DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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DEC 19 2019

Donna Frescatore
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP - 1211)
Albany, NY 12237

Dear Ms. Frescatore:

Under section 1115(a) of the Social Security Act ("the Act"), the Secretary of Health and Human Services ("Secretary") or the Centers for Medicare & Medicaid Services (CMS), operating under the Secretary's delegated authority, may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid program, as discussed below. Congress enacted section 1115(a) of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients."[1] As relevant here, the Secretary (1) may, under section 1115(a)(1), waive provisions in section 1902 of the Act; and/or (2) may, under section 1115(a)(2)(A), authorize federal financial participation (FFP) for state expenditures that would not qualify for FFP under section 1903 of the Act (i.e., provide "expenditure authority"). Section 1902 of the Act lists what elements the Medicaid state plan must include, such as provisions relating to eligibility, beneficiary protections, benefits, services, and premiums. Section 1903, "Payments to States," describes expenditures that may be "matched" with federal title XIX dollars, allowable sources of non-federal share, and managed care requirements.

For the reasons discussed below, CMS hereby approves New York's request to amend its section 1115(a) demonstration titled, "Medicaid Redesign Team" (MRT) (Project Number 11-W-001142/2). Approval of this amendment enables the state to limit the nursing home benefit in its Managed Long Term Care (MLTC) plans to three months for enrollees who have been designated as "long-term nursing home stays" (LTNHS). The amendment also aligns the lock-in policy of MLTC with Medicaid Mainstream Managed Care (MMMC) plans as discussed below.

[1] See S. Rep. No. 87-1589, at 19 (1962), as reprinted in 1962 U.S.C.C.A.N. 1943, 1961.

Extent and Scope of the Amendment

The New York Medicaid Redesign Team (MRT) demonstration (formerly known as "Partnership Plan") allows New York to implement a managed care delivery system to provide benefits to its Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to many individuals needing long term services and supports (LTSS). The demonstration was originally approved in 1997 to enroll most of the state's Medicaid recipients into managed care organizations (MCO) and it has been amended numerous times, including through the following notable amendments:

- In 2010, a Home and Community Based Services (HCBS) expansion program was added;
- In 2012, an improved care coordination model of managed LTSS was added;
- In 2013, modifications were approved to coordinate with the Medicaid expansion and other changes under the Affordable Care Act – including a) transitioning childless adults and parents and caretaker relatives with incomes up to, and including, 133 percent of the federal poverty limit (FPL) into state plan coverage; and b) mandating them into managed care arrangements;
- In 2014, a Delivery System Reform Incentive Payment (DSRIP) program was added;
- In 2015, Health and Recovery Plans (HARP) were approved to integrate physical, behavioral health and HCBS for beneficiaries diagnosed with severe mental illness and/or substance use disorder; and
- In 2019, two amendments were approved that a) exempted MMMC enrollees from cost sharing and b) enabled the state to create a streamlined children's model of care for children and youth under 21 years with behavioral health and HCBS needs.

For this amendment, CMS is approving two state requests to modify the STCs.

Modification #1

Limit the nursing home benefit in the partially capitated MLTC plans to three months for enrollees who have been designated as LTNHS in a skilled nursing or residential health care facility (nursing home). Afterwards, the individual will be involuntarily disenrolled from the partially capitated MLTC with coverage for nursing home services in the same facility provided by Medicaid fee for service (FFS), as long as the individual qualifies for institutional Medicaid coverage. Institutional eligibility is required for individuals in MLTC plans or in Medicaid FFS. Enrollees who are involuntarily disenrolled from a plan because they have reached the three-month nursing home benefit limit in their plan will have the same due process rights as individuals who are involuntarily disenrolled from the plan for other reasons.

The state's contracted agency will determine if the plan's involuntary disenrollment request is appropriate and notice the consumer of the prospective disenrollment date if the disenrollment is approved. If the enrollee is dissatisfied with the disenrollment determination, they may challenge the determination through the fair hearing process. If successful, nursing home residents will be allowed to re-enroll in an MLTC and return to the community without requiring

a Conflict Free[2] evaluation and enrollment assessment, if such movement is within 6 months of the resident's disenrollment from the plan. In addition, individuals who are dually eligible for both Medicare and Medicaid, who are 21 years of age or older, and LTNHS will be excluded from joining MLTC plans. Eligible individuals will remain in FFS to access the long-term nursing home benefit and other necessary Medicaid funded services.

Modification #2

Aligns the lock-in policy of MLTC plans with MMMC. After this policy goes into effect, mandated enrollees of partially capitated MLTC plans will be limited in their ability to transfer to another MLTC partial capitation plan for 12 months from the effective date of enrollment. Enrollees may transfer to another partially capitated plan without cause during the first 90 days of the 12-month period. Regardless of whether they transfer to another plan, after the first 90 days the enrollee may not transfer to another partial capitation plan unless there is good cause to do so. Enrollees will receive notice of this change and a list of good cause reasons. These reasons may include moving away from the service area, inability of the plan to provide appropriate and accessible services and/or supports, poor quality care, lack of access to providers experienced in caring for the individual and a determination that the enrollment was non-consensual.

The MRT demonstration remains in effect, as amended and technically corrected, through March 31, 2021.

Promoting the Objectives of Medicaid

Under section 1901 of the Act, the Medicaid program provides federal funding to participating states "[f]or the purpose of enabling each state, as far as practicable under the conditions in such state, to furnish (l) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

As this statutory text makes clear, a basic objective of Medicaid is to enable states to "furnish . . . medical assistance" to certain vulnerable populations (i.e., payment for certain healthcare services defined at section 1905 of the Act, the services themselves, or both). By paying these costs, the Medicaid program helps vulnerable populations afford the medical care and services they need to attain and maintain health and well-being. In addition, the Medicaid program is supposed to enable states to furnish rehabilitation and other services to vulnerable populations to help them "attain or retain capability for independence or self-care," per section 1901 of the Act.

We are committed to supporting states that seek to test policies that are likely to improve beneficiary health because we believe that promoting independence and improving health outcomes is in the best interests of the beneficiary and advances the fundamental objectives of

[2] "Conflict free" evaluation and enrollment assessments evaluate the patient and ensure they meet the requirements for MLTC and, if they qualify, they are given the opportunity to select an MLTC plan.

the Medicaid program. Healthier, more engaged beneficiaries also may consume fewer medical services and have a lower risk profile, making the program more efficient and potentially reducing the program's national average annual cost per beneficiary of $7590.[3] Policies designed to improve beneficiary health that lower program costs make it more practicable for states to make improvements and investments in their Medicaid program and ensure the program's sustainability so it is available to those who need it most. In so doing, these policies can promote the objectives of the Medicaid statute.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration projects are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness and help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

In its consideration of the MRT section 1115 demonstration, CMS examined whether it was likely to assist in improving health outcomes, whether it would address health determinants that influence health outcomes, and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS determined the MRT demonstration was likely to promote Medicaid objectives and the waiver and expenditure authorities sought were necessary and appropriate to carry out the demonstration.

CMS has also determined that approval of this amendment to the MRT demonstration is likely to promote the objectives of the Medicaid program for the following reasons:

- It will eliminate duplication of care management services currently provided by both the nursing home and the MLTC plan. As a result, the three-month limit on the nursing home benefit for LTNHS designees will drive program savings without undermining the care provided to nursing home residents;
- It will allow MLTC beneficiaries in nursing homes, or their authorized decision-makers, to continue engaging with nursing home staff, their physician(s) and their MLTC care manager about their discharge plans or nursing home placement; and
- It will align the lock-in policy of MLTC with MMMC.

Consideration of Public Comments

New York's state public comment period was open from July 3, 2018 to August 3, 2018, and the tribal comment period was open from June 19, 2018 to August 20, 2018. No comments were received during the state public comment period. The federal public comment period was open from September 26, 2018 to October 26, 2018 and CMS received 16 comments related to the demonstration proposal (one comment had no information). The majority of commenters did not

[3] U.S. Department of Health and Human Services 2017 Actuarial Report on the Financial Outlook for Medicaid.

support the amendment as proposed; however, CMS worked closely with the state, federal partners and other interested parties to minimize risk to the LTNHS designees.

The non-supporting comments included themes such as: (a) the amendment could incentivize MLTC plans to push some people with disabilities and those cost prohibitive into nursing homes, possibly making community transitions more difficult; (b) the amendment does not go far enough to protect beneficiary rights to receive community services; and (c) the amendment is in direct opposition to the states Value Based Payment efforts. CMS and New York worked in tandem to ensure that the advocates concerns' were minimized.

As approved, this amendment does not change the array of long term care services available to consumers – nor does it alter the state's commitment to caring for individuals in the community or consumers' protections under federal and state law or rule. This amendment does not limit access to community based care nor diminish the rights or ability of individuals to safely return to the community

Other Information

It is important to note that CMS' approval of this amendment solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

CMS' approval of this amendment is subject to the limitations specified in the enclosed authorities and STCs which define the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent they have been specifically listed as not applicable and approval is.

This approval is also subject to your written acknowledgement of the award and acceptance of the STCs within 30 calendar days of the date of this letter. Please send written acceptance to your project officer, Ms. Audrey Cassidy. Ms. Cassidy is available to answer any questions concerning your section 1115(a) demonstration and may be contacted as follows:

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7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0059
E-mail: Audrey.Cassidy@cms.hhs.gov

Official communication regarding official matters should be simultaneously sent to Ms. Cassidy and Mr. Francis McCullough, Director, Division of Medicaid Field Operations East, Regional Operations Group. Mr. McCullough's contact information is as follows:

Mr. Francis McCullough
Director, Division of Medicaid Field Operations (DMFO) East
Regional Operations Group (ROG)
Centers for Medicare & Medicaid Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063
Telephone: (212) 616-2424
E-mail: Francis.McCollough@cms.hhs.gov

If you have any questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid & CHIP Services at (410) 786-9686.

Sincerely,

Calder Lynch
Acting Deputy Administrator and Director

Enclosures

cc: Francis McCullough, Director, Division of Medicaid Field Operations East
Nicole McKnight, Acting Deputy Director, Division of Medicaid Field Operations East
Maria Tabakov, State Lead, Division of Medicaid Field Operations East
Michael Kahnowitz, Acting State Lead, Division of Medicaid Field Operations East