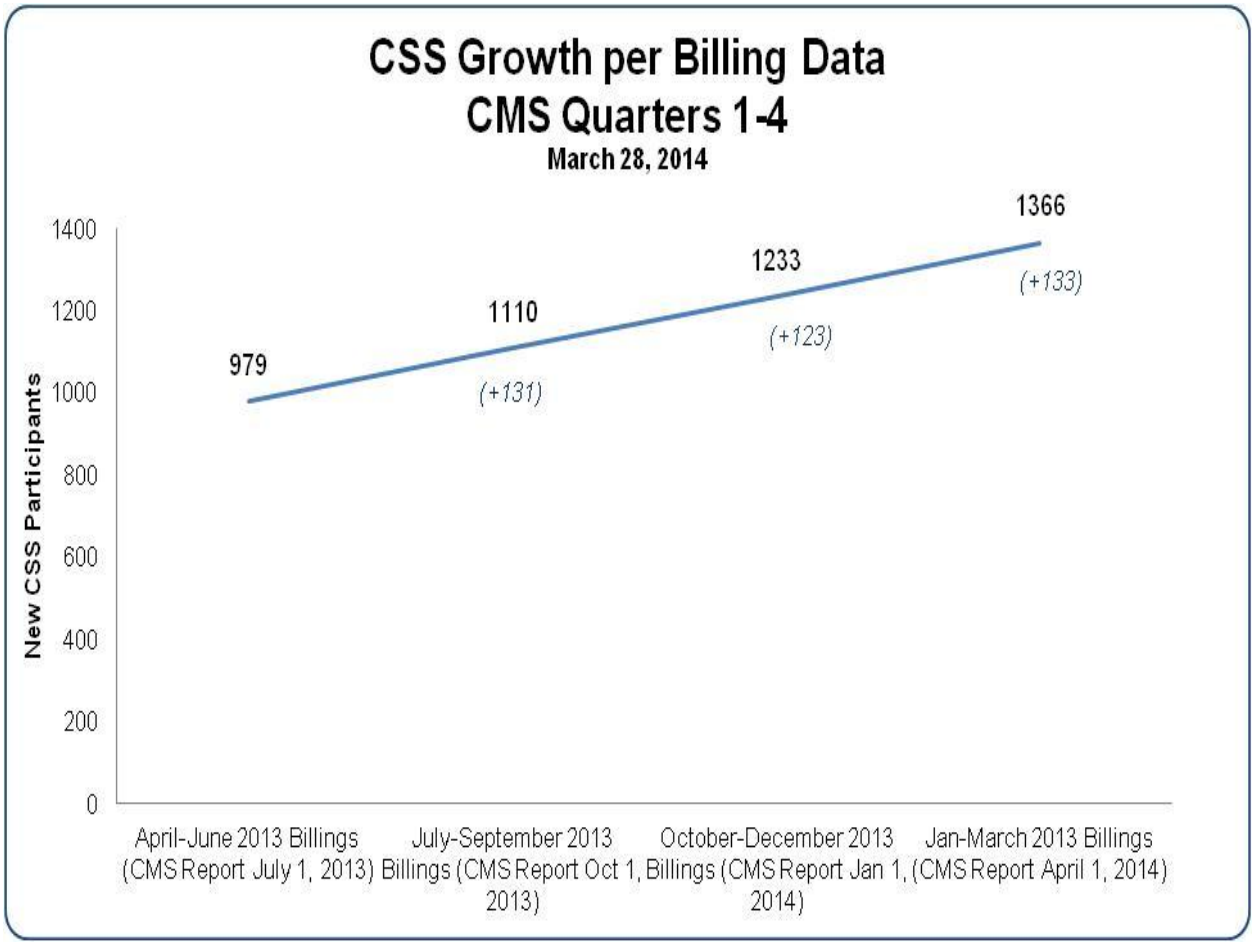
Self Direction Education Training April 1, 2013 – March 31, 2014		
	Number of Individuals	**Number of Sessions**
April 1 – June 30, 2013	1,844	85
July 1 – September 31, 2013	3,746	98
October 1 – December 31, 2013	4,440	267
January 1 – March 31, 2014	2,744	94
Total	12,774	544

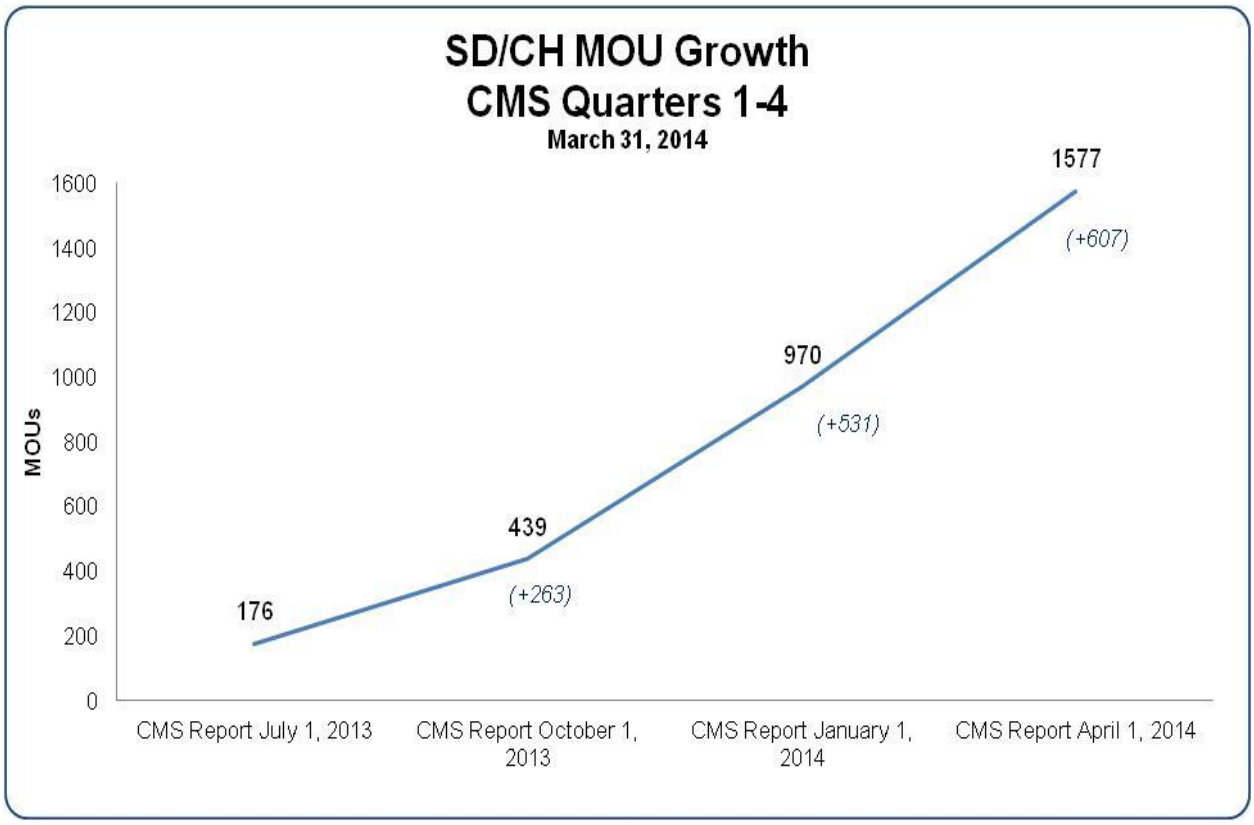
Beneficiaries with Developmental Disabilities who currently Self-Direct their Services

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*