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Citation	Condition or Requirement
<p>1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)</p>	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act</u></p> <p>The State of New York enrolls Medicaid beneficiaries into managed care entities (managed care organizations(MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans-see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii.-vii. below)</p> <p>B. <u>General Description of the Program and Public Process</u></p> <p>In April 2007, the New York legislature authorized the Department of Health (DOH) to establish Chronic Illness Demonstration Projects (CIDPs) to test models of care management and coordination to address the complex health and social needs of Medicaid fee-for-service recipients with complex behavioral and medical health conditions. Enrollment into the program will be voluntary in select geographical areas across the state.</p> <p>NY DOH will award a contract to a CIDP entity that will function as the overall Primary Care Case Management entity. Each CIDP entity will be responsible for ensuring the provision of primary care services in accordance with 1905(t)(1). CIDP entities will be responsible for the following functions: locate eligible beneficiaries; complete an initial health assessment and periodic reassessments; develop and update a care/service plan; coordinate care/discharge/referral among multiple providers; maintain state-specified frequency of contact (telephonic and in-home/provider office) with beneficiaries; and report specified process and outcome measures.</p> <p>For B.1 and B.2, place a check mark on any or all that apply.</p> <p>1. The State will contract with an <input type="checkbox"/> i. MCO</p>

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42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p><input checked="" type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)</p> <p><input type="checkbox"/> iii. Both</p> <p>2. The payment method to the contracting entity will be:</p> <p><input checked="" type="checkbox"/> i. fee for service;</p> <p><input type="checkbox"/> ii. capitation;</p> <p><input checked="" type="checkbox"/> iii. a case management fee;</p> <p><input checked="" type="checkbox"/> iv. a bonus/incentive payment;</p> <p><input type="checkbox"/> v. a supplemental payment, or</p> <p><input checked="" type="checkbox"/> vi. other. (Please provide a description below).</p> <p>Contractors will be at-risk for a portion of the monthly care coordination fee (MCCF) if quality, reporting and performance standards are not achieved. Any necessary recoupment of the MCCF will be withheld from future payments due to the contractor, and the federal portion of the recoupment will be returned to CMS.</p> <p>In addition, the DOH will make available funds for shared cost savings incentive payments. Only contractors that have met all quality, reporting and performance standards will be eligible to participate in the shared savings. Shared savings incentive payments will not exceed 105% of the aggregate payment for Medicaid services received.</p> <p>Reconciliation of at-risk and shared savings will be done annually, after the first contract year.</p>
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	<p>3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.</p> <p>If applicable to this state plan, place check mark to affirm the state has met <i>all</i> of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <p><input checked="" type="checkbox"/> i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.</p> <p><input checked="" type="checkbox"/> ii. Incentives will be based upon specific activities and targets.</p>

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CFR 438.50(b)(4)	<p> <input checked="" type="checkbox"/> iii. Incentives will be based upon a fixed period of time. <input checked="" type="checkbox"/> iv. Incentives will not be renewed automatically. <input checked="" type="checkbox"/> v. Incentives will be made available to both public and private PCCMs. <input checked="" type="checkbox"/> vi. Incentives will not be conditioned on intergovernmental transfer agreements. <input type="checkbox"/> vii. Not applicable to this 1932 state plan amendment. </p> <p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p>The demonstrations are to be established by a competitive procurement or discretionary grant. Prior to the development of the RFP document the DOH Office of Health Insurance Programs (OHIP) consulted with many stakeholders, including: New York State (NYS) DOH public health experts in chronic disease, sister agencies such as the Office of Mental Health (OMH) and the Office of Alcohol and Substance Abuse Services (OASAS); experts in public health policy; experts in Medicaid quality improvement, public health research scientists; and medical and behavioral health providers. The purpose of this collaboration was to solicit input and expertise to assist in the design of a solicitation document that would support the development of CIDP programs that would address the complex needs of this population and fulfill the intent of the legislation. Based upon the input received, the RFP document was developed and made available for comment to many of the aforementioned entities.</p> <p>In accordance with procurement regulations, an advertisement was placed in the "New York State Contract Reporter" informing the public that the CIDP RFP was to be released. The RFP and supportive documentation were also made available on the DOH website. Interested parties and potential bidders were sent letters via both the US Postal system and electronic mail informing them of the release of the RFP and inviting them to the Pre-Bid Conference. The Pre-Bid Conference, held after the RFP release, offered interested parties and potential bidders an opportunity to seek clarification and ask questions regarding the solicitation. All questions and answers discussed at the Pre-Bid Conference or submitted post-Conference were made public on the DOH website and sent to all interested parties, potential bidders and those entities that had submitted a letter of interest. A press release was issued from</p>

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1932(a)(1)(A)	<p>the Commissioner of Health, with supportive comments from both the Commissioners of OMH and OASAS, promoting the goals and availability of funding for the CIDPs. In accordance with the guidelines for bidder proposal submission evaluation and selection, applicants were competitively selected for contract award.</p> <p>During the implementation and operations of the CIDPs DOH will maintain a highly collaborative and coordinated working relationship with each of the CIDP programs. During the course of the demonstrations there will be opportunities for stakeholders to provide ongoing feedback. For example, DOH will conduct semiannual multistakeholder collaborative meetings to foster learning, information sharing, problem solving and to provide technical assistance to the CIDPs. Medical and behavioral providers, social service agencies, community based organization, local government, OMH and OASAS representatives staff and other interested parties will also be included in the collaborative sessions. Additionally DOH will solicit input on a quarterly basis at the Medical Advisory Committee meetings.</p> <p>5. The state plan program will___/will not <input checked="" type="checkbox"/> implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory___/voluntary <input checked="" type="checkbox"/> enrollment will be implemented in the following county/area(s):</p> <p style="margin-left: 40px;">i. county/counties (mandatory)_____</p> <p style="margin-left: 40px;">ii. county/counties (voluntary) <u><input checked="" type="checkbox"/> See county list-5.iv.</u></p> <p style="margin-left: 40px;">iii. area/areas(mandatory)_____</p> <p style="margin-left: 40px;">iv. area/areas –(by(voluntary)) <u><input checked="" type="checkbox"/> Portions of these counties</u></p> <p style="margin-left: 40px;">Albany Bronx Erie Kings Nassau New York Queens Rensselaer</p>

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<p>1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)</p> <p>1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2)</p> <p>1902(a)(23)(A)</p> <p>1932(a)(1)(A) 42 CFR 438.50(c)(3)</p> <p>1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)</p> <p>1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)</p> <p>1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)</p>	<p>Saratoga Schenectady Suffolk Westchester</p> <p>C. <u>State Assurances and Compliance with the Statute and Regulations</u></p> <p>If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.</p> <p>1. ___ The State assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p> <p>2. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p> <p>3. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met</p> <p>4. ___ The state assures that all applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.</p> <p>5. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.</p> <p>6. ___ The state assures that all applicable requirements of 43 CFR 438.6(c) for payments under any risk contracts will be met.</p>

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1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6) 45 CFR 74.40	7. ___The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. 8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
1932(a)(1)(A)(i)	D. <u>Eligible Groups</u> <i>Enrollment will be voluntary</i> 1. List all eligible groups that will be enrolled on a mandatory basis. 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. i. ___Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of the enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i> ii. ___Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. iii. ___Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under Title XVI. iv. ___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. v. ___Children under the age of 19 years who are in foster care or other out-of-
1932(a)(2)(B) 42 CFR 438(d)(1)	
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	
1932(a)(2)(A)(v)	

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<p>42 CFR 438.50(3)(iii)</p> <p>1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)</p> <p>1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)</p> <p>1932(a)(2) 42 CFR 438.50(d)</p> <p>1932(a)(2) 42 CFR 438.50(d)</p> <p>1932(a)(2) 42 CFR 438.50(d)</p> <p>1932(a)(2) 42 CFR 438.50(d)</p>	<p>the-home placement.</p> <p>vi. ___Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E.</p> <p>vii. ___Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.</p> <p>E. <u>Identification of Mandatory Exempt Groups</u> <i>Enrollment will be voluntary; children under age 19 are excluded</i></p> <p>1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. <i>(Examples: children receiving services at a specific clinic or enrolled in a particular program.)</i></p> <p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p>___i. program participation, ___ii. special health care needs, or ___iii. both</p> <p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p>___i. yes ___ii. no</p> <p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: <i>(Examples: eligibility database, self-identification)</i></p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>ii. Children under 19 years of age who are eligible under section 1902(e)(3) of the Act;</p>

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1932(a)(2) 42 CFR 438.50(d)	<p>iii. Children under 19 years of age who are in foster care or other out-of home placement;</p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt (<i>Example: self-identification</i>)</p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care (<i>Examples: usage of aid codes in the eligibility system, self-identification</i>)</p> <p>i. Recipients who are also eligible for Medicare.</p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p>
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> <i>Enrollment will be voluntary</i></p>
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p>The eligible group for voluntary enrollment includes disabled Medicaid FFS recipients, exempt or excluded from managed care, who are medically and behaviorally complex and receive services across multiple provider agencies, and:</p> <ul style="list-style-type: none"> • Have full Medicaid coverage, • Have multiple co-morbid chronic conditions, such as, but not limited to: asthma, cardiovascular disease, chronic kidney disease and end stage renal

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<p>1932(a)(4) 42 CFR 438.50</p> <p>1932(a)(4) 42 CFR 438.50</p>	<p>failure, congestive heart failure, coronary atherosclerosis, diabetes, history of acute myocardial infarctions, HIV/AIDS, hypertension, obstructive pulmonary disease, and sickle cell anemia;</p> <ul style="list-style-type: none"> • Are 19 years of age or older; • Are within the geographic catchment area of the CIDP; • May have mental illness and chemical dependence, either singularly or co-occurring; • May be in the Recipient Restriction Program; • May be homeless; • May be a Native American; • Are not dually eligible for Medicare and Medicaid; • Are not enrolled in a Managed Care Plan, Special Needs Plan, Managed Long Term Care Plan, or Family Health Plus; • Are not residing in a State-operated psychiatric center or free standing psychiatric hospital, Intermediate Care Facility, Residential Health Care Facility, Skilled Nursing Facility, Alcohol and Substance Abuse or Chemical Dependence Long Term Residential treatment program, or hospice; • Are not in receipt of Medicaid Home and Community Based Waiver (HCBW) services; and <p>Are not individuals who have a documented diagnosis of mental retardation or a developmental disability based on NYS Mental Hygiene Law.</p> <p>H. <u>Enrollment process</u> <i>Not Applicable (no default enrollment)</i></p> <p>1. Definitions</p> <p style="padding-left: 40px;">i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</p> <p style="padding-left: 40px;">ii. A provider is considered to have “traditionally served” Medicaid recipients if it has experience in serving the Medicaid population.</p> <p>2. State process for enrollment by default.</p>

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<p>1932(a)(4) 42 CFR 438.50</p>	<p>Describe how the state's default enrollment process will preserve:</p> <ul style="list-style-type: none"> i. the existing provider-recipient relationship (as defined in H.1.i). ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i> <p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <ul style="list-style-type: none"> i. The state will___will not___use a lock-in for managed care managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____. iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i> iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, HMO enrollment packets, etc.)</i> v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i>

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<p>1932(a)(4) 42 CFR 438.50</p>	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p>I. <u>State assurances on the enrollment process</u></p> <p>Recipient enrollment in a CIDP will be on an "opt-in", voluntary basis. Recipients will be notified by two consecutive mailings, first from the DOH and second from the CIDP contractor regarding their eligibility to enroll in a CIDP and providing information on the demonstration program. Other Department approved methods of outreach to recipients not responsive to mailings will be utilized as needed, e.g. telephoning, utilizing community outreach workers, and outreach and enrollment during network provider visits. All contractor communications with recipients will be approved by the DOH, including letters of notification, brochures and educational materials and telephonic scripts.</p> <p>Recipient enrollment may be conducted face to face or telephonically. At the time of enrollment the recipient must provide their written consent to participate in the CIDP program. At the time of enrollment each enrollee will be notified of their right to disenroll or "opt out" of the CIDP at anytime. The enrollee will be notified that enrollment in a CIDP will not limit or impair their ability to access Medicaid services to which they are entitled.</p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p>1. <input checked="" type="checkbox"/> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p> <p>2. <input type="checkbox"/> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of a least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p>3. <input type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p>

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1932(a)(1)(A)(ii)	<p>There are no Medicaid covered services excluded for CIDP enrollees. Recipients/enrollees will continue to receive all Medicaid covered services via the fee-for-service program.</p> <p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <ol style="list-style-type: none">1. The state will <u>✓</u>/will not___intentionally limit the number of entities it contracts under a 1932 state plan option.2. <u>✓</u> the state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. <i>(Example: a limited number of providers and enrollees.)</i> <p>To establish the CIDP programs NYS utilized a request for proposal (RFP) competitive procurement. Eligible bidders authorized to submit a proposal submission for a CIDP were mandated in Social Services Law § 364-1 that authorized the demonstrations. The RFP document included detailed specifications and technical requirements. Each bidder was required to submit a Technical Proposal and a Financial Proposal, which were evaluated by separate teams following criteria developed from RFP requirements, detailed specification and cost requirements. All evaluation and selection documents were reviewed and approved by the DOH Procurement Division prior to receipt of the proposals. The results of the evaluation were then reported to the selection committee, who made the final award(s) determination. Oversight of the procurement and contractor selection process is done by the NYS Office of the State Comptroller who must review and approve all processes, documents and contracts for accuracy and compliance with NYS financial and procurement laws.</p> <ol style="list-style-type: none">4. ___The selective contracting provision is not eligible to this state plan.

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