

NEW YORK STATE MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION



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Money Follows the Person (MFP) Rebalancing Demonstration

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- *Attachment B:* Regional TRAIID Centers Listings
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1. Project Introduction

New York State MFP Mission Statement

Approved by the Centers for Medicare and Medicaid Services (CMS) in 2007 and operating under the auspices of the New York State Department of Health (DOH), the New York State Money Follows the Person Rebalancing Demonstration (Demonstration) promotes an ongoing collaborative approach towards driving a substantive consumer-driven rebalancing of the Empire State's long-term care systems.

The Demonstration's current partnerships with constituent programs assure that members of vulnerable populations (e.g., seniors; individuals with physical, intellectual, and/or developmental disabilities; and individuals with traumatic brain injury) have access to home and community-based services (HCBS). New York State continues to articulate a long-term care agenda designed to restructure healthcare priorities by shifting the focus from institutional care to a patient-centered system of quality homecare via a number of mechanisms including the New York State Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waivers, New York State Office for People With Developmental Disabilities (OPWDD) waivers, and ultimately through the Managed Long-term Care (MLTC) program. The Demonstration has been an integral partner with its constituent programs since the first partnered transition in January of 2009.

Background and Assessment of the Long Term Care System

Most Integrated Setting Coordinating Council

The Most Integrated Setting Coordinating Council (MISCC), established by Chapter 551 of the Laws of 2002, is responsible for developing a comprehensive statewide plan to ensure that people of all ages with physical and mental disabilities receive care and services in the most integrated settings appropriate to their individual needs.

In November of 2006, the Council submitted its first report to the Governor and State Legislature, entitled "Addressing the Service and Support Needs of New Yorkers with Disabilities", including an "Operational Plan" to serve as a starting point for achieving the Council's goals. State agencies are responsible for implementation of applicable sections of the plan and for regular progress reports. The Council quarterly meetings are open to the public.

Medicaid Redesign Team

In January of 2011, the Medicaid Redesign Team (MRT) was tasked by Governor Cuomo to find ways to reduce costs and increase quality and efficiency in the NYS Medicaid program. The MRT has taken a phased approach in releasing recommendations and initiatives. Phase 1 saw the development of a package of reform proposals aimed at achieving the Governor's budget target and introduced structural reforms that bent the Medicaid cost curve. Phase 2 involves the creation of a coordinated plan to ensure that the program can function with spending limits and improve program quality.

On April 14th of 2014, the Governor announced the finalized terms and conditions with the federal government for the Medicaid 1115 waiver amendment. This amendment will enable NYS to implement the MRT action plan, facilitate innovation, lower healthcare costs and allow the state to reinvest \$8 billion over a five-year period. Critical issues will be addressed throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program.

Americans with Disabilities Act

The American's with Disabilities Act (ADA) was enacted into law in 1990. The law gives civil rights protections to individuals with disabilities and defends those individuals from discrimination in employment. In 2008, Congress passed the ADA Amendment to broaden the definition of the term "disability" to be more inclusive.

Olmstead Plan

On November 30th of 2012, Governor Cuomo signed Executive Order (EO) 84 creating an Olmstead Plan Development and Implementation Cabinet. The Cabinet, composed of state agencies providing services to persons with disabilities, is charged with making recommendations to the Governor concerning the development, implementation and coordination of an Olmstead Plan for New York State. The Cabinet sought the guidance and expertise of various stakeholders including members of the Most Integrated Setting Coordinating Council (MISCC); which has been working on development of an Olmstead Plan since 2002. The MISCC is comprised of representatives from various state agencies and appointed members representing seniors and people with disabilities.

In October of 2013, the final report detailing recommendations concerning establishment, implementation and coordination of the Olmstead Plan was released. A copy of the plan can be found at www.governor.ny.gov/olmstead/home. Four distinct areas of focus emerged:

- The need for strategies to address specific populations in unnecessarily segregated settings, including:
 - people with intellectual and developmental disabilities in developmental centers, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and sheltered workshops;
 - people with serious mental illness in psychiatric centers, nursing homes, adult homes, and sheltered workshops; and
 - people in nursing homes.
- The need to increase opportunities for people with disabilities to live integrated lives in the community.
- The need to develop consistent cross-systems assessments and outcomes measurements regarding how New York meets the needs and choices of people with disabilities in the most integrated setting.
- The need for strong Olmstead accountability measures.

Direct Service Workforce

In 2009, the U.S. Department of Health and Human Services set forth an initiative to develop and implement innovative strategies that would increase the opportunities for Americans with disabilities and older adults to enjoy meaningful lives in the community. As a result, the National

Direct Service Workforce Resource Center (DSW-RC) began developing a set of Core Competencies for the Direct Service Workforce. This is part of a multi-phased research project funded by CMS called the Road Map of Core Competencies for the Direct Service Workforce Resource Center (DSW-RC). The DSW-RC identified a common set of core competencies designed to inform direct support service delivery and promote best practices across community based long-term services and supports (LTSS) sectors including intellectual and developmental disabilities, behavioral health, physical disabilities and aging.

In November of 2013, the DSW-RC reached out to the New York's MFP Demonstration Project Director requesting assistance with the final phase (phase IIIB) of this project. This phase involves facilitating the process of validating the core competency set. The fourteen core competency areas are as follows: communication, facilitation of individualized services, evaluation and observation, participant crisis prevention and intervention, safety, professionalism and ethics, participant empowerment, advocacy, supporting health and wellness, community living skills and supports, interpersonal and family relationships, community and service networking, cultural competency and education, training and self-development.

New York State was one of four MFP states that have been asked to participate. The MFP Demonstration was a natural vehicle for this project because of its involvement with individuals who transition from institutional care to the community. Although many factors are considered, quality, well-trained direct service workers are an integral part in making those transitions successful.

Balancing Incentive Program

New York was awarded participation in the Balancing Incentive Program (BIP), from CMS on March 15th of 2013. The BIP focuses on transforming the state's long-term care system by increasing access to non-institutional LTSS. Through the BIP, NYS will implement the three required structural changes: a no wrong door/single entry point system (NWD/SEP), conflict-free case management services and core standardized assessment instruments.

New York currently operates a comprehensive NWD/SEP initiative known as [NY Connects](#). The system provides access to information and assistance in gaining medical and supportive services for individuals, family members and providers across all long term care populations. The system provides a full range of public education, information, initial screening, assistance, needs assessment and help toward accessing appropriate medical and non-medical services.

Consistent with the MRT strategy of "[Care Management for All](#)," NYS is committed to ensuring that recipients have options and opportunities to self-direct services, that service options are presented clearly and that there is an appeals process to assure the rights of recipients who are dissatisfied with their care. This strategy forms the basis for the assurance of conflict-free case management services.

The state has made significant strides in implementing a Uniform Assessment System (UAS-NY) for the elderly and/or physically disabled population using the InterRAI Assessment Suite. The current MFP constituent program partners will use the same general domains for population specific additions. The resulting statewide data set will be used to plan and improve services,

predict trends and report progress. Commencing in April of 2013, a new UAS-NY began phasing in those individuals who may be eligible for assisted living program (ALP), adult day health care, personal care and the Consumer Directed Personal Assistance Program (CDPAP) and Managed Care/Managed Long Term Care (MLTC); in addition to the Care at Home (CAH) I/II, Long Term Home Health Program, NHTD, and TBI waivers.

Partnerships with Constituent Programs

New York was an early leader in the development of home and community based services (HCBS) Medicaid waivers to provide a combination of homecare and supports to participants as an effective and less expensive alternative to institutional care. The state provides a wide range of community based services that enable individuals to choose an integrated setting that will meet their long term care needs. The Demonstration currently has partnerships with HCBS waivers operated by the DOH and OPWDD. HCBS waiver participants are able to access those State Plan services for which they are determined to be eligible in addition to receiving services through a respective waiver.

OPWDD Waiver

Initiated in 1991, the OPWDD waiver created a new service provision model that encouraged increased use of community resources to meet the needs and enrich the lives of persons with developmental disabilities. The initial goal of the waiver was to serve more people with a wider range of community based services that were more individualized and less expensive than institutional care. Currently, OPWDD is focusing on the HCBS waiver as a central vehicle for broad scale transformation of its service system by combining the 1915(c) waiver with a 1915(b) waiver to transition its fee-for-service system to a managed care system. The Demonstration began a partnership with the OPWDD waiver effective April 1, 2013.

TBI Waiver

Initiated by DOH in 1994 and approved by CMS in 1995, the Traumatic Brain Injury (TBI) waiver provides a coordinated continuum of care to individuals with a TBI who are between the ages of 18 and 64 at the time of application. Individuals injured during their developmental years (prior to age 22) are given access to the OPWDD comprehensive waiver. Beginning April 1, 1995, the TBI waiver repatriated several hundred individuals from out-of-state nursing homes. The Demonstration began a partnership with the TBI waiver in 2010.

NHTD Waiver

Approved in 2007 and beginning in 2008, the Nursing Home Transition and Diversion (NHTD) waiver provides seniors (age 65 and older) and individuals with physical disabilities (ages 18 to 64) an alternative to nursing home placement. Similar to the TBI waiver, the NHTD waiver works toward successful inclusion of the individual in the community. Participants have the right to control their lives and encounter and manage risks, while providers take the responsibility of assuring a participant's health and welfare. The Demonstration began a partnership with the NHTD waiver in 2007.

Managed Care - Managed Long Term Care

Managed Long Term Care (MLTC) is a program that streamlines the delivery of long term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long term care plans that are approved by the DOH. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen. As New York transforms its long term care system to one that ensures care management for all, enrollment in a MLTC plan may be mandatory or voluntary, depending on individual circumstances.

Enrollment in a MLTC plan is mandatory for those who:

- Are dually eligible (eligible for both Medicaid and Medicare), over 21 years of age and need community based long term care services for more than 120 days; and
- reside in any of the current mandatory counties

Enrollment in MLTC plan is voluntary for those who are:

- dually eligible, are 18 through 21 years of age and need community based long term care services for more than 120 days and assessed as nursing home eligible; or
- not dually eligible, are over 18 years of age and are assessed as nursing home eligible

People enrolled in MLTC plans are not currently captured in the MFP Demonstration, but will be eligible to participate as the waiver programs phase out and the transition to managed care progresses.

Current MFP Projects

Peer Outreach and Referral & Transition Centers Project

It has been identified that despite the various efforts in providing information about HCBS options, there remain individuals who are unaware of these options including any developments since being admitted to a facility. The Demonstration has directed rebalancing funds toward an initiative designed to identify and provide peer outreach counseling and support to these institutionalized individuals across all the currently served target populations.

Through a competitive bidding process, a contractor, New York Association of Independent Living (NYAIL), was selected to provide peer-based, person-centered outreach and support to institutionalized individuals and/or their legal guardians. This new initiative was designed to build upon the experience and knowledge obtained through the former Identification of and Outreach to Nursing Home Residents project.

The partnership of this rebalancing initiative with the recruitment strategies of the constituent programs enables the State to identify, contact, and provide outreach counseling to individuals interested in transitioning to the community who may or may not also be potential participants in the MFP Demonstration. Additionally, residents of nursing facilities who have been identified through the Minimum Data Set (MDS) 3.0 Section Q referral process (see Section 2 for more detail) will receive specific attention as part of the outreach process. If a resident expresses interest in returning to the community via an affirmative response to the questions in Section Q

of the MDS, then the facility must make a referral to a designated local contact agency (LCA) to provide the resident and/or their family of choice with information on community based care options. The referral process through the peer outreach project provides a further opportunity to build relationships among institutional and community care providers. It also allows for individualized choice (via an array of long-term services and supports) through person-centered planning.

NYAIL is currently in the process of setting up statewide Transition Centers to identify and assist individuals from vulnerable populations who express a desire to leave an institutional setting and return to the community. The Transition Centers provide transition planning and community readiness training to educate and support institutionalized individuals who may be subjected to a potential “disconnect” between facility discharge planners and the community-based service providers. The Transition Centers will create a supportive link that bridges the transition process from pre-discharge to early establishment within their community of choice. As such, the Transition Centers will be responsible for informing, supporting, and overseeing the transition of individuals from facility to community.

Guardianship Project

Indigent people with disabilities and seniors, who have been adjudicated by a court as incapacitated, may find that the inability to locate a legal guardian has created an artificial barrier to community care as an alternative to unwanted institutionalization. To address this issue, a portion of the rebalancing funds was used to support an Access to Court Appointed Guardians Project, implemented by a single source contract with the New York City based Vera Institute for Justice (Vera). Vera actively strives to assist low income individuals to move out of institutions and back to their home communities. In 2005, the Vera Institute, in collaboration with the New York State Office of Court Administration, established The Guardianship Project to test a new model of institutional guardianship for indigent elderly and people with disabilities who have been adjudicated by a court as incapacitated. The project currently serves over 100 individuals annually. The partnership with the Demonstration assisted Vera’s Guardianship Project in expanding capacity in Kings County and services to another New York City borough.

Community Care Connections Project

Lifespan of Greater Rochester’s Community Care Connections is a three year demonstration that will effectively integrate a community based aging services provider as an authentic member of the evolving health care delivery system to help older adults remain healthy in their own homes. Lifespan aims to prove that integrating traditional community-based aging services with medical systems of care positively affect the triple aims of cost, quality, and patient satisfaction.

Designated health care professionals will provide care coordination services through care access points to help an increasing population of older adults (60+) access ADL/IADL supportive services, reduce hospital admissions/readmissions, reduce Emergency Department use and reduce caregiver burden.

Lifespan aims to serve 2000 individuals over 3 years, receiving referrals from physicians practices, certified home care agencies, Emergency Medical Services, and a through an Emergency Department discharge transition pilot program with Highland Hospital. Lifespan will place designated health care professionals within existing physician practices, as well as employ

the expertise of RNs, LPNs, Social Workers (BSWs and MSWs), a Benefits Expert, a Chronic Disease Self-Care Management Coordinator, and a Falls Prevention Manager. The project will fund Health Care Coordinators (nurses) who will link the care transition team in the hospital to aging services and coordinate the care of high risk and traditional patients in primary care physician sites by arranging for medical appointments and facilitating conversations between patient/family and the physician. Care Navigators (social workers) will serve as a link to older adults in the community to physicians' offices and to home care. There will be a special Care Navigator who will specialize in working with older adults with mental health issues. Later in the project, a care navigator will work with the local EMS and EDs to address the needs of those clients who are using both services more frequently. Funding will be used for temporary, emergency transition services such as meals and minor home modifications so to ensure transitions are more successful. The addition of a Chronic Disease Self-Care Management Coordinator and a Falls Prevention Manager is another way this demonstration is taking a proactive approach in keeping older adults healthy and in their homes longer by offering classes to teach skills for the patient to be in control of his/her health and health outcomes.

Lifespan will utilize MFP Demonstration funds to create an electronic tracking system and to retain an independent evaluator to design the evaluation of the program and collect, track and analyze data from multiple points. Outcomes which will inform effective approaches to integrating community-based aging services with medical systems of care will also be examined. The goal of the evaluation is to provide a replicable, effective care integration model for NYS, as well as increase medical providers understanding of how a patient's social determinants affect health outcomes, provide increased knowledge of which social services make the most difference for patients/caregivers, and provide "tools" for medical systems of care that improve quality of care and patient satisfaction.

Technology-Related Assistance for Individuals with Disabilities (TRAID) Project

To promote a long-term care system in which individuals at risk of institutional placement or those individuals interested in transitioning from institutional settings have access to needed durable medical equipment, the Demonstration partnered with the NYS Justice Center to provide additional funding for the Technology-Related Assistance for Individuals with Disabilities (TRAID) Project.

TRAID serves to increase well-timed access to and acquisition of assistive technologies (AT), such as durable medical equipment (DME), in support of individuals wishing to remain in or transition to a community setting. A significant barrier traditionally facing these individuals is the delay in receiving AT via typical funding mechanisms such as through State Plan services, HCBS waivers or non-Medicaid services. (See *Benchmark Three* for additional information on the TRAID project.)

Housing

Status of Housing Issues in New York State

New York State Homes and Community Renewal (HCR) is responsible for the supervision, maintenance and development of affordable, low and moderate income housing in New York State. DOH and OPWDD partnered with HCR to improve the functionality of the agency's website and create a statewide online housing listing and locator service-

www.nyhousingsearch.gov. One-time rebalancing funding was provided to create the website and market it to landlords and people with disabilities. The registry serves as an important information and resource repository for people seeking accessible housing. In order to provide a seamless tool for persons with disabilities to identify and access housing, HCR recognized a need for a more proactive role in populating the site with usable information. In September 2007 the HCR Office of Fair Housing and Equal Opportunity (OFHEO) began requiring, as part of an Affirmative Fair Housing Marketing Plan (AFHMP), that managers/landlords register their accessible properties no later than 90 days prior to engaging in marketing activities on the site and post vacancies once the project is completely rented.

HCR undertook a comprehensive review of the state's Qualified Allocation Plan (QAP), which set forth the criteria and preferences by which low-income housing tax credits will be allocated to housing capital projects. The QAP is the guiding document for award of this most important housing development resource. The QAP was last reviewed in 2005. By Executive Order, HCR was designated as the state's Housing Credit Agency to allocate the credit in a manner that maximizes the public benefit by addressing the State's need for low-income housing and community revitalization incentives. In order to undertake this review, a public meeting process was conducted to bring stakeholders into the discussion in an effort to ensure the State is utilizing this program as effectively as possible. A draft QAP has been released for public comment and notification has been published in the State Register. In addition, a public hearing has been scheduled to seek comments on the proposed plan.

Subsidies

Housing subsidy programs are currently available for NHTD, TBI and OPWDD Comprehensive waiver participants. Housing subsidies allow participants to access affordable housing as an alternative to unwanted institutionalization. These subsidies or programs are maintained and overseen by the respective constituent program.

Additionally, the NHTD, TBI and OPWDD Comprehensive waivers offer two essential services that will promote the availability of housing for Demonstration participants:

1. Community Transition Services (CTS) are intended to assist the participant to transition from an institutional setting to a qualified residence in the community. This service includes the cost of moving furniture and other belongings, security deposits, including broker's fees required to obtain a lease on an apartment or home; purchasing essential furnishings; set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or one time cleaning prior to occupancy. CTS is a one-time service per waiver enrollment.
2. Environmental Modifications Services (E-mods) can be used to make a NHTD, TBI, or OPWDD waiver participant's dwelling more physically accessible and functional to allow for greater independence.

Within MLTC, the additional income that an individual will be allowed to retain is available when the individual enrolls in a MLTC plan. The amount of the special income standard for housing expenses will vary based on the region of the State where the individual resides. The 2012 monthly amounts range from \$386 for the Central Region to \$1,187 in Long Island. These

amounts are subject to annual changes based on increases to the Medicaid income levels and US Department of Housing and Urban Development (HUD) rates. Individuals may not participate if they are considered an “institutionalized spouse.” To be eligible for the housing allowance, an individual must be at least 18 years of age; have been a resident of a nursing home for at least 30 days; Medicaid made payment toward the cost of care in the nursing home; require the community based long term care services of the plan for more than 120 days; and have a housing expense such as rent or a mortgage. The special income standard for housing expenses is not available to individuals who are receiving home and community-based waiver services, are already enrolled in a MLTC plan, or are a married individual who participates in the Program of All Inclusive Care for the Elderly (PACE) since they are considered an institutionalized spouse for spousal impoverishment budgeting purposes. Plans are encouraged to work with their existing referral sources, such as network nursing home social workers or discharge planners, who may be identifying potential candidates. For specific information on the Medicaid eligibility process, please contact your Local Department of Social Services.

Current Perspectives and Initiatives

The home one lives in, the neighborhood, nearby amenities, and the proximity to needed services all play a key role in an individual’s ability to choose community based care as an alternative to unwanted care in an institutional setting. For this reason, the MRT Housing Subcommittee is implementing numerous initiatives related to developing and promoting a broader range of community based affordable accessible housing opportunities for individuals with physical and developmental disabilities. The cross-system MRT Affordable Housing workgroup is evaluating current supportive housing programs for individuals with disabilities across all service systems.

In April of 2014, two requests for applications (RFAs) were issued to address barriers to housing for individuals also in need of services. The Nursing Home to Independent Living Supportive Housing RFA announced the availability of state funds to establish supportive housing services and provide rental subsidies for high-need Medicaid beneficiaries, specifically, for seniors and individuals with physical disabilities who require nursing home level of care and who currently are homeless, reside in the community or in nursing homes, or those who are at risk of nursing home placement. The inability to locate affordable, accessible housing creates an artificial barrier to community living. Many people living in nursing homes would choose to live in a community setting if they had access to appropriate housing and services. Likewise, there are many people currently living in the community who are at significant risk of needing to enter a nursing home.

The Senior Supportive Housing Services RFA announced the availability of State funds to establish senior supportive housing services projects to serve low income, Medicaid eligible seniors who are homeless or reside in the community and who are at risk of nursing home placement and seniors transitioning out of nursing homes into community living who require long term care services. The project is defined as the pairing of capital assistance and supportive services within existing senior housing communities. For seniors in poor health, the inability to locate stable, affordable and accessible housing often creates an artificial barrier to community living.

OPWDD Housing Initiatives and Future Activities

The Office of Home & Community Living within OPWDD continues to host a statewide series of Continuum of Housing Options Forums and conduct several other initiatives related to housing for people with intellectual and developmental disabilities. These Forums bring together families, people with intellectual and developmental disabilities, voluntary provider agencies, housing coordinators and a diverse group of affordable housing developers, financial institutions and local municipalities that are affiliated with and/or seeking to become affiliated with the OPWDD system. The basic discussions include the following:

- Expanding the inventory of affordable and accessible rental units for individuals with ID/DD;
- Facilitating opportunities for individuals with ID/DD to transition from institutions to the most integrated setting appropriate to their needs;
- Increasing access to rental subsidies; and
- Building understanding and awareness of informed choice for independent living.

These forums also highlight existing best practices in supportive housing options available within the OPWDD system and represent a multi-year initiative to increase options for individuals to live in the most integrated setting. Among other issues discussed at these forums are best practices in the dissemination of information to diverse audiences with a focus on people with intellectual and developmental disabilities, parents and other family members, policy makers, frontline workers and others within and outside of the OPWDD system.

OPWDD has also 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 financial education, understanding mortgages, and the pros and cons of renting and owning a home. Given OPWDD's certification as a HUD-Approved Housing Counseling agency, training and technical assistance is also provided to other populations in need of housing assistance, including families facing foreclosure and those in need of refinancing.

The Home of Your Own (HOYO) program continues to be active by providing homeownership counseling and training. The number of requests for loans from individuals with intellectual and developmental disabilities, their families and the workforce through the HOYO program has increased tremendously. In response, OPWDD's Office of Home and Community Living is working to increase the number and type of financial organizations and banks that will work with the HOYO program. Currently, OPWDD Housing Counselors are working with voluntary agencies to host training sessions on the HOYO Program throughout New York State. Training began in Western NY and will culminate in Long Island.

OPWDD interacts with local housing authorities to request housing choice vouchers for people with disabilities and to utilize the waiting list option when necessary and is working to generate increased interest in housing choice vouchers and engagement among individuals with intellectual and developmental disabilities and their families.

OPWDD also continues to provide input to NYS Homes and Community Renewal (HCR) on a statewide housing registry entitled NYhousingsearch.gov. This registry assists all people

with/without disabilities to learn about and access affordable and accessible apartments throughout New York State.

In addition, there has been an increase in the number of families with members who have an intellectual and developmental disability living in shelters and seeking assistance from OPWDD with locating apartments and obtaining a housing subsidy for the member with the disability. OPWDD is now providing training to staff working in New York City homeless shelters.

OPWDD is in the process of developing a Community Living Project in order to educate people with intellectual and developmental disabilities and their families on the variety of non-certified housing options and community supports available to assist with transitioning to a less restrictive living environment. This project will be a collaborative effort between OPWDD, Self-Advocates, Parents, Provider Agencies, and NYS Universities and is based on a project underway at Rutgers' School of Public Health.

OPWDD received a grant from the Money Follows the Person (MFP) project to support the certification of housing specialists throughout NYS. In June of 2015 OPWDD will host a training session conducted by Neighbor Works America, a national organization that specializes in providing training for housing counselors. Three types of certification will be offered:

- Introduction to Housing Counseling;
- Rental Assistance; and,
- Fair Housing.

In November of 2015 OPWDD will host a statewide housing conference in Albany, NY. This event will feature presentations on best practices in non-traditional housing options for people with intellectual and developmental disabilities by industry leaders from provider agencies, affordable housing developers, and university centers.

OPWDD will host a series of webinars on "Making Homes That Work" by George Braddock of Creative Housing Solutions, LLC. These webinars will feature information on how to utilize environmental modifications and technology to make homes accessible and healthy for people with Autism. The first Webinar will be held during the last week of April 2015.

Target Population Service Model

Demonstration Service Model

MFP is a state-operated, federal Demonstration that partners with constituent programs providing support for home and community based living. Via the Demonstration, CMS reimburses the state when individuals move from long term, institutional placements to integrated settings such as individual homes and apartments in the community. Participation in the Demonstration is transparent to all individuals who express a desire to leave an institutional setting and receive a combination of home and community based services and Medicaid State Plan services through any of the above-mentioned, currently-partnered constituent programs (NHTD, TBI and OPWDD, and later MLTC).

Quality of Life (QoL) Survey

Each potential Demonstration participant will be approached to voluntarily complete the MFP Quality of Life (QoL) survey. The core QoL survey was developed by Mathematica Policy Research, Inc. (MPR) and provides information through participant responses on the subject of quality of life in and out of an institution. Please refer to Attachment C for a copy of the survey with the New York State MFP insert page included. Each participant will receive a series of three surveys. The baseline survey is conducted prior to transitioning from the institution and is followed by a one-year and two-year follow-up survey. All information that is collected is submitted to MPR for evaluation of the MFP Demonstration on both state and national-levels.

The first 365 days post-transition, and subsequent enrollment in a constituent program, constitutes an individual's participation in the Demonstration. An individual receives a combination of qualified home and community based services and State Plan services through enrollment in the constituent program. Qualified home and community based services are currently provided by the state through Medicaid waivers or the Medicaid State Plan. The state receives an enhanced match for these services delivered to a MFP participant during the participant's 365-day Demonstration period. The enhanced match, Federal Medical Assistance Percentages (FMAP), equates to 25% of the overall costs for HCBS during each individual's participation period. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year. Section 1905(b) of the Act specifies the formula for calculating FMAPs. Following participation, an individual will continue to receive services as long as the eligibility requirements for the constituent program continue to be met.

Benchmarks

Required Benchmarks

New York continues to achieve the following two required benchmarks assessing progress in transitioning individuals to community care and rebalancing the state's long term care system.

Benchmark One: Number of Individuals Transitioned

The chart below represents the actual and projected number of eligible individuals in each target group to be assisted in transitioning from an institutional setting to a qualified residence during each year of the Demonstration. Participants will transition from institutional care to community based care through enrollment in a constituent program. Older adults/seniors and individuals with physical disabilities are commonly associated with the NHTD waiver. Individuals with intellectual and/or developmental disabilities (ID/DD) are associated with the comprehensive OPWDD waiver. Traumatic brain injured and dually diagnosed individuals are typically associated with the TBI waiver.

The projections for calendar years 2015 to 2018, for the physically disabled, older adults, and other (TBI, dually diagnosed) target populations were calculated as follows: The average of the actual transitions from previous years is multiplied by a gradually increasing percentage (15% for 2015, 20% for 2016, 25% for 2017, and 30% for 2018), and then less the percentage of the total for that year. The justification for the percentage reduction is on account of the presumed increase in diversion activities being performed under the managed long-term care environment. These activities will have a slight negative impact on the Demonstration's transition efforts.

Annual Transitions (projections in bold):

Target Population	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Physically Disabled (NHTD)	47	59	96	137	92	69	70	65	59	54
Older Adults/Seniors (NHTD)	32	46	72	102	91	65	58	54	49	43
Traumatic Brain Injured and/or Dually Diagnosed (TBI)	8	60	72	103	102	85	61	56	51	46
ID/DD (OPWDD)	0	0	0	0	89	140	175	175	150	100

Benchmark Two: Qualified Expenditures for HCBS

The chart below represents the actual and projected qualified expenditures for HCBS during each federal fiscal year of the Demonstration. Qualified expenditures are total Medicaid HCBS expenditures (federal and state funds) for all Medicaid recipients (not just MFP participants), including: expenditures for all 1915c waiver programs, home health services, and personal care if provided as a State Plan optional service, as well as HCBS spending on MFP participants (qualified Demonstration and supplemental services), and HCBS capitated rate programs to the extent that HCBS spending can be separated from the total capitated rate. The per-member-per-month rate under the managed long-term care umbrella is reduced by 4% in New York City and 14% in upstate New York in order to carve out the nursing facility portion.

NOTE: The decrease in 2010-2011 and 2011-2012 HCBS expenditures resulted from fee-for-service expenditures decreasing as managed care expenditures increased. At that time, managed care expenditures were not included in the Demonstration's calculation of overall HCBS expenditures. Subsequently, in 2012-2013, the Demonstration going forward decided to include managed care expenditures in the overall calculation.

Qualified HCBS Expenditures (projections in bold):

FFY	HCBS Expenditures	Percent of Annual Increase
2007-2008	\$10,776,311,606	-
2008-2009	\$11,728,261,206	8.8%
2009-2010	\$13,002,971,647	10.9%
2010-2011	\$12,408,784,471	-4.6%
2011-2012	\$11,687,679,466	-5.8%
2012-2013	\$12,740,251,651	9%
2013-2014	\$13,315,836,102	4.5%
2014-2015	\$14,121,780,984	6.0%

2015-2016	\$14,391,887,456	1.9%
2016-2017	\$14,658,548,312	1.8%

Additional Benchmarks

In addition to the required benchmarks, New York State continues to develop a variety of benchmarks to direct funds toward initiatives aimed at rebalancing the state's long term care system. Rebalancing initiatives, supported through the FMAP, will be directed to all New Yorkers in need of long term care services, not just those individuals currently in receipt of Medicaid. In some cases, individuals receiving services from a particular waiver/program could benefit from services offered by another waiver/program but cannot access these services due to a diagnosis or disability that may conflict with the other waiver/program's eligibility criteria. The proposed rebalancing initiatives are intended to bridge the service gaps that are created in these types of situations. Benchmarks are developed based on historical data (when available), available funding from the Demonstration and information about regional needs.

Benchmark Three: Availability of Assistive Technology

A significant barrier facing individuals who wish to avoid or transition from institutional care is the delay in receiving durable medical equipment (DME) despite typical funding mechanisms such as through State Plan services, HCBS waivers or non-Medicaid services. In many cases, the purchase of equipment to use in the interim period is necessary to establish and maintain the individual's independence in the community. Purchases of DME are typically made after the individual has moved into the community, and unfortunately the delay in receiving and adapting to such equipment often causes hardships or introduces unnecessary hazards for the individual and/or the caregiver(s). To address this barrier, CMS has clarified several avenues for states to pursue in order to facilitate successful transitions by making medically necessary DME available to individuals in advance of placement in the community. As stated in a [CMS letter to State Medicaid Directors](#), options include, 1) Utilizing a trial period from sellers/manufacturers of DME prior to transition, 2) Utilizing the Nursing Facility Benefit to transfer ownership of previously purchased DME to the individual at the time of transition, or 3) Utilizing the flexibility available through HCBS waivers when making the claim for DME.

Furthermore, to promote a long term care system in which individuals at risk of institutional placement or those individuals interested in transitioning from institutional settings have access to needed durable medical equipment in a timely manner, the NYS Justice Center administers the Technology-related Assistance for Individuals with Disabilities (TRAID) Program. The Justice Center supports Regional TRAIID Centers (RTCs), where staff provides information, training, device demonstration, device reuse, device exchange and device loans. TRAIID staff also provides technical assistance and advocacy on how to obtain and use AT services and devices. Please refer to Attachment B for a listing of the regional TRAIID offices in NYS.

The Demonstration partnered with the NYS Justice Center to provide additional funding for the TRAIID Program. This funding is used for a variety of activities, including the purchase of new inventory to increase needed equipment loans and increase staffing to provide device demonstrations. This enhanced funding opportunity has allowed the TRAIID Project to secure and maintain AT and DME that will be available long after the Demonstration period ends in NYS. Additionally, this project is unique in that it allows for the recycling and reuse of equipment, which is more cost-effective than continual purchases of new items.

The options for flexibility detailed within the CMS letter to Medicaid Directors – in conjunction with TRAIID’s robust DME inventory and service infrastructure – collectively address the current and projected needs for these services today and into the future.

Annual Number of New Items Purchased (projections in bold):

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Number of items	338	1806	0	0	1194	902	927	775	775

Purchase of additional items is contingent upon the availability of additional funding. The number of new items purchased, and their respective cost, will ultimately vary due to client need. Based on historical data, the availability of existing equipment, and funding provided through the Demonstration for staffing and marketing materials, it is expected that the number of equipment loans will continue to exceed the number of items purchased.

Annual Number of Equipment/Device Loans (projections in bold):

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Number of loans	161	1268	895	951	1565	1816	2040	1600	1600

Funding for this initiative also allows for the provision of device demonstrations so that individuals who are at risk of institutional placement or transitioning from institutional settings can learn to use the DME necessary for them to live independently in the community.

Annual Number of Equipment/Device Demonstrations (projections in bold):

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
Number of demonstrations	62	614	705	596	881	1455	2171	1400	1500

The projected number of items purchased, equipment loans and device demonstrations was determined by reviewing the TRAIID Project’s previous data, annualizing the data and forecasting a percentage based on the amount available for this initiative. In addition, the Program Director of the TRAIID Project queried staff from the regional TRAIID Centers to determine the needs of the region. Benchmarks were developed based on historical data, available funding from the Demonstration, and information regarding regional needs.

Benchmark Four (Revised & Updated): Peer Outreach to Institutionalized Individuals

It has been identified that despite the various efforts in providing information about home and community based options, there remain individuals who are unaware of these options including any developments since being admitted to the facility. The Demonstration has directed rebalancing funds toward an initiative designed to identify and provide outreach counseling and peer support to these institutionalized individuals across all the currently served target

populations. Additionally, residents of nursing facilities who have been identified through the Minimum Data Set (MDS) 3.0 Section Q referral process will receive specific attention, as part of the outreach process. If a resident expresses interest in returning to the community, via an affirmative response to the questions in Section Q of the MDS, then the facility must make a referral to a designated local contact agency (LCA) to provide the resident and/or their family of choice with information on community base care options. Maintenance of the Section Q referral process through the peer outreach project provides a further opportunity to build relationships among institutional and community care providers, as well as, to implement care based on an individual's choice from an array of long term care services and supports.

Through a competitive bidding process, a contractor (NYAIL) was selected to provide peer-based, person-centered outreach to all institutionalized individuals and/or their legal guardians, in order to provide general information about the discharge/transition planning process. The partnership of this rebalancing initiative with the recruitment strategies of the constituent programs enables the state to identify, contact, and provide outreach and peer support to individuals interested in transitioning to the community, who may or may not participate in the MFP Demonstration. Peer support through this initiative is provided prior to discharge from the institutional setting and is therefore not duplicative of the various peer support and counseling services listed in Attachment F.

Projected Annual Number of Individuals to Receive Initial Visits made by Peers:

	CY 2015	CY 2016	CY 2017	CY 2018
Number of Individuals	300	300	300	300

Projected Annual Number of Individuals to Receive Additional Peer Support (not including initial visits):

	CY 2015	CY 2016	CY 2017	CY 2018
Number of Individuals	200	200	200	200

In addition to this initiative, the NYS Office for the Aging (NYSOFA) developed [NY Connects](#) to provide comprehensive information about long term care options and linkages to services for individuals with long term care needs. NY Connects helps individuals identify appropriate levels and types of services to prevent or delay the need for institutional care.

Benchmark 5 (Revised & Updated): Transition Assistance for Institutionalized Individuals

Individuals currently residing in skilled care/nursing facilities and ICF/IIDs may have limited access to knowledgeable and consistent resources for promoting safe and timely discharge to a community of choice. This initiative was designed to build upon the experience and knowledge obtained through the operation of the former Identification of and Outreach to Nursing Home Residents project, within the MFP Demonstration. An institutionalized individual may or may not possess the self-advocacy skill set necessary to pursue discharge from the facility on her/his own. This experience has been noted during stakeholder meetings, discussions with service providers, and observations from surveys. There is an apparent rift that is created during this

part of the process and as a result may, in some cases, prevent a successful discharge from the facility.

NYAIL's Transition Specialists and Peers will bring additional information and resources to the transition planning process for individuals leaving long-term care facilities. Specifically, NYAIL will contribute by identifying additional community-based supports and services that can contribute to an individual's person-centered service plan and adaptive technology that can enhance an individual's ability to live with greater independence. The Transition Centers will create a supportive link that bridges the transition process from pre-discharge to early establishment in the community of choice. As such, the Transition Centers will be responsible for informing, supporting, and overseeing the transition from facility to community.

Projected Annual Number of Initial Visits made by a Transition Specialist:

	CY 2015	CY 2016	CY 2017	CY 2018
Number of Individuals	900	1000	700	500

Projected Annual Number of Transition Plans Leading to Discharge:

	CY 2015	CY 2016	CY 2017	CY 2018
Number of Plans	450	500	350	250

Projected Annual Number of Individuals to Receive Community Preparedness Education:

	CY 2015	CY 2016	CY 2017	CY 2018
Number of Individuals	350	400	275	175

Continued contact with those individuals that transition to one of the participating constituent programs is essential for evaluating the quality of life in the community, of those individuals. Monitoring of the QoL surveys, by the Centers, will set a natural pace for this necessary contact.

This initiative will coordinate with ongoing participant recruitment strategies related to the closure of campus-based developmental centers (large ICF/IID) and the promotion of opportunities to live in the most integrated setting possible for all individuals with developmental disabilities. The state will identify and NYAIL's Transition Centers will contact residents of ICF/IIDs who are planning to or who may be interested in transitioning into the community, and provide them with information about home and community based options and support. In its efforts to provide opportunities for more individuals with developmental disabilities to live and receive supports and services in smaller, community based settings, OPWDD understands that individuals residing in ICF/IIDs may desire and benefit from such assistance and support.

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2. Demonstration and Procedures

Participant Recruitment and Enrollment

Identification and Recruitment

In partnership with constituent waiver programs, the Demonstration serves adults with disabilities, including seniors, and individuals of all ages with physical, intellectual and/or developmental disabilities, who are receiving Medicaid benefits for inpatient services and have resided in a qualified institution (nursing facility, hospital, or intermediate ICF/IID) for a least ninety (90) consecutive days, excluding Medicare covered rehabilitative care that is expected to be short term in nature. Some of these individuals may be dually diagnosed with a co-occurring mental health disorder. All of the Demonstration participants will be served by any of the currently partnered constituent programs: the CMS authorized Nursing Home Transition and Diversion (NHTD), Traumatic Brain Injury (TBI), or the Comprehensive OPWDD HCBS Medicaid waivers. Participants will transition from institutional care to community based care through enrollment in a constituent program. Older adults/seniors and individuals with physical disabilities are commonly associated with the NHTD waiver, individuals with intellectual and/or developmental disabilities are associated with the comprehensive OPWDD waiver, and traumatic brain injured and dually diagnosed individuals are typically associated with the TBI waiver.

A variety of strategies are used to identify and recruit Demonstration participants including the development and dissemination of materials specific to each target population. Outreach, recruitment and enrollment activities will be conducted by the MFP Transition Centers. Additionally, the NHTD and TBI waiver Regional Resource Development Centers (RRDCs) and OPWDD staff will continue to conduct related activities. The Transition Centers will receive referrals from a variety of sources, such as nursing homes (mainly via Section Q of the MDS Assessment), and OPWDD program staff.

NHTD and TBI Waivers

NYSDOH contracts with nine Regional Resource Development Centers (RRDC) to administer, under the direction of the waiver staff, the NHTD and TBI waivers in the regions. (See Appendix E.1 for a map of the RRDC regions) Each RRDC is required to employ, at a minimum, one Lead RRDS and a Nurse Evaluator. Additional staff within the RRDC, such as an Assistant RRDS, provides support to the RRDS. The primary responsibilities of the Nurse Evaluator are to assist the RRDS in reviewing medically complex Service Plans, resolve level of care evaluation issues, and provide them with technical assistance. (See Appendix E.2 for a complete list of the RRDC contractors.)

For both NHTD and TBI, the RRDC staff is responsible for the development, management, administration, and monitoring of the waivers on a regional level. RRDC staff are a key component in delivering the program objectives of the NHTD and TBI waivers and facilitating resource development. RRDC staff promotes participant choice, ensure the delivery of high quality services, assist in the development of needed services and oversee waiver cost-effectiveness.

(See Appendix F1 for NYSDOH waiver specific recruitment and enrollment processes). A complete guide to NHTD and TBI waiver implementation policies and procedures is posted on the NYSDOH website respectively at http://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/ and http://www.health.ny.gov/health_care/medicaid/reference/tbi/.

OPWDD Comprehensive Wavier

OPWDD DDRO staff plays a central role in the HCBS waiver by administrating and overseeing waiver implementation and providing assistance to more than 500 non-profit organizations that serve waiver enrollees in their geographic catchment areas. In addition, OPWDD itself provides HCBS waiver residential and day services where needed.

Services are delivered in various ways in accordance with the needs of the waiver participants. Many of the participants have intermittent waiver supports such as staff that come to their residence a few days or hours per week. Other participants have greater needs. They may have 24/7 staffing in a certified residence and use an intensive day service such as day habilitation five days per week.

Approximately 50 percent of waiver enrollees live in their own home or family home where they receive services that enable them to live as independently as possible and work or engage in meaningful activities in their communities. Wherever a person lives, works or interacts with the community, OPWDD uses the waiver with natural supports and community based resources to allow the participant to be as independent, and, when possible, as self-directing, as he or she can possibly be. See Appendix F2 for OPWDD waiver specific processes. A complete guide to OPWDD waiver implementation policies and procedures is posted on the NYSDOH website at http://www.health.ny.gov/health_care/medicaid/program/longterm/omrdd.htm.

Managed Long Term Care

Managed Long Term Care (MLTC) is a program that streamlines the delivery of long term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long term care plans that are approved by the DOH. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen. As New York transforms its long term care system to one that ensures care management for all, enrollment in a MLTC plan may be mandatory or voluntary, depending on individual circumstances.

Enrollment in a MLTC plan is mandatory for those who:

- Are dually eligible (eligible for both Medicaid and Medicare), over 21 years of age and need community based long term care services for more than 120 days; and
- reside in any of the current mandatory counties

Enrollment in MLTC plan is voluntary for those who are:

- dually eligible, are 18 through 21 years of age and need community based long term care services for more than 120 days and assessed as nursing home eligible; or
- not dually eligible, are over 18 years of age and are assessed as nursing home eligible

People enrolled in MLTC plans are not currently captured in the MFP Demonstration, but will be eligible to participate as the waiver programs phase out and the transition to managed care

Uniform Assessment System

The Uniform Assessment System for New York (UAS-NY) is a comprehensive assessment system that evaluates an individual's health status, strengths, care needs, and preferences, and guides the development of individualized long-term care service plans; The UAS-NY is administered by a licensed professional who works collaboratively with the respective constituent program's Service Coordinator during transition planning.

Section Q Referral

The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. As stated earlier, implementation of the MDS 3.0 Section Q provides the opportunity to build relationships between institutional and community care providers to implement care based on an individual's choice from an array of long term care services and supports. If the nursing home resident expresses interest in returning to the community, the nursing home must make a referral to a designated local contact agency (LCA) within ten business days. The goal of a successful MDS Section Q referral is to initiate and maintain collaboration between the nursing home and the LCA, to support the individual's expressed interest in the possibility of being transitioned to community living. This includes the nursing home supporting the individual in achieving his/her highest level of functioning, the LCA providing information about community living services and supports, and collaboration to assist the individual to transition to community living. MDS 3.0 Section Q policy has been revised, so that nursing home residents are periodically assessed to determine the interest in discharge to the community. The assessments must be completed upon admission to the nursing home, quarterly, annually and whenever there is a significant change in condition requiring a reassessment. OPWDD operates a Pre-Admission Screening Resident Review (PASRR) process and is working to secure community placement for individuals when it is desired and appropriate. In addition, OPWDD and the DOH are working to ensure that the PASRR pre-screening information is shared with nursing homes and updated if needed as individuals complete Section Q surveys, so that OPWDD remains up to date on individuals' stated desires.

Verification of Medicaid Eligibility

All Demonstration participants must have been eligible for and have received Medicaid benefits for inpatient services for at least one day prior to discharge from a qualified institutional setting to a qualified residence in the community. Information provided by the individual, transition specialist, and/or any advocate aiding in the transition process will assist in making a preliminary determination about the individual's eligibility for the Demonstration. Once it is pre-determined that the person is eligible for the demonstration, the transition specialists will obtain informed consent, which is then referred onto the constituent program. The constituent program remains responsible for the clinical assessment and will collaborate with the transition specialist who may start community readiness training while the resident is still in the facility.

Using eMedNY, Demonstration staff will then verify the individual's Medicaid eligibility to assure the individual was Medicaid eligible for at least one day prior to transition. All verifications will be completed prior to making any claims for federal reimbursement of qualified HCBS.

Demonstration Criteria

Potential Demonstration participants must meet the following specific MFP eligibility criteria:

1. be in receipt of Medicaid benefits for inpatient services for at least one day prior to the transition from a nursing home;
2. have resided in a nursing home, hospital, or ICF/IID for at least ninety consecutive (90) days, less any Medicare short-term rehabilitation days, prior to transitioning to the community; and
3. transition into a qualified residence. A qualified residence is considered to be a home or apartment owned or leased by the individual or individual's family members, or a community based residence with no more than four unrelated individuals.

In addition, participants must meet the eligibility and enrollment criteria of the constituent program through which they will receive LTC services.

Qualified Institutions and Residency Requirements

Demonstration participants transition from one of the following qualified inpatient facilities: a hospital, nursing home, or ICF/IID, into a qualified residence in the community. Nursing homes and hospitals are included in the definition of "inpatient facility" as defined by Section 6071 (b) (3) of the Deficit Reduction Act (DRA) of 2005.

The Demonstration will target all nursing homes and ICF/IID facilities in New York State. MFP enrollment for campus-based ICF/IID residents will be targeted geographically based on the planned closure and downsizing of these institutions. It should be noted, however, that all residents of campus-based ICF/IID programs are continually evaluated to determine whether they continue to require an active treatment program in an ICF/IID setting. Discharge planning efforts begin at admission and the individual's readiness for discharge and need for continued active treatment in an ICF/IID setting are reviewed at least annually.

The constituent program's regional staff will be responsible for reviewing and determining that eligibility for the respective HCBS waiver is met, in addition to ensuring that the Demonstration criteria has been met. Staff will obtain verification from the nursing home and/or hospital of the individual's most recent admission date into the nursing home. If additional information is needed, Demonstration staff will gather this information from eMedNY.

Qualified Residence Type

Demonstration participants transitioning from institutional settings will transition into one of three qualified residences as defined by Section 6071(b) (6) of the DRA:

1. a home owned or leased by the individual or the individual's informal supports;
2. an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or

3. a residence, in a community based residential setting, in which no more than four unrelated individuals reside.

If the individual is not transitioning into a qualified residence, she/he will not be eligible for participation in the Demonstration; however, she/he may still be eligible for participation in a constituent program. If a participant moves from a qualified residence to a non-qualified residence, the individual will be discharged from the Demonstration, but may still be eligible for participation in the constituent program. The Demonstration is responsible for tracking the information regarding the type of residence, for all participants, and reporting this information on a regular basis.

Participation

Participation in the Demonstration begins when the individual has successfully transitioned to the community and starts receiving services through the respective constituent program's provider. The first 365 days of service utilization through the constituent program constitutes the participant's 'Demonstration period.' At any point in time, all individuals currently in the 365 day Demonstration period are considered 'active.' Any individual that has completed the 365 day period is considered inactive for the Demonstration; but may continue to receive services through the constituent program. As stated earlier, each Demonstration participant will be approached to voluntarily complete a series of three QoL surveys. The surveys are designed to measure an individual's assessment of her/his quality of life pre- and post-transition. Completion of the surveys is not a requirement for participation in any constituent program's services.

Dis-enrollment & Re-enrollment

Participants who are re-admitted to a qualified institution during the Demonstration period will be dis-enrolled from the Demonstration upon discovery of their re-institutionalization. However, former participants will be permitted to re-enroll in the Demonstration provided they continue to meet the eligibility criteria, without re-establishing the 90-day institutional residency requirement. Upon re-admittance to the Demonstration, such individuals will be eligible to participate in MFP for the balance of days remaining in the 365-day Demonstration period. Inpatient days will not be counted against the Demonstration period. Re-enrollment into services provided by a constituent program/waiver may require an additional review by the respective program depending on the length of the inpatient stay.

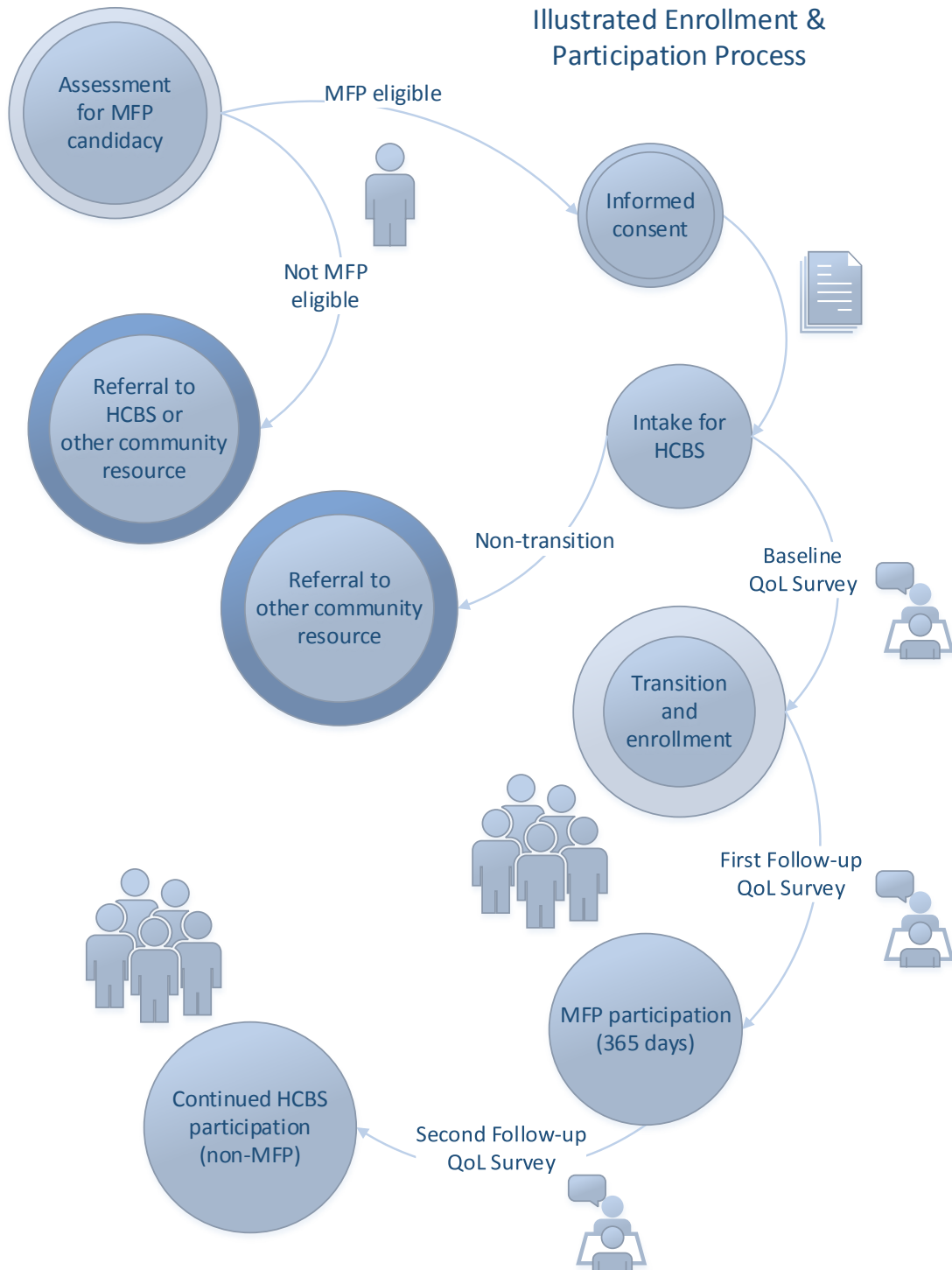
Continuity of Care Post-Demonstration

Participants in the Demonstration receive home and community based services through a constituent program. At the end of the participant's Demonstration period, she/he will continue to receive services without interruption or modification as long as she/he chooses and continue to meet the constituent program's eligibility criteria. Ending participation in the Demonstration will have no negative impact on the continued receipt of constituent program services

All of the 1915(c) waivers through which participants receive services are authorized by CMS for five year periods. Waivers with effective dates prior to the end of the Demonstration will be entered in the application renewal process, as consistent with the DOH planned transition to mandatory managed care and OPWDD development of the People First Waiver under the 1915(b)/1915(c) authority.

There is adequate capacity under the current waiver authorizations to accommodate all anticipated participants through the authorization Demonstration period. Continuity of care after participation in the Demonstration is assured as long as the individual continues to meet the eligibility requirements of the waiver in which they are enrolled.

Money Follows the Person Demonstration Illustrated Enrollment & Participation Process



Constituent Program Information

NHTD and TBI Waivers

All individuals interested in the Demonstration are provided with information about their HCBS options. This includes the appropriate information on both NHTD and TBI waivers at the time of referral. The NHTD and TBI waivers have a similar process for enrolling participants. The following describes the processes and the information provided for becoming a NHTD or TBI waiver participant. Reference to the “participant” also means his/her legal guardian if applicable.

Referral

A potential participant or an individual acting on her/his behalf contacts the RRDC in the region where she/he chooses to reside or where she/he is currently living. The RRDC representative completes the referral form and makes a determination whether to proceed to the intake process, which may include potential Demonstration enrollment. If the individual is considered not to meet the basic criteria for the NHTD or TBI waiver (e.g. age) or indicates her/his preference not to pursue admission into the NHTD or TBI waiver; then the representative will provide available options for referrals to other programs/services, including the State’s NWD/SEP system- NY Connects.

Intake

The representative meets with the potential participant, in the facility, and/or her/his legal guardian/representative to describe the waiver philosophy and available services. If the potential participant has a legal guardian, the representative reviews the guardianship order and advises the legal guardian that the Service Coordinator will be requesting a copy of the guardianship order during the application process. The representative will review the waiver-specific intake documents with the individual. If the individual agrees, she/he will sign the documents and receive a copy. In addition, the individual signs a release of information form.

The representative makes a preliminary determination of probable eligibility for the waiver and Demonstration enrollment. Formal approval for waiver enrollment is contingent upon the development of an Initial Service Plan that assures the potential participant’s health and welfare. The individual indicates interest in pursuing admission into the NHTD or TBI waiver and signs the appropriate waiver documents. The individual will be determined ineligible for the waiver if she/he refuses to pursue Medicaid, is under the age of eighteen, or indicates a preference not to pursue admission into the waiver.

Enrollment

Potential NHTD/TBI 1915 (c) waiver participants must choose to live in the community rather than in a nursing home and choose to participate in NHTD or TBI waiver services. She/he must be a recipient of Medicaid coverage for community based long term care. For the [NHTD waiver](#), she/he must be at least 18 years of age or older with a physical disability, or aged 65 or older upon application to the waiver. For the [TBI waiver](#), she/he must be between the ages of 18 and 64 upon application to the waiver and have a diagnosis of traumatic brain injury. For either waiver, the individual must be assessed to need a nursing home level of care. Nursing home eligibility for both waivers is presently determined by completion of the Universal Assessment System (UAS) tool. The individual must also be capable of living in the community with needed

assistance of available informal supports, non-Medicaid supports and/or Medicaid State Plan services and need one or more NHTD or TBI waiver services.

A complete guide to NHTD and TBI waiver implementation policies and procedures is posted on the NYSDOH website respectively at:

http://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/

and

http://www.health.ny.gov/health_care/medicaid/reference/tbi/

OPWDD Comprehensive Waiver

OPWDD Developmental Disabilities Regional Office (DDRO) staff plays a central role in the HCBS waiver by administrating and overseeing waiver implementation and providing assistance to more than 500 non-profit organizations that serve waiver enrollees in their geographic catchment areas. In addition, OPWDD itself provides HCBS waiver residential and day services where needed.

Services are delivered in various ways in accordance with the needs of the waiver participants. Many of the participants have intermittent waiver supports such as staff that come to their residence a few days or hours per week. Other participants have greater needs. They may have 24/7 staffing in a certified residence and use an intensive day service such as day habilitation five days per week. Approximately 50 percent of waiver enrollees live in their own home or family home where they receive services that enable them to live as independently as possible and work or engage in meaningful activities in their communities. Wherever a person lives, works or interacts with the community, OPWDD uses the waiver with natural supports and community based resources to allow the participant to be as independent, and, when possible, as self-directing, as she/he can possibly be.

As OPWDD closes and downsizes campus based Developmental Centers (DCs) where people with the greatest service needs reside, the organization's priority is to assist individuals to move into the most integrated community based services that can effectively meet the needs of each person. OPWDD Regional Vacancy Management Teams and Access to Residential Opportunities Committees (AROCs) will help potential MFP participants to understand Medicaid HCBS waiver and State Plan services, and community living options and resources, including self-direction. These committees facilitate collaboration on initiatives with provider agencies that might facilitate placement of individuals from DCs and ICF/IIDs, who desire to transition. OPWDD's strategies for recruiting individuals residing in non-campus-based ICF/IIDs and nursing homes will be statewide, while the strategy for recruiting individuals in DCs will be geographically targeted in coordination with the planned closure and downsizing of current institutions.

A complete guide to OPWDD waiver implementation policies and procedures is posted on the NYSDOH website at:

http://www.opwdd.ny.gov/opwdd_regulations_guidance/guidance_documents/the_key_to_individualized_services_hcbs_waiver_manual

Managed Long Term Care

Once a MLTC provider receives a prospective enrollment referral from a nursing home on behalf of a Medicaid recipient, the MLTC provider must assess the consumer in a timely manner (within

30 days of receiving the referral). The MLTC provider should assess the individual where she/he is located at the time of the referral, i.e., the nursing home. The assessment conducted in the nursing home setting will include and consider: diagnoses, current Plan of Care, discharge plan, proposed community residence, tentative discharge date and need for community based long term care services.

In addition to the assessment conducted in the facility, the MLTC provider must also assess the potential enrollee's proposed community residence which must be available for viewing prior to the date of discharge. A home visit by the MLTC provider is required to determine the potential enrollee's health and safety in the actual residence, identify any risk factors, and develop an effective and efficient Plan of Care. The potential enrollee does not need to be at the proposed residence during the home visit.

As the MLTC provider is responsible for the individual's health and safety beginning on the enrollment date, the assessment process must be completed, the final definitive Plan of Care established and MLTC provider services must be in place on, or set up prior to the day of the individual's discharge to the community setting.

A complete guide to MLTC implementation policies and procedures is posted on the NYSDOH website at:

https://www.health.ny.gov/health_care/managed_care/mltc/

Informed Consent and Guardianship

Informed Consent

Informed consent will be obtained from all Demonstration participants at the time of referral through signature on the MFP Informed Consent form. This form (Attachment H) will be provided by the Transition Centers. Participants are provided with information regarding the Demonstration via the referral and informed consent process. The Transition Centers will provide information regarding the transition process, constituent program services available during and after the Demonstration period, and the participant's rights and responsibilities. Informed consent will be obtained either directly from the potential participant or the individual's legally designated representative.

Guardianship

Some Demonstration participants may have legal guardians. The CMS approved constituent programs/waivers have policies and procedures surrounding guardianship and how it applies to their respective service model. As a result, this issue is considered outside the purview of the Demonstration itself to ensure that participants have their voice heard. Article 17-A of the New York State Surrogate Court Procedure Act (SCPA) establishes procedures for the appointment of a guardian for the person or property of a person with mental retardation or a developmental disability. Guardianship orders issued under this authority are subject to the court's authority to modify such order if in its judgment the interests of the guardian are adverse to those persons with mental retardation or a developmental disability or if the interests of justice will be better served (SCPA §§1755 and 1758). The SCPA does not specify a frequency for communication between a guardian and the person for whom he/she has been appointed to serve. Guardians for MFP Demonstration participants will be bound by the requirements set forth in applicable

statute (generally MHL Article 81 or SCPA Article 17-A) and the court order establishing the guardianship.

Article 81 of the New York State Mental Hygiene Law (MHL) also establishes a procedure for the appointment of guardians to satisfy the personal and/or property needs of an incapacitated person. Each guardianship order is tailored to the needs of the incapacitated person and is based on the incapacitated person's functional level, ability to understand the consequences of his/ her functional limitations and preferences and desires with regard to managing his/her activities of daily living. The specific powers given to the guardian constitute the least restrictive form of intervention consistent with the incapacitated person's functional limitations. The guardian must only exercise those powers authorized by court order. Article 81 (see appendix G) is designed to protect the incapacitated person who cannot make personal and/or property decisions for himself/herself. As such, the law specifies the guardian shall visit the incapacitated person not less than four times per year or more frequently as specified in the court order. Each person ordered by the court to be a guardian must complete an approved training program. The legal duties and responsibilities of the guardian, including the required number of visits, are explained during this training. In addition, guardians are required to submit an initial report within ninety (90) days after appointment and annually thereafter, which includes a report of the guardian's personal visits with the incapacitated person.

Services and Consumer Supports

Qualified Program Services

All Demonstration participants will also be enrolled in and receive services through a constituent program's HCBS waiver or both HCBS waiver and Medicaid State Plan services, during the individual's Demonstration period and after. During the development of the individual's service plan, participants in need of State Plan personal care services, home health and/or skilled nursing services will have the choice between a provider-managed model or a participant-directed model. For a comprehensive listing of benefits and services offered to TBI, NHTD, and OPWDD waiver participants, as well as MLTC services, State Plan services and mainstream Managed Care services, please refer to **Attachments F1 & F2**.

Each constituent program will offer service coordination, case management, or an equivalent service. The purpose of this type of service is to offer an individually designed intervention that provides primary assistance to the participant in gaining access to needed waiver and Medicaid State Plan services, as well as other local, state and federally funded educational, vocational, social and medical services. The provider will assist potential waiver participants desiring to transition from institutional settings and ensure that continuity and quality of care is in place, as necessary for a safe return to the community.

As stated, each constituent program has a well-developed set of policies and procedures regarding the recruitment and enrollment of participants. The individual program is responsible for maintaining an ongoing referral and intake process in order to ensure that there are no waiting lists for eligible individuals desiring to leave institutional care.

Backup Systems

New York State, in collaboration with the constituent programs, will monitor, assess, and strive to improve systems such as risk assessment mitigation, 24/7 backup for critical services, and incident management. As part of the HCBS provider enrollment process, all Medicaid waiver and MLTC service providers must sign a provider agreement that includes the responsibilities of the waiver service provider. All waiver service providers are responsible for assuring services are provided in accordance with the participant's individualized service plan. Providers will ensure back-up for critical services through operation and maintenance of an emergency on-call system within the Licensed Home Care Service Agency (LHSCA). For certain waiver services, when a single provider cannot provide the amount of services needed by the participant, the participant may choose an additional provider to supplement that particular service. The coverage will be detailed in the individualized service plan. This plan must reflect coordination between all providers involved with the participant. It is necessary to obtain input from agencies other than waiver service providers that authorize and/or directly provide needed services, and address the individual's risks related to the choice of community based care.

The service coordinator or care coordination team must identify information regarding the individual's health and safety, and safeguard needs that will be reflected in the service plan. Safeguards are supports that are needed to keep the participant safe and actions to be taken when the health or welfare of the participant is at risk. Safeguards address significant issues discovered during the planning process that are individualized and specific to the participant.. The service plan includes a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, community inclusion activities, dietary concerns, behavioral concerns, financial transactions, and vulnerabilities at home and in the community. Safeguards are not meant to be so wide-ranging that routine supports are always identified.

In addition to a comprehensive service plan, each constituent program provides a plan for protective oversight (PPO) detailing information regarding safety needs and safeguards. The PPO focuses on all activities that directly affect the health and welfare of the participant and clearly identifies the individual(s) responsible for providing the assistance. For individuals transitioning into the TBI or NHTD waiver, the service plan will include a signed PPO detailing the additional information. The PPO includes a section on the back-up plan and specifies who will be assisting the participant if services cannot be provided. For individuals transitioning into OPWDD's Comprehensive 1915(c) waiver, a separate and formal PPO is only required for individuals living in certified residential settings, although all individuals receiving waiver services must have an individualized service plan. For individuals living in non-certified settings, the individual works with his/her family/advocates, Medicaid Service Coordinator and service providers to address health and safety needs and safeguards.

While the Service Plan and PPO are comprehensive documents designed to prevent unexpected absences of unpaid or paid supports, there may be emergencies where such supports are unavailable. As stated, all service providers are responsible for providing services in accordance with the participant's individualized plan. In the DOH system, if a direct service worker (DSW) is unable to perform a scheduled service, it is the DSW agency's responsibility to contact the participant, her/his legal guardian and the service coordinator as soon as the waiver service provider realizes they cannot perform the service as scheduled. The service coordinator will

then secure other coverage for the service and, depending on the severity of the situation, contact Adult Protective Services (APS) or 911. If a non-waiver provider cannot perform the scheduled service, the participant's service coordinator will work with the LDSS and/or provider agency to assist the participant in accessing necessary coverage.

Pursuant to the 1115 waiver, an individual is expected to require at least one (1) of the following medically necessary services covered by the MLTC plan for more than 120 days from the effective date of enrollment:

- nursing services in the home
- therapies in the home
- home health aide services
- personal care services in the home
- adult day health care
- private duty nursing
- Consumer Directed Personal Assistance Services

For additional 1115 eligibility requirements, please visit:

https://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_overview.pdf.

In the OPWDD service system, it is the provider agency's responsibility to develop a back-up plan for instances in which the direct support professional is unable to provide a scheduled service. The agency, individual, and family need to follow this back-up plan. The service provider agency must notify the service coordinator if the individual's service plan or services need to be revised due to providers being unable to perform scheduled services.

In addition to the safeguards established as part of the planning process, agencies providing care management in the DOH system must have a 24-hour phone number that is answered by agency staff, or an answering service that contacts a staff person. The person receiving services and her/his advocate(s) are reminded annually of the emergency contact information. It should be noted that OPWDD does not currently have care coordination in their system.

Direct Service Workers

The Direct Service Workforce (DSW) is a vital pool of workers that provide daily services and supports to diverse individuals with a wide range of needs. They perform a number of duties for, and on behalf of, the elderly, individuals with disabilities, and their families. Competent, well-trained direct service workers are an integral part in making transitions from institutions to the community successful.

Educational Materials

In addition to the information provided by peers and the Transition Specialists, the provision of educational materials is primarily the responsibility of the constituent program.

Repair and Replacement of Durable Medical Equipment

The repair and replacement of DME remains the responsibility of the constituent program, in the participant's individualized service plan.

Transportation

While the provision of transportation remains the responsibility of the constituent program, the MFP Demonstration continues to advocate for the transportation needs of constituent populations.

Self-Direction

Participants who choose to enter the OPWDD Comprehensive 1915(c) waiver have the opportunity to create a person-centered service environment that is innovative and focused on community resources and self-direction principles. The HCBS waiver provides opportunities for a person to self-direct his or her services with budget and/or employer authority, and includes services that assist and support the person and his or her family with self-direction. Support Brokers assist waiver participants (or the participant's family or representative as appropriate) to self-direct and manage some or all of their waiver services. See Attachment I.

The State does not currently offer self-directed NHTD or TBI waiver services, but a Self-Direction option is available to those deemed eligible, and can be accessed through the Medicaid State Plan. This option is known as the [Consumer Directed Personal Assistance Program](#) (CDPAP). In order to be considered for CDPAP, the waiver participant must be willing and able, or have a legal guardian, or have designated a relative or other adult who is willing and able, to direct the participant's CDPAP services. Managed Care enrollees can also access the CDPAP as part of the Managed Care benefit of services.

Quality

Quality Assurance

To ensure that each State Plan service meets quality requirements, the Demonstration utilizes the same quality management programs that are in place for the constituent programs, including review of Serious Reportable Incidents (SRIs). The quality management program for each waiver combines quality assurance and quality improvement strategies to meet assurances established by CMS, as part of a 1915(c) application. NYS assures that transitioned participants have a comprehensive and integrated quality improvement system that uses critical processes of discovery, remediation and systems improvement in a structured manner. Each participant has a level-of-care (LOC) assessment and comprehensive plan-of-care that is responsive to the individual's needs.

Through a robust system of discovery (including consumer satisfaction surveys, Serious Reportable Incident database tracking, and audits of contractors), information is gathered and analyzed to determine when there are problems and where the locus of the problem primarily lies, for example at provider or program level. Once appropriate action is taken to remedy the problem, the system of discovery is used continuously to assure the proposed solution has been successful. DOH and waiver service provider agencies work collaboratively with waiver participants, embracing the "participant-centered approach" to service provision, with a focus on satisfaction and choice.

The MLTC plans are required to conduct performance improvement projects that focus on clinical and non-clinical areas consistent with the requirements of 42 CFR 438.240. The purpose of these studies will be to promote quality improvement within the MLTCP. At least one performance improvement project each year will be selected as a priority and approved by DOH. Results of each of these annual studies will be provided to DOH in a required format. Results of other performance improvement projects will be included in the minutes of the quality committee and reported to DOH upon request. Under MLTC, the MCOs are required to complete an annual performance improvement project. The purpose of this project is to ensure that the necessary quality assurance and quality improvement measures are being followed and updated/revised on an ongoing basis.

The OPWDD Division of Quality Improvement (DQI) is responsible for oversight and monitoring of OPWDD programs and services. On at least an annual basis, the division's Bureau of Program Certification (BPC) reviews each waiver service that an agency is providing. Survey instruments called protocols are used to guide this process as well as specific types of visits, processes and methodologies. During both annual agency and certified site visits BPC includes a review of agency/program compliance with the requirements of regulations governing incident management and staff qualifications and training.

Complaint Process

NYS Medicaid rules mandate that each service provider under its respective constituent program develop, maintain and implement policies and procedures for responding to complaints or grievances raised by the participants. These policies and procedures subsequently apply to all Demonstration participants and must detail how a complaint or grievance is filed, investigated and documented, as well as, the manner in which a participant is informed of the outcomes of the investigation. In addition, any changes in agency policies and procedures related to the outcome of the investigation must be recorded and implemented. Each investigation must be conducted to satisfy the confidentiality standards set by the Health Insurance Portability and Accountability Act (HIPAA).

Demonstration participants enrolled in either DOH waiver are informed that registering a complaint with a service provider is not a prerequisite or substitute for a conference or fair hearing and that she/he may do so without jeopardizing the provision of services established in the individualized service plan. Participants are provided with a detailed listing of her/his rights and responsibilities in accordance with the respective constituent program. This document is designed to enable the participant to understand his/her right to: submit complaints about any violation of rights or concerns regarding services; and to have such complaints investigated and to be informed of the results of such investigations. This document is reviewed and signed annually by the participant. The complaint, once received and investigated, may warrant being categorized as a critical incident. If so, each constituent program is responsible for maintaining an approved system for categorizing and providing follow-up to each critical incident. The Demonstration is responsible for gathering the information regarding critical incidents, for all active participants, and reporting this information on a regular basis.

Demonstration participants enrolled in the OPWDD waiver are informed that if informal attempts to resolve complaints are not successful, the objecting party can request a hearing. During administrative review, every feasible effort is made to maintain the person in at least her

or his current level of programming, except for when an objection to a placement or discharge is undergoing review. The commissioner can approve a relocation or discharge if needed to protect health, safety or welfare. Regulations require notification upon admission to a facility, enrollment in the waiver or as changes occur in an individual's service plan that will reduce, suspend or discontinue a waiver service.

Incident Management

In order to support the mission of helping people with developmental disabilities live richer lives, OPWDD and its provider agencies adhere to Title 14 of New York Code, Rules and Regulations Part 624. These regulations are designed to protect people receiving OPWDD services and require all providers of services to follow certain steps when an incident occurs. These steps include the reporting, investigation, recording and review of incidents as well as the safeguarding of people receiving services. Only incidents of abuse and neglect, significant incidents and serious notable occurrences need to be reported to OPWDD. Minor notable occurrences or other potentially harmful situations that do not rise to the level of a reportable incident or notable occurrence do not need to be reported, but providers must have systems in place to manage them. Reportable incidents that happen in programs and services certified or run by OPWDD are reported to the Justice Center for the Protection of People with Special Needs as well as OPWDD.

When any type of incident occurs, providers must ensure the safety of the person receiving services. An incident report must be completed and submitted to appropriate agency staff for review. An investigator must be assigned to gather information from a variety of sources and prepare a report that includes a summary of evidence, conclusions, and recommendations. In the case of a report of abuse or neglect, the report must also include a finding of "substantiated" or "unsubstantiated." The investigative report is then submitted to the agency's Incident Review Committee for review. The committee is required to review and monitor investigatory procedures (except when the Justice Center decides to conduct the investigation instead of allowing the provider agency to do so).

Both DOH waiver programs have similarly robust incident management policies and procedures to ensure the wellbeing of people receiving their services. A detailed description of these procedures can be found in the waiver handbooks noted above in "Consumer Supports."

All MLTC providers are required to submit critical incident reports to DOH regarding enrollee health and welfare pursuant to Article VIII of the MLTC contract, within fifteen (15) days of the close of each quarter, including the number of critical incidents that were investigated by the MLTC provider and the enrollee outcome (as set forth in section L of Article V of the [MLTC Contract](#)).

In relation to the QoL surveys, intervention may be warranted for program participants whose health, safety, or well-being seems threatened. Despite any pledge of confidentiality made, it may be required by state law or policy to report some incidents of alleged abuse or neglect described. NYS has an established procedure to follow if it is believed that a program participant is in jeopardy, through abuse, neglect, unsafe living conditions, or inadequate services. When these incidents are noted in a QoL baseline survey, the information will be communicated to the appropriate institutional representative for follow-up. When an incident is noted in either the

First Follow-up or Second Follow-up Survey, the information will be reported through the constituent program's critical incident reporting process.

Outreach, Marketing, and Education

History

NHTD waiver and MFP Demonstration staff conducted outreach, marketing and education regarding the Demonstration throughout the pre-implementation phase and expanded on these activities during the implementation phase of the Demonstration. During pre-implementation, presentations were provided to nursing home discharge planners and community based service providers, and conducted at institutional and community based provider association conferences, statewide long term care conferences, inter-agency meetings, Long Term Care Ombudsmen meetings and at statewide meetings of Local Departments of Social Services. These outreach activities continued throughout the implementation phase. Prior to and during pre-implementation, NHTD waiver staff maintained a database of phone calls and email received from potential participants, family members and potential waiver service providers regarding the Demonstration. As the state moved closer to implementation, the NHTD RRDCs were provided with the names of interested persons and contacted these individuals to provide additional information and conduct outreach activities.

Current Efforts and Materials

An ongoing and updated PowerPoint presentation highlighting the Demonstration's current efforts is presented during stakeholder meetings. Please refer to Attachment E for a copy of the most recent presentation. This presentation details the current progress of the Demonstration and provides an overview of eligibility criteria. Additional information has been included regarding prospective plans for the Demonstration and potential partnerships with additional constituent programs.

The DOH NHTD and TBI waiver management staff continue to work with the RRDCs to provide information during quarterly meetings. Additionally, outreach and education is and will continue to be provided through various Demonstration initiatives (Benchmarks 4 and 5). These initiatives, in part, address the requirement to provide outreach to nursing home residents who have been referred through the MDS 3.0 Section Q process.

Beginning in 2013, OPWDD initiated statewide outreach and education of its staff, voluntary service provider agencies, individuals with developmental disabilities, their family members and other stakeholders about the Demonstration.

In addition, OPWDD established a peer counseling network under contract with the Self Advocacy Association of New York State (SANYS) to provide extensive outreach that reached individuals and staff across the state. These peers used a variety of materials such as videos, posters, informational flyers and handouts to inform potential MFP participants and other parties of the Demonstration and Medicaid Home and Community-Based Services, including options for self-direction. Starting in 2015, these activities have been supplanted by the new statewide Transition Centers and Peer Outreach activities of NYAIL.

The Medicaid Managed Long Term Care plans help provide services and support to people with a long-lasting health problem or disability. The DOH issued a guide entitled *Medicaid Managed Long Term Care: Your options for home care and other long term services*. This guide is also available on CD and in Braille.

Stakeholder Involvement

History and Current Efforts

Since its inception, the Demonstration has routinely hosted or actively participated in an array of outreach, marketing, and educational activities during the pre-implementation and implementation phases. Such activities have included but have not been limited to presentations to nursing home discharge planners and community-based providers, organizing and conducting intra- and inter-agency meetings and statewide conferences, reaching out to potential constituents, and routinely communicating with Local Departments of Social Services and the State's Medicaid Redesign Team.

In 2011, the Medicaid Redesign Team initiative drew upon the experience and expertise of many stakeholders. Public forums were held throughout New York State in Buffalo, Syracuse, Albany and the Bronx between June 12, 2012 and June 20, 2012. More than 400 people attended the forum; over 100 people spoke. In addition, the MRT website provides information and the list-serve provides opportunities for additional stakeholder involvement. The MRT has a Facebook page and a Twitter account that is used for additional input. The MRT Housing Work Group was established to explore options by which to expand access to affordable and supportive housing for Medicaid recipients. The work group is comprised of a diverse set of stakeholders, including the large operators of supportive housing across the state. The Demonstration has ongoing collaboration with this workgroup.

As the Demonstration begins to shift its focus from serving as a catalyst for transitional pilot initiatives towards being a champion for long-term sustainability, the significance of maintaining effective communications with stakeholders is now more important than ever. In an effort to drive and maintain a high level of communications with its stakeholders, the Demonstration formed the MFP Stakeholder Advisory Committee (Committee). Comprised of individuals, family members, and service provider associations, the Committee meets on a regular quarterly basis and fosters knowledgeable guidance and dialogue regarding the development and sustainable utilization of rebalancing initiatives. Committee members were identified and recruited to ensure fair representation across constituent groups. Members were identified by MFP constituent programs, MFP contractors, and other community partners, however new stakeholders are welcomed and would be included at any point.

Stakeholder feedback and involvement is solicited specifically at quarterly meetings, as well as on an ongoing basis through direct communication between stakeholders and DOH/OPWDD management. The stakeholder meeting is facilitated using a modified town-hall format. Updated information on policies, procedures, new initiatives, and progress toward achieving the State's MFP benchmarks is presented during the first part of each meeting. Following the presentation, questions and comments are elicited from the stakeholders, participating directly and/or via teleconference and video-conference. The feedback and comments are recorded and discussed internally by Demonstration staff. Additional State government representatives are sought for

further input or comment based upon the nature of the stakeholder questions. This information is incorporated, when applicable, into the subsequent iteration of the Operational Protocol and presented during the following Stakeholder Advisory Committee meeting. The Committee has been exposed to the Operational Protocol through the drafting process. Representatives of the Committee are engaged to ensure an effective implementation.

Additionally, stakeholder feedback is solicited via email survey after the Committee meeting is held to gather information on preferences for the meeting format, location, duration, and particular topics of interest to be addressed in the next quarter. Any items of an urgent nature are addressed through direct communication between MFP staff and the individual stakeholder.

Stakeholder Summary

The following is a current list of participating stakeholders, however the Committee meeting employs an open format which allows for enhancement through inclusion of new stakeholders at any given point.

Stakeholder Groups	
<ul style="list-style-type: none"> • State Agencies 	<ul style="list-style-type: none"> • NYS Department of Health (NYSDOH) • NYS Office for People With Developmental Disabilities (OPWDD) • NYS Office For the Aging (NYSOFA) • NYS Office of Mental Health (OMH) • NYS Homes and Community Renewal (HCR)
<ul style="list-style-type: none"> • State Advisory Groups 	<ul style="list-style-type: none"> • NYS Olmstead Cabinet • NYS Medicaid Redesign Team • Most Integrated Setting Coordinating Council (MISCC)
<ul style="list-style-type: none"> • Contractors 	<ul style="list-style-type: none"> • Regional Resource Development Centers (RRDCs) • Vera Institute for Justice • Community Caregivers Project - Lifespan • New York Association of Independent Living (NYAIL) • The Justice Center • Regional Technology Related Assistance for Individuals with Disabilities Centers (TRAID)
<ul style="list-style-type: none"> • Community Stakeholders/Advocates 	<ul style="list-style-type: none"> • Alzheimer’s Association of New York • LeadingAge New York • Sinergia • Home Care Association of NYS • NYS ADAPT • Coalition of MLTC Plans • Wheels of Progress • Epilepsy Foundation of NENY

	<ul style="list-style-type: none">• Supportive Housing Network of NY• Association of Health Care Providers, Inc.• Health Plan Association• Rensselaer ARC• Interagency Council of DD Agencies• NYS Multiple Sclerosis Society• Self-Advocacy Association of NYS• New York Association of Independent Living (NYAIL)
<ul style="list-style-type: none">• Participants and Family Members	<ul style="list-style-type: none">• Not listed to assure confidentiality

3. Organization and Administration

Orientation of the Demonstration within New York State

The NYS Department of Health is designated as the single state agency responsible for the administration of the Medicaid program. The Deputy Commissioner of the Office of Health Insurance Programs (OHIP), within DOH, is the Director of the State Medicaid Program. Under OHIP is the Division of Long Term Care (DLTC) and under DLTC is the Bureau of Community Integration and Alzheimer's disease (BCIAD). The Demonstration is housed within the BCIAD. Placement of the Demonstration in this Division encourages effective management and coordination with other State Offices and partners. The Director of the Division of Long Term Care reports directly to the State Medicaid Director, who has the final authority with regard to the administration of all aspects of the Medicaid program in New York State. The MFP Demonstration Project Director is also the Bureau Director for the BCIAD. State Office partners will be detailed in this section and the organizational chart will be updated to reflect those relationships.

Staffing Plan

The staffing plan detailed below supports the effort to ensure successful administration and oversight throughout the course of the Demonstration in New York State:

MFP Demonstration Project Director

The State MFP Demonstration Project Director provides executive-level oversight of New York's MFP Demonstration. As such, the Project Director will be responsible for assuring that all of the activities of the MFP Demonstration are successfully completed, in addition to duties associated with other titles. This includes supervising professional and non-professional staff, coordinating activities and reporting with OPWDD, assuring compliance with the MFP Operational Protocol, assuring that the State has satisfied all of the CMS reporting requirements; assuring compliance with fiscal requirements, providing content expertise, providing overall direction of contractors for MFP related initiatives and facilitating collaboration with other state agencies, advocates, providers and other stakeholders. New York State has selected David Hoffman as the Demonstration Project Director. In addition to his duties as Project Director, Mr. Hoffman additionally serves as Director of the Bureau of Community Integration and Alzheimer's Disease (BCIAD) within which the Demonstration is organizationally situated. Mr. Hoffman's duties are split on a 51% (MFP) /49% (BCIAD) basis. Please see Attachment G for a copy of Mr. Hoffman's resume.

Project Directors (100% FTE MFP)

Duties: Reports to the State MFP Demonstration Project Director. Provides oversight of the MFP team in restructuring and rebalancing activities. Responsibilities include daily management of the MFP Demonstration staff and activities, preparation of revisions to the Operational Protocol as needed, ensures preparation and submittal of all CMS- and state-required reports on time. Provides oversight of the MFP Demonstration to assure accountability and timely delivery of project components, provides expertise in shaping program decisions.

Minimum Qualifications: Bachelor's degree and three years of experience coordinating the implementation of a healthcare program designed to provide alternatives to institutional care. A Master's degree can be substituted for one year of relevant experience.

Preferred Qualifications: Experience with grant or project management working within a government agency responsible for the administration of alternative long term care program(s). Candidates should have a working knowledge of issues faced by persons of all ages who are in need of long-term care services, particularly with those related to nursing home transition, and a deep commitment to person-centered planning and consumer choice. Candidates should have a firm understanding of Medicaid eligibility and coverage, as well as 1915(c) Medicaid waivers, possess excellent written and oral communication and organizational skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

Project Supervisors (100% FTE MFP)

Duties: Assists the Project Director in the supervision of Coordinators and Assistants in the oversight of the MFP Demonstration to ensure the ability to meet Federal program requirements. Duties include supervisory activities in all aspects of program implementation in the administration of Project related activities, including public outreach and education, training and technical assistance; supervision, guidance, including oversight of assigned MFP staff; MOU execution; single/sole source contract requests; drafting of Requests for Applications, review of protocols/oversight of vendor selections; coordination of financial/statistical data for CMS reports; development of policies and procedures related to MFP participants and related LTC rebalancing activities; development of Operational Protocol updates for DOH management for submission to CMS; reconciliation of vendor payment vouchers and program reports to assure meeting contract deliverables; overseeing completion of the MFP Quality of Life surveys; compilation of cross contractor survey data; development of annual Project budgets; provision of technical assistance/training to MFP staff and contractors; oversight of NYS statewide Minimum Data Set 3.0 Section Q implementation; represent MFP Project Director in her/his absence.

Minimum Qualifications: Bachelor's degree with a concentration in a human sciences or services curricula. Four years of professional clinical or administrative experience in a federal, state, or local government agency, or in a not for profit entity contracted to serve as the governmental agency representative. Three years of this experience must be in a professional administrative position in which a major duty involved performing planning, coordinating, gathering information related to, and/or evaluating a statewide or regional program for long term care eligible individuals. A Master's degree in a human sciences or services specialty or in public administration, business administration, health administration, health care profession, or hospital administration may substitute for up to one year of the non-specific experience.

Preferred Qualifications: Master's degree in a human science or services or field preferred. Five years of professional clinical or administrative experience in a federal, state, or local government agency, or in a not for profit entity contracted to serve as the governmental agency representative. Four years of this experience and a working knowledge gained in a professional administrative position in which a major duty involved planning, coordinating, gathering information related to, and/or evaluating a statewide or regional program for long term care

eligible individuals. Grant or project management experience working within a government agency responsible for the administration of alternative long term care program(s). Candidates are preferred with a firm understanding of Medicaid eligibility and coverage, as well as 1915(c) Medicaid waivers, and who possess excellent written and oral communication and organizational skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

Project Coordinators (100% FTE MFP)

Duties: Reports to the Project Director and Supervisor. Leads the team directly responsible for daily management of MFP Demonstration activities plus maintaining and updating the MFP Operational Protocol ensuring correct and timely reporting to CMS. The Project Coordinator is responsible for managing multiple projects involved in this Demonstration and will be responsible for assisting in oversight of MFP funded contract deliverables. Supervise activities regarding complex federally required data collection, mining, reporting and data base development and management for MFP system change initiatives.

Minimum Qualifications: Bachelor's degree and two years of relevant experience working in a government agency in community based long term care projects or five years of professional experience administering a relevant Medicaid program in a local department of social services, or other comparable work experience in a private setting.

Preferred Qualifications: Preferred candidates should have a working knowledge of issues faced by persons of all ages who are in need of long-term care services, particularly with those related to nursing home transition, and a deep commitment to person-centered planning and consumer choice. Candidates should have a firm understanding of Medicaid eligibility and coverage, as well as 1915(c) Medicaid waivers, possess excellent written and oral communication and organizational skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

Project Transition Coordinator (100% FTE MFP)

Duties: Reports to the Project Director and Supervisor. Coordinates and leads efforts between OPWDD Front Door staff and staff planning the move out of the institution to ensure consistency in community transitions and that individual needs are being met in a timely and efficient manner. Develops guidance and provides technical assistance to OPWDD staff and staff assisting with transitions. The Transition Coordinator works with the MFP team and is the liaison with the transition center vendors to ensure clear definition of roles and processes between the vendors and state agency staff.

Minimum Qualifications: Five years of relevant experience working in a government agency in community based long term care projects or five years of professional experience administering a relevant Medicaid program in a local department of social services, or other comparable work experience in a private setting.

Preferred Qualifications: Preferred candidates should have a working knowledge of issues faced by persons of all ages who are in need of long-term care services, particularly with those related to nursing home transition, and a deep commitment to person-centered planning and consumer choice. Candidates should have a firm understanding of Medicaid eligibility and coverage, as

well as 1915(c) Medicaid waivers, possess excellent written and oral communication and organizational skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

Housing Analyst (100% FTE MFP)

Duties: Meets the MFP Demonstration's housing related goals, including the Housing Education Initiative. Responsible for MFP rebalancing activities and other projects designed to increase the availability of affordable, accessible and integrated housing. Acts as a resource to NYSDOH NHTD and TBI waiver staff regarding housing subsidy programs and environmental modifications and supports the MRT Supportive Housing Initiative. In addition, the Housing Analyst serves a role as liaison with local Independent Living Center (ILC) TRAIID organizations and helps resolve housing accessibility issues that block choice of community based long term care.

Minimum Qualifications: Bachelor's degree and two years of relevant and related work experience with State and/or federal housing programs and other housing related issues or a Master's degree plus one year of related work experience.

Preferred Qualifications: Preferred candidates should have an understanding of housing development, the public and private real estate industry, as well as Public Housing Authorities. In addition, candidates should have a working knowledge of State and federal housing programs, particularly the Section 8 Housing Choice Voucher Program, familiarity with housing issues as they relate to persons with disabilities, an understanding of New York State's Consolidated Planning process, experience working with advocates and the ability to create and nurture working partnerships both internally and externally. Candidates should possess excellent communication, analytic and research skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

IT Project Coordinator (100% FTE MFP)

Duties: Oversees and manages MFP data reporting requirements with regard to participant information and service expenditures. Performs critical activities including supervising the development, maintenance, enhancement and troubleshooting of the MFP participant database. The MFP participant database is inclusive of demographic, service utilization information, and expenditures. Oversees the management of Section Q MDS data for the Peer Outreach project. Supervises the development of business requirements, analysis, systems design, and user acceptance testing, implementation, maintenance, and post implementation review. Oversees the design and maintenance of waiver databases. Creates complex queries using the DOH Medicaid Data Warehouse, Salient, and other data sources. Oversees documentation and flowcharting of assigned system projects and manages reconciling financial data collection for CMS required reports and generates statistical and financial reports.

Minimum Qualifications: Bachelor's or graduate degree in Computer Science, mathematics, statistics, accounting, finance, business administration, public administration, or equivalent, with one year's qualifying experience, or in any field with college level expertise in computer science and/or data processing, program analysis, qualitative analysis, quantitative analysis, and two years qualifying experience or 60 semester hours / Associate's degree or equivalent including 15 college credits of computer science/data processing and/or program analysis courses and three years qualifying experience. Qualifying experience must include familiarity

with claims data reporting and basic statistical methods. Experience must include, for example, systems analysis including design and development of computer based user applications, expertise in trend reporting, development of test data, generation of systems specifications coding, parallel testing, post install follow-up, flowcharting, debugging of application programs, and database query generation and end report running.

Preferred Qualifications: Six months or more of experience in systems support and data management to support a Medicaid program project. Knowledge of Microsoft Access or SQL to support advanced queries. Candidates should have a working knowledge of other Microsoft Suite products including Word and Excel, possess excellent analytic and research skills, and familiarity with Oracle products, Salient, Hummingbird BI Query and Bi Analyze tools, Java, and the like. Knowledge and experience in a NYS Medicaid or other public sector health care programs strongly preferred.

Project Assistants (100% FTE MFP)

Duties: Assists the Project Coordinator in CMS required reporting, and assists in evolving long term care service infrastructure. The position is needed to create and administer required satisfaction surveys and other quality/risk assessment tools; assist with tracking of MFP participant data, and assist in administering high profile MFP activities including RFA/Ps, contracts, work plans, etc.

Minimum Qualifications: Bachelor's degree and one year of relevant experience working in or administrating a health care program designed to provide alternatives to institutional care or four years of professional experience administering a Medicaid program in a local department of social services, or other comparable work experience.

Preferred Qualifications: Preferred candidates should have a working knowledge of issues faced by persons of all ages who are in need of long-term care services, particularly with those related to nursing home transition, and a deep commitment to person-centered planning and consumer choice. Candidates should have a firm understanding of Medicaid eligibility and coverage, as well as 1915(c) Medicaid waivers, possess excellent written and oral communication and organizational skills, and have experience with Microsoft Office products, such as Microsoft Word, Excel, and Access.

IT Project Assistant (100% FTE MFP)

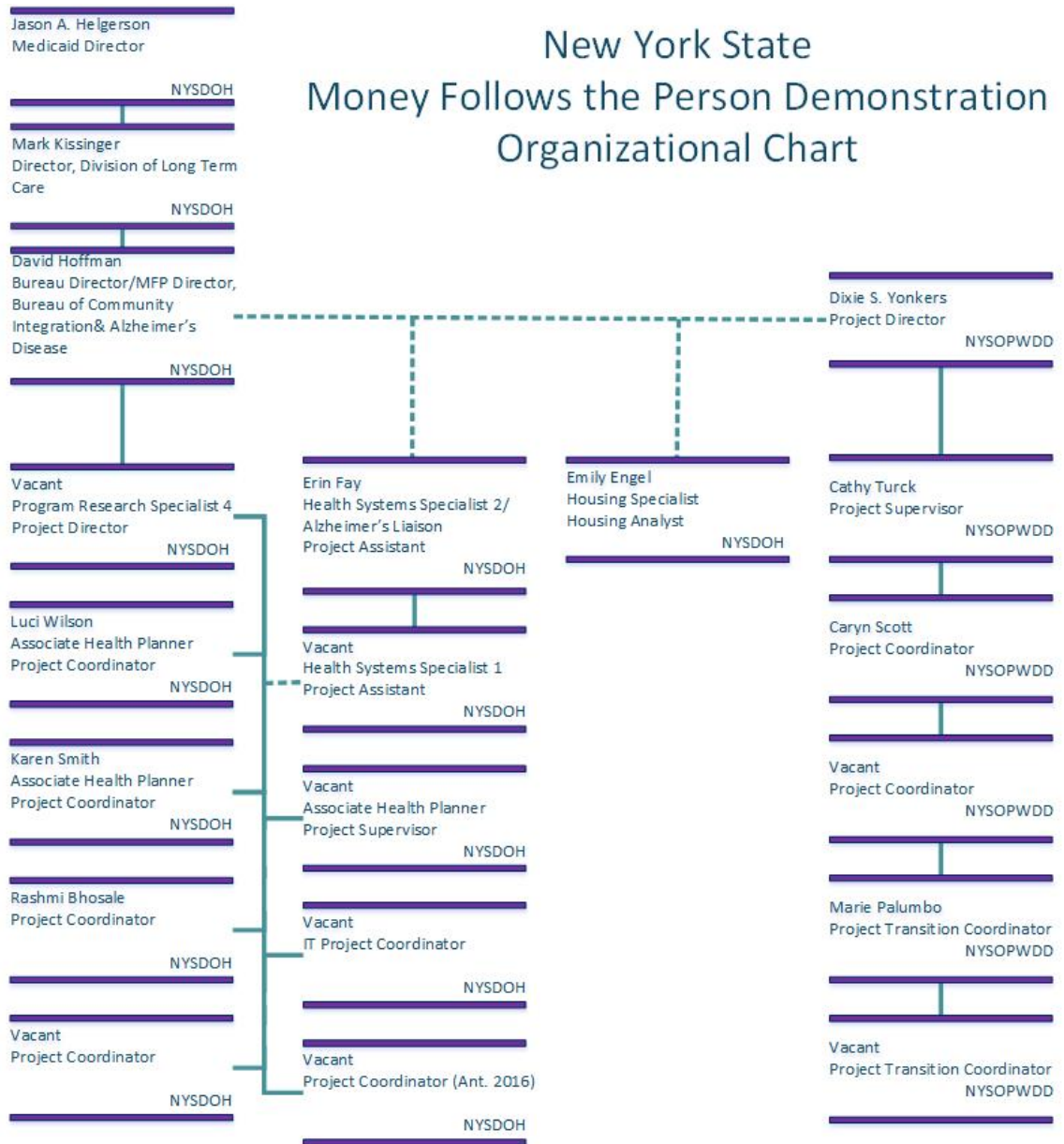
Duties: Assists in daily data collection and input in the MFP databases which are required to track utilization and expenditures for CMS. Assists with the development of systems to track MFP Demonstration participants and expenditures; and assists in the development of business requirements, analysis, systems design, and user acceptance testing, implementation, maintenance and post implementation review. Provides hands-on database training throughout the State for agency and Regional Resource Development Center (RRDC) staff managing the Traumatic Brain Injury (TBI) and Nursing Home Diversion (NHTD) waivers.

Minimum Qualifications: Bachelor's or graduate degree in Computer Science or equivalent, with six months' qualifying experience or in any field with additional 15 college level credits in computer science/data processing/program analysis and one year qualifying experience or 60 semester hours / Associate's degree or equivalent including 15 college credits of computer

science/data processing and/or program analysis courses and two years qualifying experience. Qualifying experience must include familiarity with the MFP reporting requirements and statistical methods necessary to sustain a CMS approved MFP Demonstration project as well as experience including but not limited to systems analysis including design and development of computer systems including feasibility studies, development of test data, generation of systems specifications coding, parallel testing, post install follow-up, and debugging of applications.

Preferred Qualifications: Preferred candidates should have had six months or more of experience in systems support and data management that is applicable to a CMS approved MFP Demonstration project. Candidates are preferred who have knowledge of Microsoft Access and SQL to support advanced queries. Candidates should have a working knowledge of other Microsoft Suite products including Word and Excel. Candidates should possess excellent analytic and research skills. Familiarity with Hummingbird BI Query and Bi Analyze tools a plus. Knowledge and experience in a NYS Medicaid or other public sector health care programs preferred.

Organizational Chart



Billing and Reimbursement Procedures

The state designates services provided through the Medicaid State Plan and HCBS waivers to waiver participants, and monitors billing and payment systems to insure provision of authorized service, duplication of payment, and fraud control.

DOH is the state agency responsible for monitoring payments made under the NYS Medicaid Program. As part of this responsibility, the Department's Office of Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the eMedNY provider manuals.

18 NYCRR 517.3(b) (2) states, "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department, the Secretary of the United States Department of Health and Human Services, the Medicaid Fraud Control Unit or NYSDOH for audit and review. . . ."

To ensure the integrity of provider claims for Medicaid payment of waiver services, the OMIG will conduct audits of waiver providers as part of the agency's fiscal audit plan. All waiver providers are subject to audits performed by the OMIG. The frequency of audit of waiver providers will be dictated by overall audit demands and audit resources available to the OMIG. These providers will be targeted via Data Warehouse (eMedNY) monitoring and provider profiling which will identify claiming patterns that appear suspicious or aberrant. The DOH waiver staff and the Regional Resource Development Specialist may also recommend providers to be audited and reviewed. In addition, an audit will be requested if issues such as questions about staff qualifications, record keeping, etc., are discovered during a provider survey.

As with any Medicaid service, the costs of waiver services that are the responsibility of a third party must be paid by that third party. If a waiver participant has a third-party insurance coverage, he/she is required to inform the Local Department of Social Services of that coverage. Waiver service billing is the same as all Medicaid billing. Claims will be subject to the same adjudication process, which involves prepayment edits for third party billing.

If a waiver participant has third party coverage in the system and a provider tries to submit a bill to Medicaid prior to billing the third party, an edit will prevent the provider from receiving payment. If it was found that a claim was paid prior to the input of third party insurance information, the State will pursue retroactive recovery of funds from the potentially liable third party insurance.

The flow of billing goes from the waiver provider directly to the State's claims processing system, eMedNY. In the eMedNY system, the reimbursement for the services provided are tested against whether the waiver service: was provided to a Medicaid recipient who has been approved for this waiver, has the right rate code, and if waiver provider has been approved to provide the billed service.

The Medicaid provider is responsible for ensuring the accuracy of appropriate Medicaid data, such as the Medicaid provider ID, Medicaid recipient ID, that the service was provided to an approved waiver participant and the rate code for the services provided.

When the payment claim is submitted to eMedNY there are a series of edits performed that ensures the validation of the data. Some of the edits include whether the waiver participant is Medicaid eligible; whether the individual was enrolled in the waiver program; and, whether the Service Providers are enrolled waiver service providers. Confirmation of the edit test ensures that a participant is eligible for waiver services and verifies that the participant was eligible on the date the service was provided. All waiver claims paid through eMedNY will be subject to all the common payment integrity edit tests, as well as those specific to waiver transactions.

To ensure that claims will meet the essential test that billed waiver services have actually been provided to waiver participants, the OMIG conducts waiver provider audits to verify that all Medicaid claims for reimbursement are supported with a record of the services including:

- Name of participant;
- Date of Service;
- Staff performing the activity and time and attendance records;
- The start and end time of each session;
- A description of the activities performed during the session; and
- The participant's service goal plans that are being worked on and the participant's progress toward attaining those goals.

Furthermore, as part of the claim submission process, providers must sign a Claim Certification Statement which includes certification that services were furnished and records pertaining to services will be kept for a minimum of six years.

The Explanation of Medical Benefits (EOMB) process is designed to verify with waiver participants that services billed by providers were actually delivered. eMedNY provides waiver participants with an EOMB and instructions to be used as a means of communicating any discrepancies as it relates to the services billed by the waiver providers. An EOMB can be produced for all, or for a random sample of participants who received services. They can also be produced for specific participants, participants who received services from a specified provider, or participants receiving services related to a specified procedure or formulary code. The population of participants who receive EOMBs is dictated by a set of user specified criteria.

Staff may also validate billed services through a Participant Satisfaction Survey during which participants are asked about their experience with the services that they have received. Responses to the Survey are shared with staff that follow up on areas of concerns and may request a financial audit to verify the validity of billed services.

Payments for non-medical services (such as Community Transitional Services, Assistive Technology purchases, Environmental Modifications, Moving Assistance, etc.) will also be processed in eMedNY. Each specific payment will be based on the tasks performed or the equipment or parts provided. DOH has instituted a variety of mechanisms to ensure that claim

amounts are accurate and valid. DOH has assigned separate rate codes for the amount of dollars for each of these services to track the amount/cost of each service that is provided. This allows the waiver provider to bill the specific number of units that reflects the cost for these services.

4. Evaluation of Demonstration

At this time, New York State is not planning to conduct an independent evaluation of its MFP Demonstration but reserves the right to do so in the future.

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5. Final Budget

Please see Attachment A for the most recently completed Demonstration Supplemental Budget Request.

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