NEW YORK STATE DEPARTMENT OF HEALTH

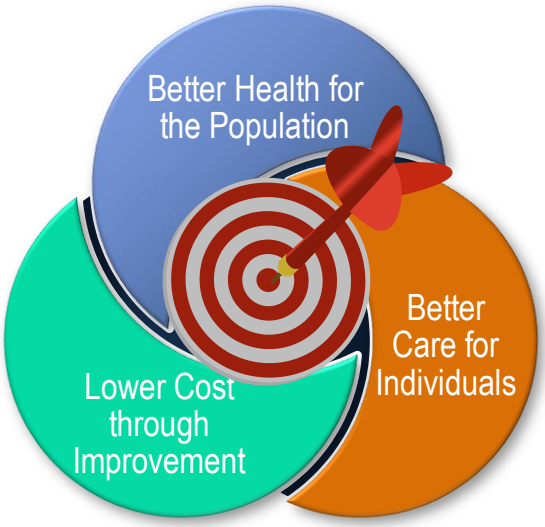
PARTNERSHIP PLAN MEDICAID SECTION 1115 DEMONSTRATION (NO. 11-W-00114/2)

INTERIM EVALUATION REPORT

SEPTEMBER 11, 2012

EXECUTIVE SUMMARY

New York State Department of Health (the Department or NYSDOH) has experienced great success with its current Medicaid Section 1115 Waivers (Partnership Plan and F-SHRP) and is seeking an extension of the Partnership Plan Waiver in order to continue to realize improvements in access, quality and cost effectiveness, consistent with CMS and New York State's Triple Aims.



The current Waivers have achieved remarkable results in support of the major goals:

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

Measures of success for each of the major components of the Partnership Plan Waiver have been documented and are discussed in this Interim Evaluation Report.

MEDICAID MANAGED CARE

- 12.6 percent increase in enrollment from 2010 to 2012.
- 84 percent of eligible Medicaid recipients enrolled as of October 2010.
- 98 percent of the national quality benchmarks have been met.
- PCPs per 1,000 enrollees increased from 4.54 to 4.79 from 2010 to 2011.
- Without the Waiver in place, projected expenditures would have been 225 percent higher for TANF children and 157 percent higher for TANF adults.
- For the three year period 2009 to 2012, Medicaid Managed Care under the Waiver will yield of $20.4 billion for TANF children and $5.4 billion for TANF adults.

FAMILY HEALTH PLUS

- 11 percent increase in enrollment from 2010 to 2012.
- 85 percent of national quality benchmarks exceeded.
- Without the Waiver in place, projected expenditures for Family Health Plus adults with children would have doubled.

FAMILY PLANNING BENEFIT PROGRAM

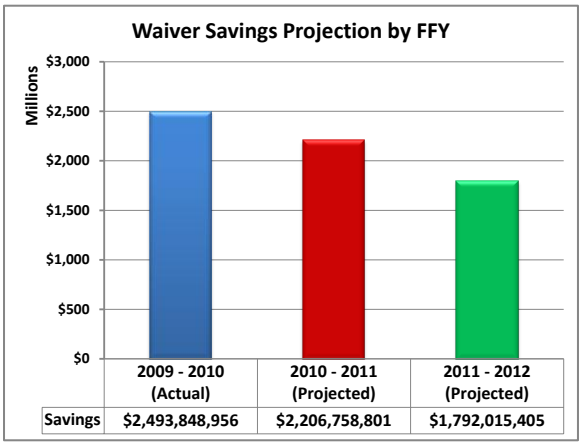
- 61 percent increase in enrollment 2009 to 2012.
- Reduction in unintended pregnancies.

HOME AND COMMUNITY BASED SERVICES EXPANSION

- Enrollment increase experienced in Nursing Home Transition and Diversion, Traumatic Brain Injury and Long Term Home Health Care Demonstrations.
- Due to the recent implementation of the demonstrations, quality and cost efficiency improvements cannot yet be measured.

BUDGET NEUTRALITY

The Partnership Plan Waiver has achieved budget neutrality and realized significant savings. Net Waiver savings for the three year period is projected to be $6.5 billion as shown in the graph below.



NEXT STEPS

In addition to continuing the current, successful Demonstrations, and implementing all aspects of the Medicaid Redesign Team Action Plan, New York State will introduce additional Demonstrations, including:

- Implement mandatory managed long term care for dual Medicaid and Medicare eligible adults who require home and community based services for greater than 120 days.
- Implement the Hospital-Medical Home program.
- Test strategies to reduce potentially preventable readmissions.

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

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LIST OF ACRONYMS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CHPlus	Child Health Plus
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DHSP	Designated State Health Programs
DOH	Department of Health
DY	Demonstration Year
EQRO	External Quality Review Organization
ESHI	Employer Sponsored Health Insurance
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FHPlus	Family Health Plus
FHP-PAP	FHPlus Premium Assistance Program
FHPBI	FHPlus Buy-In
FPBP	Family Planning Benefit Program
FPL	Federal Poverty Level
F-SHRP	Federal-State Health Reform Partnership
H-MH	Hospital-Medical Home
HCBS	Home and Community-Based Services
IPRO	Island Peer Review Organization
LTHHCP	Long Term Home Health Care Program
MCO	Managed Care Organization
MCP	Managed Care Plan
MEG	Medicaid Eligibility Group
MEQC	Medicaid Eligibility Quality Control
MLTC	Managed Long Term Care
MMC	Medicaid Managed Care
MMCARP	Medicaid Managed Care Advisory Review Panel
MMIS	Medicaid Management Information System
MRT	Medicaid Redesign Team
NCQA	National Committee on Quality Assurance
NHTD	Nursing Home Transition and Diversion
NYS	New York State
OHIP	Office of Health Insurance Programs
PCCM	Primary Care Case Management
PCP	Primary Care Physician or Primary Care Provider
PCMH	Patient Centered Medical Home
PDF	Portable Document Format
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PPR	Potential Preventable Readmission
QARR	Quality Assurance Reporting Requirements
RFA	Request for Application
SCHIP	State Children's Health Insurance Program
SCP	Specialty Care Provider
SEIU	Service Employees International Union
SN	Safety Net
SNP	Special Needs Plan
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury

1.0 INTRODUCTION

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

This report briefly describes the history of New York State's Partnership Plan Demonstration and the degree to which the Demonstration goals and objectives have been achieved and/or key activities have been implemented. The report summarizes the Demonstration's progress, performance and accomplishments to date. The report concludes with a brief overview of "next steps" in implementation of newly approved components of the Waiver.

1.1. Background/Purpose

The Department is in the process of submitting a request for an additional extension of New York's Partnership Plan Medicaid Section 1115 Demonstration (Project No. 11-W-00114/2) to the Centers for Medicare and Medicaid Services (CMS). The current Partnership Plan Demonstration is scheduled to expire on December 31, 2014, with some components ending on December 31, 2013 and others on March 31, 2014.

The State believes that the waiver extension will prepare it to fully implement the health care reforms contained in the Affordable Care Act (ACA). While the ACA presents a number of challenges, it provides the potential for the State to significantly decrease the number of people without health insurance and improve overall population health among New Yorkers of all incomes. The State estimates that more than one million New Yorkers will gain access to health insurance – many for the first time, under the ACA. The State faces numerous financial and operational challenges in preparing its health care system to meet the challenges of providing high quality care to an additional population of newly enrolled individuals seeking medical care. Targeted re-investment of savings from the State's Medicaid reform initiatives are imperative to ensure that the State's health care delivery system is capable of meeting the needs of all New Yorkers.

In addition to reforms related to the ACA, New York has developed a comprehensive Action Plan to restructure and improve its Medicaid Program. In 2011, Governor Andrew M. Cuomo established a Medicaid Redesign Team (MRT) which brought together stakeholders and experts from throughout the State to work cooperatively to reform the State's Medicaid system in order to improve the quality of care and to reduce overall Medicaid spending. The MRT created the most sweeping Medicaid reform plan in State history. The State believes that extension of the Partnership Plan Waiver will allow for successful

implementation of the MRT Action Plan, which includes a comprehensive set of quality and cost reform initiatives. It is anticipated that full implementation of the MRT Action Plan will require five years.

New York State plans to use waiver funds to launch new partnerships and to test new models of care that have a high potential for replication throughout New York and in other localities across the nation. The State strongly believes the current extension is necessary in order to provide the State sufficient time to implement the full MRT Action Plan. Key goals of the Action Plan are as follows:

- Providing high quality primary care options.
- Strengthening the health care safety net.
- Providing health care to the 1.7 million New Yorkers who will still be uninsured after implementation of the ACA.
- Reducing health disparities.
- Transitioning Medicaid enrollees to care management and putting an end to the uncoordinated fee-for-service (FFS) Medicaid model.

The Department believes that the quality improvements and savings achieved through the Partnership Plan's care management strategies will expand quality health care coverage to hundreds of thousands of vulnerable, low-income New Yorkers while lowering the overall cost of the State's publically-financed health care system.

1.2. Methods

In preparing this interim report, IPRO reviewed the following source materials:

- Partnership Plan Medicaid Section 1115 Annual Reports for Federal Fiscal Year (FFY) 2008-2009, FFY 2009-2010, and FFY 2010-2011.
- Partnership Plan Medicaid Section 1115 Quarterly Reports for FFY 2011-2012:
  - October 2011-December 2011,
  - January 2012-March 2012, and
  - April 2012-June 2012.
- Application for Extension, New York State Medicaid Section 1115 Demonstration, March 31, 2009.
- Application for Extension (Draft), New York State Medicaid Section 1115 Demonstration (as of August 29, 2012).

- Medicaid Managed Care and Family Health Plus MCO Contract Surveillance Tool, Revised October 2007; NYSDOH, Office of Health Insurance Programs (OHIP), Division of Managed Care and Program Evaluation.
- CMS 372 Report, Annual Report on Home and Community Based Services Waivers, submitted by the NYSDOH, February 2012.
- Primary Care/Specialty Care Participation Rate Report, NYSDOH, Division of Health Plan Contracting and Oversight, Calendar Years 2009, 2010, and 2011.
- Family Planning Benefit Program Expenditure Report, NYSDOH, OHIP DataMart, December 2011.
- Managed Care Plan Performance: A Report on the Quality, Access to Care, and Consumer Satisfaction (QARR); NYSDOH, 2008, 2009, 2010, and 2011.
- Demographic Variation in Medicaid Managed Care, NYSDOH, 2011.
- Managed Care Access and Utilization Report, NYSDOH, 2009, 2010, and 2011.
- CAHPS® 4.0 Adult Medicaid Survey, Medicaid Managed Care Program, NYSDOH, April 2010
- New York State Medicaid Redesign Team Waiver Amendment, NYSDOH, 2012.
- Partnership Plan Evaluation, Program Evaluation of Medicaid Section 1115 Waiver Program – Final Report, Delmarva Foundation, January 2010.
- Managed Long Term Care Plan Member Satisfaction Survey Report, IPRO, September 2011.
- The State of Health Quality, 2011, National Committee for Quality Assurance, 2011.
- New York State Partnership Plan: Budget Neutrality Impact Analysis October 2009 through September 2012, NYSDOH, September 7, 2012.

IPRO reviewed the following websites:

- http://www.health.ny.gov/health_care/managed_care/consumer_guides/
- http://www.health.ny.gov/health_care/managed_care/reports/docs/medicaid_satisfaction_report.pdf
- http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm
- http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2011/docs/qarr2011.pdf
- http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/

- http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm
- http://www.health.ny.gov/health_care/managed_care/reports/docs/2009_pip_abstract_compendium_final.pdf
- http://www.ncqa.org/tabid/836/Default.aspx

IPRO consulted with senior managers and staff in the following NYSDOH organizational units:

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

1.3. Partnership Plan Waiver History

In July 1997, New York State received approval from CMS (formerly the Health Care Financing Administration) for its Partnership Plan Medicaid Section 1115 Demonstration. The Partnership Plan Demonstration was originally authorized for a five year period and has been extended several times, most recently through December 31, 2014. The primary purpose of the initial Demonstration was to enroll most of the State's Medicaid population into managed care. There have been a number of the modifications to the Partnership Plan Demonstration since the initial 1997 approval. Significant changes are described in the subsections that follow.

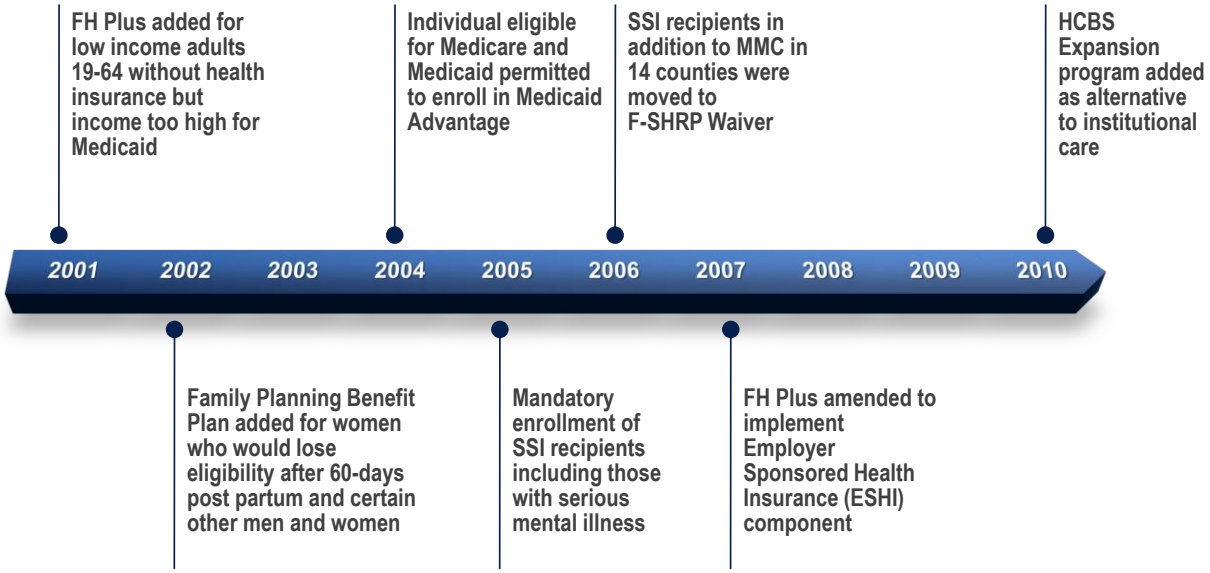
1.3.1. 2001 to 2010 Coverage and Program Expansions

Changes in coverage and program expansions between 2001 and 2010 are listed below followed by a summary shown in Figure 1-1: Summary of Coverage and Program Changes.

- 2001 - Family Health Plus (FHPlus) was added for low income adults between the ages of 19 and 64 who do not have health insurance, but have incomes too high to qualify for Medicaid.
- 2002 - Family Planning Expansion Program (also referred to as the Family Planning Benefit Program) was added to provide family planning services to women who would lose eligibility at the conclusion of their 60-day postpartum period, and to certain other men and women. (It is anticipated that this program will be moved out of the Partnership Plan and into the State Plan on November 1, 2012.)
- 2004 – An amendment permitted individuals eligible for Medicare and Medicaid to enroll in Medicaid Advantage.

- 2005 – Mandatory enrollment of the Social Security Income (SSI) population began and was expanded to include those with serious mental illness.
- 2006 – SSI recipients and new enrollees in 14 counties were moved to the Federal-State Health Reform Partnership (F-SHRP) Waiver.
- 2007 – FHPlus was amended to implement an employer-sponsored health insurance component.
- 2010 – The Home and Community-Based Services (HCBS) Expansion program was added to provide in-home and community-based services to certain adults with significant medical needs as an alternative to institutional care.

Figure 1-1: Summary of Coverage and Program Changes



1.3.2. 2011 Waiver Renewal and Demonstration Enhancements

In 2011, CMS approved renewal of the Partnership Plan Demonstration for the period August 1, 2011 through December 31, 2014. (As noted in the following discussion, some Partnership initiatives will expire prior to December 2014 to reflect implementation of the ACA). The 2011 renewal added three new components to the State's Partnership Plan:

- A ***Hospital-Medical Home (H-MH) initiative*** to provide funding and performance incentives to hospital teaching programs to improve the coordination, continuity and quality of care to individuals receiving primary care in outpatient hospital settings.
- The ***Potentially Preventable Readmission (PPR) initiative*** which will reduce the rate of re-hospitalizations.
- An ***Indigent Care Pool*** to fund the State's program to cover uncompensated care.

1.3.3. Medicaid Redesign Team Related Amendments

- In September 2011, March 2012, and August 2012, CMS approved three additional amendments, representing five key changes, to the Partnership Plan in order to incorporate the following key features of the Governor's MRT proposals:
  - Individuals were given 30 days to select a managed care organization (MCO) before automatic assignments were made.
  - Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for the MCO can continue with that sub-specialist for six months.
  - Exemptions/exclusions were eliminated for: people temporarily living outside their social services district, pregnant women receiving prenatal care from a provider that does not participate in any managed care plan, people with a language barrier, people without a Primary Care Physician (PCP) choice within 30 minutes/30 miles, people in mental health family care, the homeless, non-dually eligible people with end stage renal disease (ESRD) diagnosis, and infants born disabled or weighing less than 1200 grams.
  - Individuals who are only eligible for emergency Medicaid are exempt from Medicaid Managed Care (MMC).
  - Dual eligible Medicaid recipients, 21 years old and older, who are in need of home and community based care coordination for more than 120 days will be enrolled in Managed Long Term Care (MLTC) Programs so that they can benefit from better care coordination.

1.4. Waiver Components Expiring Prior to December 2014

As previously mentioned, some components of the current waiver will expire prior to December 2014 as follows:

- **December 31, 2013** – FHPlus, Safety Net (SN) adults, Indigent Care pool. The Family Planning Benefit Program was originally scheduled to expire at this time but will be moved into the Medicaid State Plan in November 2012.
- **March 31, 2014** – MMC Program, Medicaid Eligibility Quality Control (MEQC), Facilitated Enrollment Services, Twelve-Month Continuous Eligibility Period, HCBS Expansion Program, H-MH Demonstration, PPR Demonstration, Designated State Health Programs (DHSP).

2.0 PARTNERSHIP PLAN: IMPLEMENTATION STATUS AND ACCOMPLISHMENTS

With the original Demonstration and subsequent amendments, the Partnership Plan Demonstration currently consists of four major program components:

1. **Medicaid Managed Care** – providing Medicaid State Plan benefits through comprehensive MCOs to most recipients eligible under the State Medicaid Plan;
2. **Family Health Plus** – providing a more limited benefit package, with cost-sharing imposed, for adults with and without children with specified income;
3. **Family Planning Benefit Program** – provided to men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period; and
4. **Home and Community-Based Services Expansion** – providing an expansion of three 1915(c) waiver programs by eliminating a barrier to financial eligibility to receive care at home.

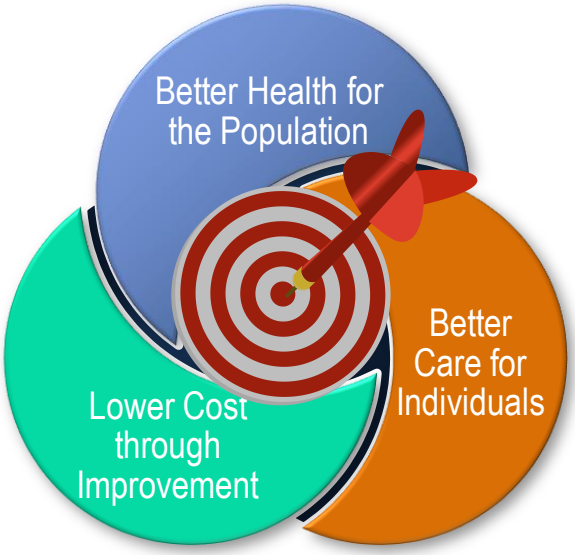
The State's goal in implementing the Partnership Plan is to improve the health status of low income New Yorkers by improving access to health care in the Medicaid program, improving the quality of health services delivered and expanding coverage to additional low income New Yorkers. Through the original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

- Improve access to health care for the Medicaid population.
- Improve the quality of health services delivered.
- Expand coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The Triple Aim of the Demonstration, as illustrated in Figure 2-1: The MRT Triple Aim, is to:

- ***Improve the Quality of Care***
- ***Improve Population Health***
- ***Reduce Per Capita Costs***

Figure 2-1: The MRT Triple Aim



Program Initiative goals are addressed and achieved by:

- Implementing a Managed Care Delivery System to deliver benefits.
- Creating efficiencies in medical programs.
- Extending coverage to individuals otherwise not eligible.
- Implementing FHPlus to provide health coverage to adults with incomes above the State Plan eligibility standards.
- Implementing FHPlus with an ESHI component.

Medicaid reform must also mean health care system reform. The Department plans to achieve this by breaking down traditional delivery silos through new models of care such as Accountable Care Organizations (ACOs), hospital/nursing home partnerships that better manage transitions in care, telehealth initiatives, and new approaches that integrate physical and behavioral health services.

2.1. Medicaid Managed Care Program

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

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

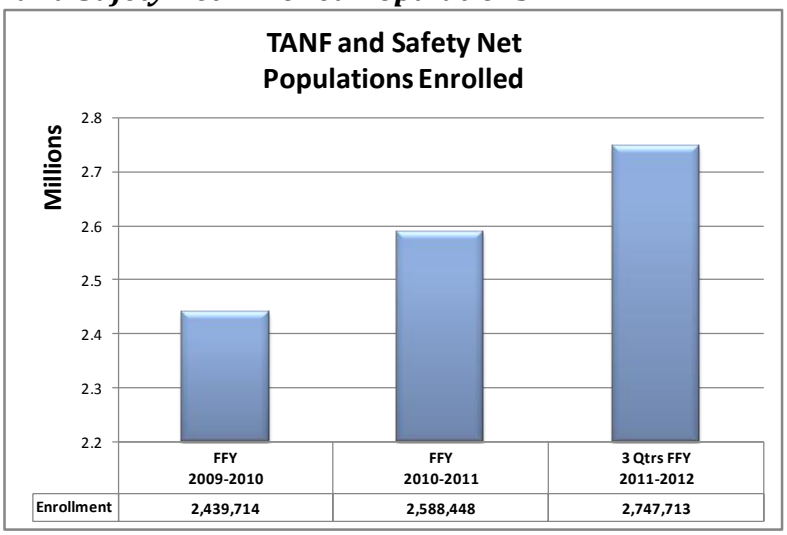
2.1.1. Accomplishments: Coverage and Access

The MMC program accomplishments in the area of coverage and access include increased enrollment, expansion of mandatory enrollment and increased penetration rates.

2.1.1.1. Increased Enrollment

As of June 2012, there were 2,747,713 people enrolled in the State's Medicaid Managed Care program under the Partnership Plan Waiver.[1] From September 2010 through June 2012, enrollment in the MMC program has increased by 12.6 percent or more than 300,000 beneficiaries statewide, as shown in Figure 2-2: TANF and Safety Net Enrolled Populations.

Figure 2-2: TANF and Safety Net Enrolled Populations



2.1.1.2. Mandatory Enrollment Expanded

Geographic coverage of mandatory enrollment expanded to 57 of the State's 62 counties. The Partnership Plan was implemented in October 1997 using a geographic phase-in strategy. Today, all but five upstate counties have instituted mandatory Medicaid Managed Care programs. By the end of 2012, all counties in New York State are expected to be operating mandatory programs.

[1] This figure only includes individuals enrolled through the Partnership Plan Waiver. It does not include all Medicaid beneficiaries enrolled in MCOs, such as those enrolled through the F-SHRP Waiver.

2.1.1.3. Penetration Rate

As of October 2010, the penetration rate of eligible Medicaid recipients enrolled in managed care was 84 percent statewide (88 percent in New York City and 77 percent in the rest of the State).

2.1.2. Accomplishments: Quality

The MMC program accomplishments include improved quality and improved PCP to enrollee ratios.

2.1.2.1. Improved Quality

The quality of health care delivery in New York, as measured by nationally recognized indicators of quality, and improvement on over time.

Quality of care and member satisfaction for each certified MCO plan is measured using national benchmarks such as the 2011 National Committee on Quality Assurance (NCQA) benchmarks. (See Attachment I. Medicaid Managed Care QARR/National Benchmark comparison 2007 & 2010).

In 2010, New York met or exceeded 98 percent of the national benchmarks.

- Thirty-six of the NCQA measures are included in the State's Quality Assurance Reporting Requirements (QARR).
- A comparison of the QARR 2007 and 2010 benchmarks show that performance increased on 75 percent of the measures between 2007 and 2010.
- Only seven of the 2010 measures were lower than in 2007.
- All QARR measures of access to care improved between 2007 and 2010.

Annual required External Quality Review Organization (EQRO) Performance Improvement Projects (PIPs) are conducted by IPRO.

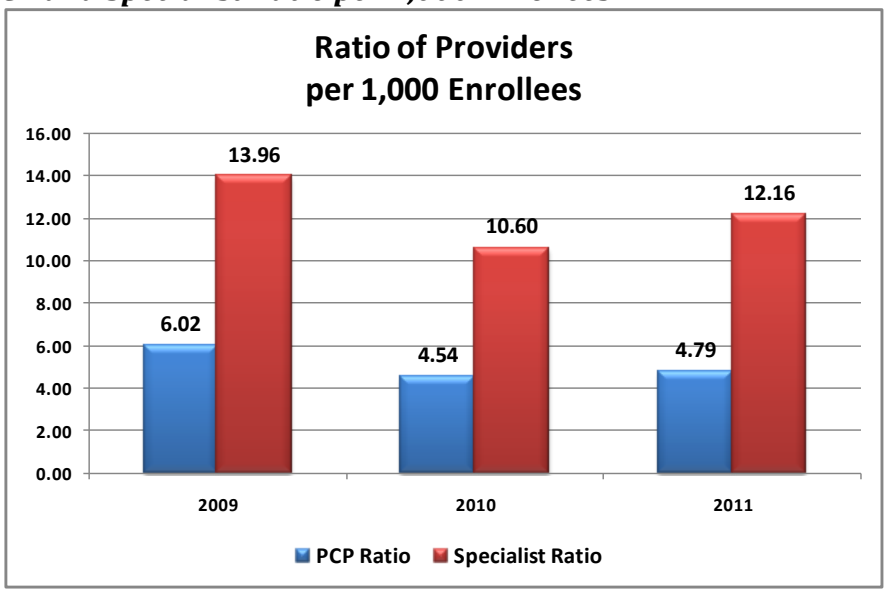
2.1.2.2. PCP to Enrollees Standard Exceeded

The State's MMC program exceeded the standard of one PCP for every 1,500 enrollees for the period 2009 through 2011. New York's MMC program uses a variety of mechanisms to assess the overall adequacy and capacity of the MMC network. The provider network data, health plan reports and health plan network physicians' reports were reviewed and appeared to be accurate. Reports reviewed reflect continued compliance and ability to support enrollment based on a standard of one PCP for every 1,500 enrollees.

2.1.2.3. PCP to Enrollee Ratio Increased

The PCP to 1,000 enrollee ratio increased from 4.54 in 2010 to 4.79 in 2011 while the specialty physician ratio per 1,000 enrollees increased from 10.60 to 12.16 in the same period, as shown in Figure 2-3: PCP and Specialist Ratio per 1,000 Enrollees.

Figure 2-3: PCP and Specialist Ratio per 1,000 Enrollees



The total participation level of PCPs and specialty care physicians (SCPs) in Medicaid Managed Care is nearly twice the number that participated in the Medicaid FFS program.

The decrease in the ratio of PCPs per 1,000 enrollees from 6.02 in 2009 to 4.54 in 2010 is likely explained by the large increase in the number of enrollees – including MMC, FHPlus, FFS, Children's Health Insurance Program (CHIP) and SSI populations – from 2009 to 2010 of 32.2 percent, from 2.85 million to 3.77 million. At the same time, the number of PCPs stayed the same at about 17,000. Therefore, the ratio of PCPs to enrollees dropped. In the following year, 2011, enrollment decreased by 8.2 percent to 3.5 million enrollees while again the number of PCPs stayed flat at about 17,000. Therefore, the ratio of PCPs to 1000 enrollees rose to 4.79. Across the same period, the same pattern occurred for specialist physicians.[2]

Increasing the number of qualified physicians participating in the Medicaid program continues to be an important objective of the Partnership Plan Demonstration. The Department carefully monitors physician participation in both Medicaid MCOs and the Medicaid fee-for-service program. In recent years, the Department has taken significant steps to increase physician participation in the Medicaid program. For example, in 2009, the State increased physicians' fees by 80 percent over the 2007 levels. In August 2012, the State awarded $2,052,383 in grants under the Doctors Across New York (DANY) program, which assists in the training and placement of physicians in rural and inner-city areas where a shortage of health care providers has been identified.[3]

[2] NYSDOH, Office of Health Insurance Programs, August 20, 2012.
[3] More information about the increase in physician reimbursement can be found at: http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/presentations/vendor-7_22_2009.pdf.

2.1.2.4. Consumer Access to Information

The state has provided consumers with access to information that supports informed choice. A Medicaid Managed Care Regional Consumer Guide has been prepared for each region of the State and is distributed to members. Reports for each region can be accessed online at http://www.health.ny.gov/health_care/managed_care/consumer_guides/.

2.1.2.5. Enrollee Satisfaction

In general, Medicaid beneficiaries enrolled in managed care report satisfaction with their care and experiences. Members who received care from their PCPs were the most satisfied. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is a comprehensive tool designed to assess consumers' experience with health care and health plans. CAHPS® is the survey instrument that asks health plan members about experiences with access to care, health care providers and health plans. The Department sponsors a CAHPS® survey every other year for the Medicaid Managed Care plans and uses the results to determine variations in member satisfaction among the plans. [4]

2.1.2.6. Stakeholder Engagement

The State has established regular processes and forums for stakeholder engagement. The State uses a variety of methods to monitor plan operations, identify issues, resolve problems and explore program improvements including a variety of periodic stakeholder coalition meetings.

- The State provides continued technical assistance to providers and training to both providers and their own staff.
- Meetings of the Managed Care Operational Issues Workgroup are held routinely. This Workgroup was convened to serve as an open forum for the discussion and clarification of operational issues related to Medicaid Managed Care.
- There is a Medicaid Managed Care Advisory Review Panel (MMCARP) appointed by the Governor and the New York State legislature that meets regularly. This Panel was established to assess and evaluate multiple facets of the MMC Program, including provider participation and capacity, enrollment targets, phase-in of mandatory enrollment, the impact of marketing, enrollment and education strategies, and the cost implications of exclusions and exemptions.
- Input from stakeholders is continually cultivated through webinars, conference calls and surveys. The State conducts bi-annual onsite operational surveys of the MCOs and focused surveys are conducted for each MCO at regular intervals each year. (See

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The press release announcing the DANY grant awards can be found at http://www.health.ny.gov/press/releases/2012/2012-08-30_state_health_department_award.htm.

[4] The results of the 2010 Survey can be found at http://www.health.ny.gov/health_care/managed_care/reports/docs/medicaid_satisfaction_report.pdf. The 2012 Plan-level surveys are available at http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2012/index.htm.

Attachment III. New York State Department of Health Comprehensive MCO Operational Survey Questions). The most frequent category of complaints relates to billing issues.

2.1.2.7. Policy Changes Implemented

The State has implemented a number of policy changes to improve quality and efficiency.

- **Eliminated funding that was included in Medicaid and FHPlus premiums for direct marketing of Medicaid recipients by managed care organizations (MCOs).** In the early implementation of the program, it was important to allow managed care organizations the ability to market directly to Medicaid recipients in order to increase the level of enrollment in managed care since enrollment in many counties was voluntary. Now, the program is mature, and those Medicaid recipients not enrolled are generally exempt or excluded from the program or reside in voluntary enrollment counties. According to the Department, marketing dollars were largely spent by health plans to attract members of other plans and not specifically focused on enrolling the uninsured. In addition, as more counties have been included in mandatory enrollment, recipients have been required to enroll or be auto-assigned into an MCO, which greatly reduces the need for marketing.
- **Extension of mandatory managed care enrollment to Medicaid beneficiaries with HIV/AIDS.** One quarter (or 9,375) of all Medicaid Managed Care eligible HIV positive beneficiaries were voluntarily enrolled in either a mainstream MCO or one of three HIV Special Needs Plans (SNPs) that serve the metropolitan New York area. Of the estimated 52,000 Medicaid beneficiaries with HIV currently residing in NYC, 15,000 are excluded from Medicaid Managed Care due to their status as dually eligible for Medicare and Medicaid or because they are nursing home residents or meet other exclusion criteria. The State's decision to require mandatory managed care enrollment for HIV positive beneficiaries is consistent with the goals of the Partnership Plan. According to the Department, fourteen years of data demonstrated that Medicaid beneficiaries enrolled in MCOs receive better quality care than those in FFS Medicaid. and studies of those who voluntarily enrolled in managed care have shown a steady improvement in quality of care and improvement in chronic care disease management for those in Medicaid MCOs.
- **Establishment of twelve months continuous coverage.** In support of the State's efforts to simplify Medicaid eligibility rules for consumers and eligibility workers in local departments of social services, revisions were made to Chapter 58 of the New York State Social Services Law in 2007 to provide continuous coverage for certain Medicaid beneficiaries and FHPlus enrollees for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. Simpler eligibility rules help meet the State's goal of ensuring that all children and eligible adults have access to, enroll in, and remain enrolled in affordable health insurance coverage.
- **Ongoing design and implementation of quality improvement initiatives.** In 2012, notable illustrations of the State's continuing efforts to improve quality of care

and health outcomes for Medicaid beneficiaries include the Hospital-Medical Home and the Potentially Preventable Readmissions Demonstrations.

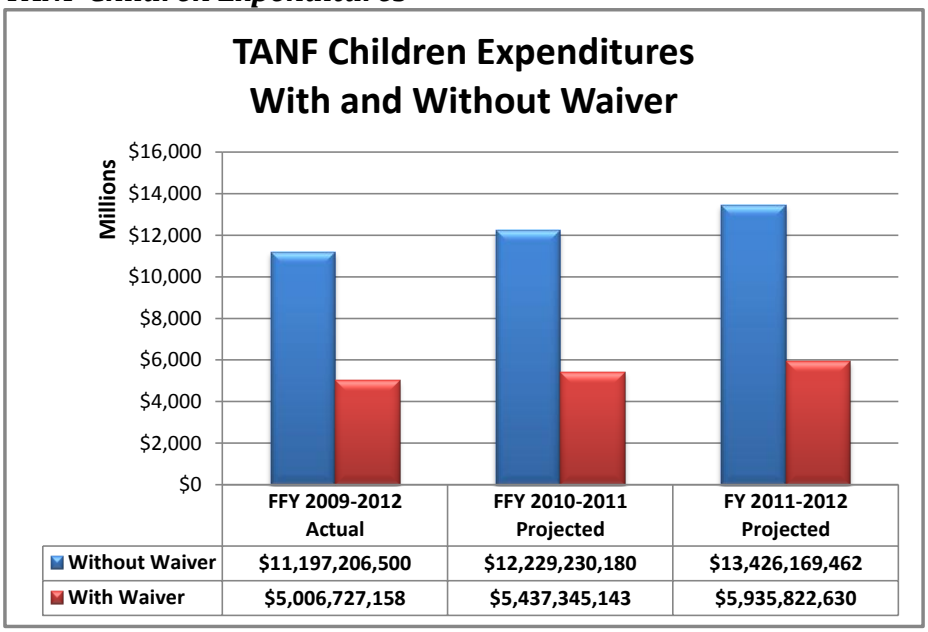
2.1.3. Accomplishments: Cost

To review the cost effectiveness of the MMC program, the evaluation compared program expenditures With Waiver to expenditures for these populations Without Waiver. (See section 2.5.1 for an explanation of With Waiver and Without Waiver). This method was applied to both TANF children and TANF adults.

2.1.3.1. Expenditures for TANF Children With Waiver Reduced

For TANF children, expenditures without the waiver would have been 225 percent greater than with the waiver. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded $20.4 billion in projected savings, as shown in Figure 2-4: TANF Children Expenditures.

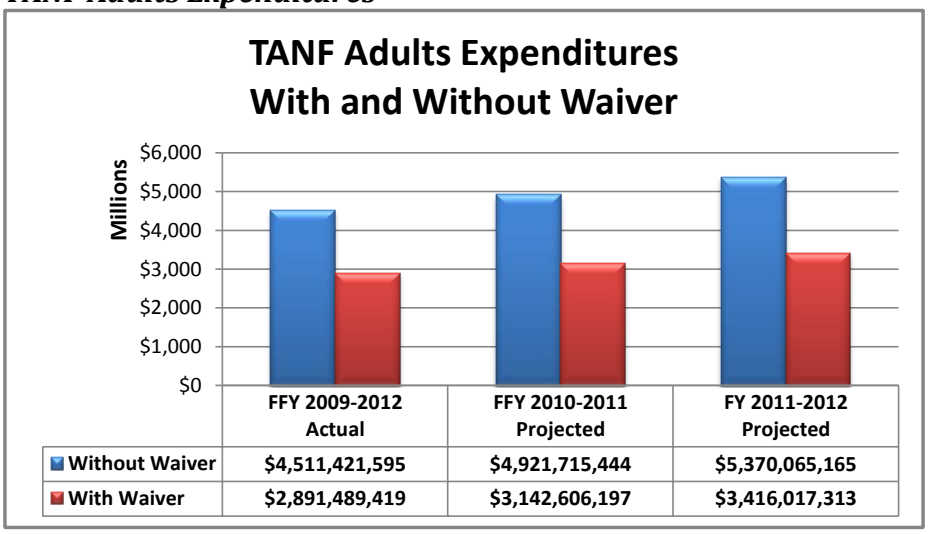
Figure 2-4: TANF Children Expenditures



2.1.3.2. Expenditures for TANF Adults With Waiver Reduced

For TANF adults, expenditures without the waiver would have been nearly 157 percent greater than with the waiver. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded $5.4 billion in projected savings, as shown in Figure 2-5: TANF Adults Expenditures.

Figure 2-5: TANF Adults Expenditures



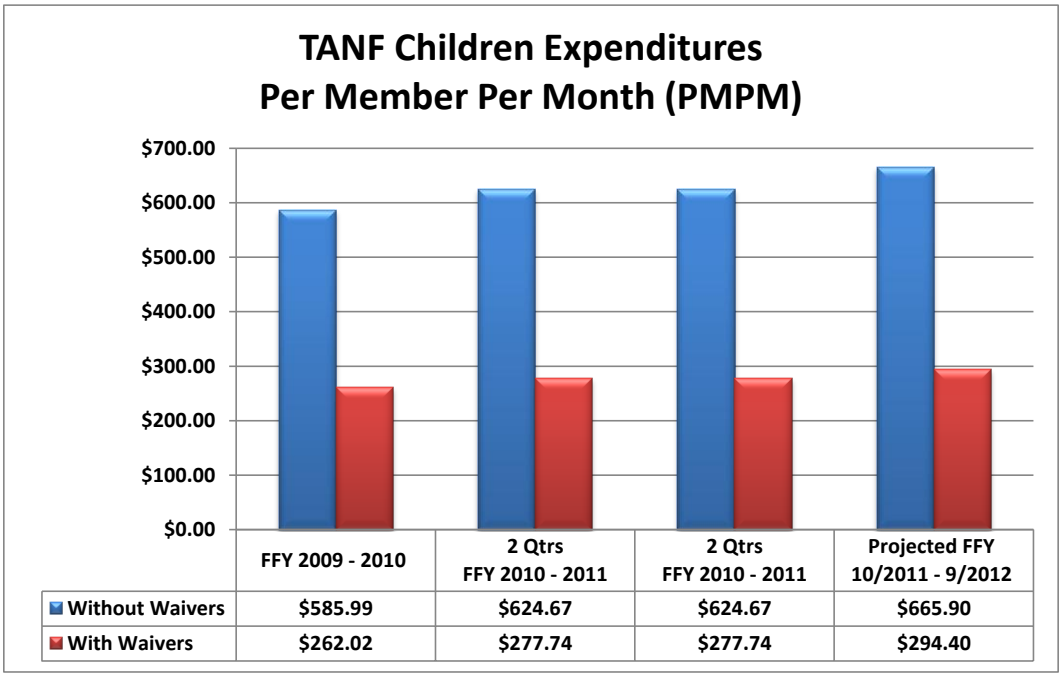
	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected
Without Waiver	$4,511,421,595	$4,921,715,444	$5,370,065,165
With Waiver	$2,891,489,419	$3,142,606,197	$3,416,017,313

NYSDOH, Office of Health Insurance Programs, August 20, 2012.

2.1.3.3. PMPM Payments With Waiver Reduced

The difference between per member per month (PMPM) payments with the waiver and without the waiver is consistent with the analysis of program expenditures as a whole. For example, PMPM payments for TANF children without the waiver were 225 percent greater than with the waiver, as shown in Figure 2-6: TANF Children PMPM.

Figure 2-6: TANF Children PMPM



	FFY 2009 - 2010	2 Qtrs FFY 2010 - 2011	2 Qtrs FFY 2010 - 2011	Projected FFY 10/2011 - 9/2012
Without Waivers	$585.99	$624.67	$624.67	$665.90
With Waivers	$262.02	$277.74	$277.74	$294.40

2.1.3.4. MMC Demonstration Highly Successful

Taking these two populations together, total savings for the three year period FFY 2009-2010 through FFY 2011-2012 are projected to be $25.8 billion. From a cost effectiveness standpoint, the MMC Demonstration has been highly successful.

2.2. Family Health Plus

Family Health Plus (FHPlus), enacted by the State legislature in December 1999 and approved by CMS in May 2001, is a public health insurance program for adults who are aged 19 to 64 who have income too high to qualify for Medicaid. The primary objective of the FHPlus program is to improve access to care.

FHPlus is available to single adults, couples without children, and parents who are residents of New York State and are United States citizens or fall under one of many immigration categories. FHPlus is provided through participating MCOs and provides comprehensive coverage, including prevention, primary care, specialty care, hospitalization, prescriptions and other services. There are minimal co-payments for some FHPlus services. In July 2011, CMS approved an amendment to the Partnership Plan that increased the income eligibility standard for adults with children from 150 percent to 160 percent of the FPL. However, in light of the federal policy changes in the ACA, the State has postponed implementation of the increased eligibility standards indefinitely.

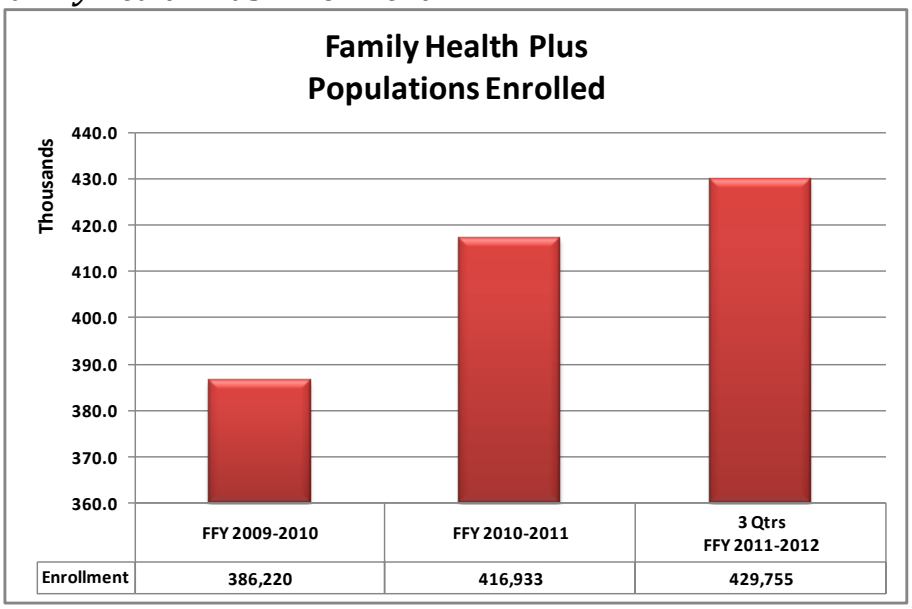
2.2.1. Accomplishments: Coverage and Access

The FHPlus program accomplishments in the area of coverage and access include an expansion of coverage, simplified eligibility and growth in enrollment in the ESHI initiative.

2.2.1.1. Family Health Plus Resulted in Significant Expansion of Coverage

FHPlus has resulted in a significant expansion of coverage to previously uninsured and underinsured New Yorkers. The current program enrollment is 430,000. In the last three years program enrollment has increased more than 11 percent. The growth in enrollment is illustrated in Figure 2-7: Family Health Plus Enrollment.

Figure 2-7: Family Health Plus Enrollment



Note: Enrollment figures are for the two Demonstration populations (eligible adults with children and adults without children) for the period FFY 2009-2010 through the first three quarters of FFY 2011-2012.

2.2.1.2. Impact of Simplified Medicaid Eligibility Process

The State attributes the more recent growth in enrollment to policy changes that have simplified the Medicaid eligibility process. For example:

- In January 2010, the State eliminated the resource test for FHPlus applicants.
- In 2011 the Pharmacy benefit was added and local jurisdictions were required to submit monthly listings of cases that meet review criteria.

2.2.1.3. Enrollment in FHP-PAP Program has Grown

To further increase coverage rates among uninsured but employed New York State residents with access to private insurance, State legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative (ESHI). This initiative, called the FHPlus Premium Assistance Program (FHP-PAP) helps low-income workers who are eligible for the regular FHPlus Program to access insurance offered by their employers, and to help the State recognize the savings that could be achieved by maximizing use of private, employer sponsored insurance coverage. Enrollees in FHP-PAP are also entitled to the services that FHPlus covers but are not covered by the ESHI plan – including dental services and prescription drugs, if determined to be cost effective. These services are referred to as "wrap around benefits." FHPlus eligible individuals that have access to ESHI are required to enroll in FHP-PAP. Adults in this program use ESHI as their primary insurance policy. The State will reimburse any deductibles and co-pays to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under FHPlus.

Enrollment in the ESHI program has also grown fairly rapidly from 1,800 to 3,080 in the period from FFY 2009-2010 through the first three quarters of FFY 2011-2012.[5] Over the three years under review, the FHP-PAP program is projected to have expended $10,537,200.

2.2.1.4. Significant Enrollment in FHPlus Buy-In Initiative

United Federation of Teachers and the NYS Office of Children and Family Services contracted with FHPlus to provide health insurance coverage to 25,000 licensed and registered child care providers and workers on a buy-in basis. The premium for eligible child care workers is paid by the State. The Civil Service Employees Association also received legislative authority and appropriations to provide health insurance coverage through the FHPlus Buy-In (FHPBI) program.

In February 2009, an estimated 47,500 individuals were enrolled in the FHPBI program. Service Employees International Union (SEIU) 1199 employees originally participated, but left the Buy-In program in the first quarter of FFY 2011-2012.

2.2.2. Accomplishments: Quality

The FHPlus program accomplishments in the area of quality are confirmed by complaint information and QARR data.

2.2.2.1. Impact of Waiver on Customer Complaints

According to the Department's Annual and Quarterly reports, customer complaints appear to be limited and generally are related to billing issues.

2.2.2.2. FHPlus Plans and QARR Data

A comparison of the national HEDIS® quality measures to the FHPlus QARR data for 2010 indicates that FHPlus was above the national quality metric for almost 85percent of the quality measures (i.e., 21/25 measures).[6] Impressively, for several of these measures the FHPlus performance score was much greater than the HEDIS® national average. For example, the Adult BMI measure indicates that nationally Medicaid HMOs are only at 42 percent while FHPlus is at 70 percent. This large difference is also evident with COPD testing, breast cancer screening, and ambulatory follow-up for mental illness. (See Attachment II. Family Health Plus QARR/National Benchmark Comparison 2010).

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[5] Although data about cost-effectiveness of the FHP-PAP program was not obtainable, a cost effectiveness determination is required for each applicant. The first test is to confirm that the ESHI includes the eight essential "benchmark" services. If all services are included in the ESHI plan, the application proceeds to the second test. If all benchmark services are not provided, payment of this insurance is denied and the applicant is enrolled in FHPlus and referred to a participating managed care plan. For the second test, the cost effectiveness calculation accounts for the cost of the ESHI premiums, deductibles, and co-payments. The calculator will determine if the cost of the ESHI premium plus the cost of the Medicaid wrap-around services (optional services not included in the ESHI plan), deductibles and co-payments are less than the regional FHPlus managed care rates for adults and Medicaid managed care rates for eligible children.

[6] The HEDIS® data was taken from the NCQA *The State of Health Care Quality 2011*; specifically, the Medicaid HMO section which represents data from 2010.

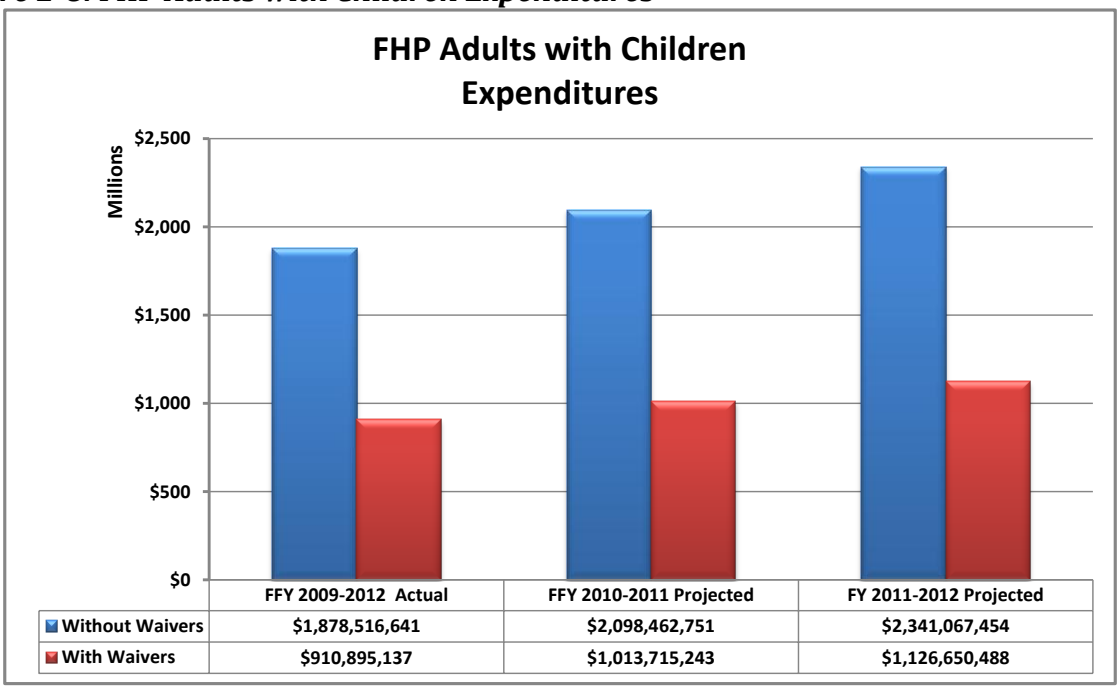
2.2.3. Accomplishments: Cost

The FHPlus program accomplishments in the area of cost are confirmed by expenditure data.

2.2.3.1. Without Waiver Expenditures Would Have Doubled

According to analysis of data provided by the NYSDOH, expenditures without the waiver would have been approximately double the expenditures with the waiver, as shown in Figure 2-8: FHP Adults with Children Expenditures.

Figure 2-8: FHP Adults with Children Expenditures



	FFY 2009-2012 Actual	FFY 2010-2011 Projected	FY 2011-2012 Projected
Without Waivers	$1,878,516,641	$2,098,462,751	$2,341,067,454
With Waivers	$910,895,137	$1,013,715,243	$1,126,650,488

2.2.3.2. FHPlus Demonstration Highly Successful

From a cost effectiveness standpoint, the FHPlus Demonstration has been highly successful. For the three year period FFY 2009-2010 through FFY 2011-2012, the waiver has yielded a projected $3.3 billion in savings.

2.3. Family Planning Benefit Program

The goal of the Family Planning Benefit Program (FPBP) is to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies.

The program is available to men and women who are otherwise not eligible for Medicaid but are in need of family planning services who have net incomes at or below 200 percent of the federal poverty level (FPL) and to women who lose Medicaid eligibility at the end of their 60-day postpartum period. Review of the program is prefaced by the fact that the

entire program is expected to be moved into the Medicaid State Plan on November 1, 2012. Transportation will be added to the FPBP benefit package when this move takes place.

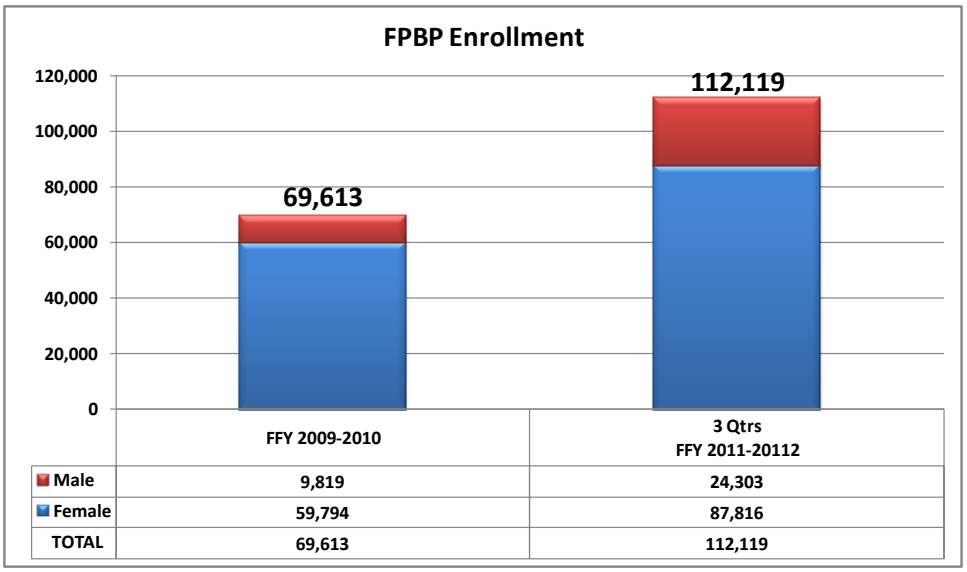
2.3.1. Accomplishments: Coverage and Access

The FPBP program accomplishments in the area of coverage and access are confirmed by growth in program participation and a reduction in unintended pregnancies.

2.3.1.1. Program Participation has Grown

FPBP participation has grown quickly from 69,613 in 2009 to 112,119 by the end of June 2012, as shown in Figure 2-9: FPBP Enrollment.

Figure 2-9: FPBP Enrollment



2.3.1.2. Unintended Pregnancies Have Been Reduced

Using a CMS methodology and 2000 as the base year, the fertility rate for FPBP enrollees is 134.7 per thousand. Based on this formula, there were 5,301 averted births in Calendar Year (CY) 2011.[7]

2.3.2. Accomplishments; Quality

While there has not been an evaluation of clinical quality that has focused specifically on the FPBP beneficiary population, the State has taken steps to ensure and improve program quality.

2.3.2.1. Program Policies, Procedures and Referral Lists are in Place

Program policies, procedures and referral lists are in place. The State has also introduced policy changes to ensure that the federal Medicaid share is claimed appropriately. For example, changes were made to procedure and billing codes in both 2008 and 2010. These

[7] NYSDOH, Office of Health Insurance Programs, August 20, 2012.

changes help to ensure that only CMS-approved family planning procedures are claimed for FPBP and that the federal share is claimed appropriately.

2.3.3. Accomplishments: Cost

The FPBP program accomplishments in the area of cost are suggested by a significant reduction in avoided delivery costs.[8]

2.3.3.1. Total Delivery Costs Avoided

As previously mentioned, the program has averted more than 5,000 births. The average cost of a Medicaid delivery in New York State in 2011 was $6,863.[9]

2.4. Home and Community-Based Services Expansion Program

The Home and Community-Based Services (HCBS) Expansion eliminated a barrier to receiving care at home posed by eligibility rules that would otherwise lead to spousal impoverishment. The Waiver allows special spousal budgeting provisions.[10] Savings realized by the Partnership Plan efficiencies offset the resulting increased costs of participation in three 1915(c) HCBS Demonstrations – the Nursing Home Transition and Diversion (NHTD) Program, the Traumatic Brain Injury (TBI) Program, and the Long Term Home Health Care Program (LTHHCP).

Without the HCBS Expansion special spousal budgeting provisions, the Department believes there would be serious disincentives to avoiding or preventing nursing home placement or returning home from a nursing home placement.

2.4.1. Accomplishments: Access and Coverage

The HCBS program accomplishments in the area of access and coverage are demonstrated by an increase in enrollment.

[8] An internal NYSDOH analysis for the five quarter period April 2011 through September 2011, found that expenditures would have been slightly lower without the Waiver. The analysis found that expenditures would have been $1.26 PMPM less without the Waiver; and for the period October 2011 through June 2012, expenditures would have been $1.72 PMPM less without the Waiver. A closer examination of this expenditure data over a longer period of time would be necessary in order to arrive at a more complete picture of the cost effectiveness of this program.

[9] NYS Department of Health, Office of Health Insurance Programs, September 6, 2012.

[10] Under normal Medicaid eligibility rules, spouses living together at home are treated as a household of two and the basic two-person income and resource standards are applied. However, under SSA § 1924, when an institutionalized person with a spouse in the community applies for Medicaid, special spousal budgeting provisions allow the community spouse to retain substantial amounts of the couple's combined income and resources. This helps prevent the community spouse, who is legally responsible for the institutionalized spouse, from becoming impoverished by exhausting all of the couple's resources to help pay for institutional care.

2.4.1.1. Access to Home and Community Based Services Increased

Approximately 1,400 Medicaid beneficiaries have gained access to home and community-based services as a result of the HCBS Demonstration. For the period FFY 2009-2010 through FFY 2011-2012, the HCBS Expansion increased program enrollment as follows: LTHHCP by 1,347 participants, NHTD by 60 participants and TBI by 3 participants.

2.4.2. Accomplishments: Quality and Cost Effectiveness

As this program is relatively new and the affected population relatively small, the State has not undertaken a comprehensive cost or quality evaluation to determine the effectiveness of this waiver component.

2.4.2.1. Per Participant Spending on Waiver Services

Annual average per participant spending on Partnership Plan Waiver services ranges from a projected $2,100 in the LTHHCP to $40,000 in the TBI program. The projected annual expenditures for each program in FFY 2011-2012 are:

- LTHHCP at $2,823,312 per year.
- NHTD at $1,461,600 per year.
- TBI at $120,024 per year.

The total expenditure for all three categories was approximately $4,404,936 per year. For the three year period, total expenditures are projected to be $13,214,808. These expenditures are summarized in Figure 2-10: HCBS Services Expansion Program Projected Enrollment and Spending, 2011.

Figure 2-10: HCBS Services Expansion Program Projected Enrollment and Spending, 2011

Waiver Program	Enrollment	Projected Annual Expenditure	Projected Total Three Years	Average Annual Expenditure Per Enrollee
Long Term Home Health Care	1,347	$2,823,312	$8,469,936	$2,096
Nursing Home Transition & Diversion	60	$1,461,600	$4,384,800	$24,360
Traumatic Brain Injury	3	$120,024	$360,072	$40,008
TOTAL	1,410	$4,404,936	$13,214,808	$3,125

Projected annual three year expenditures are for the period FFY 2009-2010 through FFY 2011-2012.

2.5. Compliance with Budget Neutrality Requirements

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

2.5.1. Partnership Plan Waiver Has Achieved Budget Neutrality and Realized Significant Savings

Available documentation strongly suggests that the Partnership Plan waiver has been successful not only in achieving budget neutrality but in realizing significant savings for the State and federal government.

The neutrality formula consists of two components: Without Waiver expenditures and With Waiver expenditures. Budget neutrality is continuously updated and monitored to ensure that the projections are current and that the waiver is budget neutral.

Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) times the trended PMPM allowance agreed to with CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

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

- TANF children under the age of 1 through age 20,
- TANF adults ages 21 through 64,
- FHPlus adults with children, and
- Family Planning Benefit Program.

A fifth eligibility group was agreed upon – FHPlus adults with children at 160 percent of the federal poverty level – but the State has postponed implementing the increase in the eligibility level indefinitely.

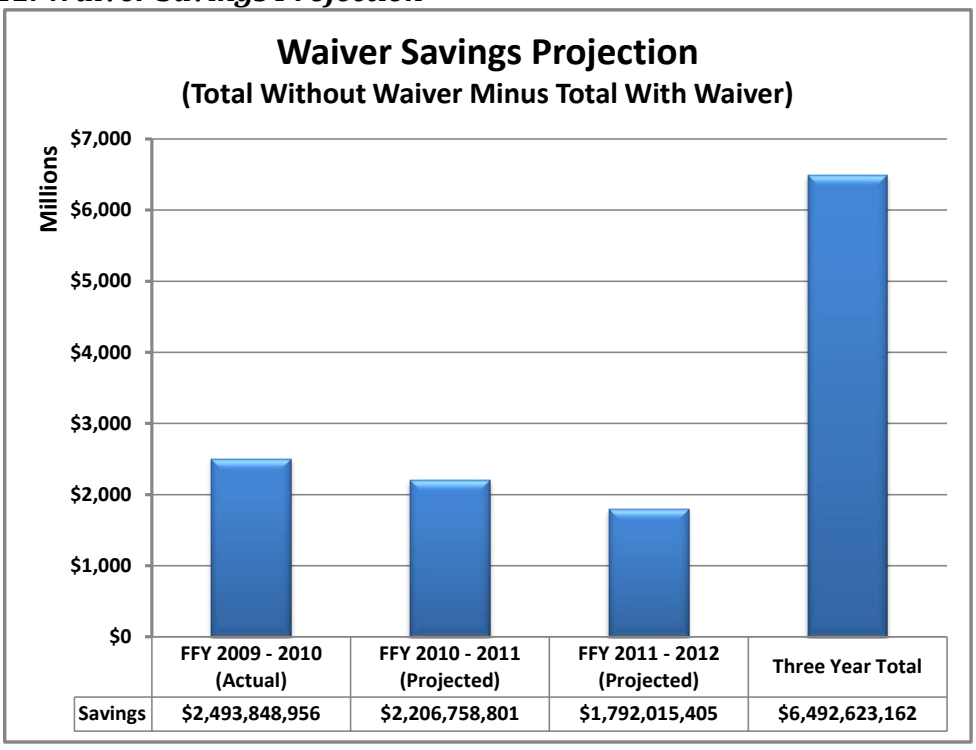
With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual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

Expenditures for the four agreed upon MEGs are included in the With Waiver calculations as well as other expenditures, including Safety Net adults, FHPlus without children, HCBS Expansion, Indigent Care Pool direct costs, Designated State Health Programs, and the newly added Managed Long Term Care program. (See Attachment IV. New York State Partnership Plan Budget Neutrality Impact October 2009 through September 2012).

2.5.2. Waiver Savings Projection

Between October 2009 and September 2012, the Department projects that the waiver will have saved $6,492,623,162.[11] After subtracting the With Waiver expenditures from the Without Waiver calculation of expenditures, the State realizes almost $6.5 billion in projected savings, as shown in Figure 2-11: Waiver Savings Projection, and pays for five more programs than are included in the Without Waiver populations.

Figure 2-11: Waiver Savings Projection



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

[11] With the permission of CMS, the State has reinvested some of the savings gleaned from some of the demonstration projects (such as MMC) in initiatives to expand access and improve quality. Thus, the net savings figures reported in this section are lower than the aggregate of savings reported for the four major programs.

3.0 CONCLUSION AND NEXT STEPS

The Partnership Plan Demonstration has played a central role in expanding health care coverage to underinsured and uninsured populations and has well prepared New York State to take a lead role in implementing federal health care reform initiatives supported by the ACA and to continue compatible efforts to expand managed care enrollment, develop innovative ways to expand health care coverage, and improve the quality of care as well as access to that care.

3.1. Summary of Key Accomplishments

Figure 3-1: Summary of Key Accomplishments presents the key accomplishments as they relate to program goals.

Figure 3-1: Summary of Key Accomplishments

DEMONSTRATION GOALS	ACHIEVED?	KEY ACCOMPLISHMENTS
Goal 1: To expand managed care enrollment	✓	▪ MMC enrollment increased by 12.6 percent between October 2009 and June 2012
Goal 2: To improve health care access for Medicaid beneficiaries in New York	✓	▪ PCP ratio increased from 4.54 in 2010 to 4.79 in 2011 per 1,000 enrollees while specialty physicians ration per 1,000 enrollees increased from 10.6 to 12 in the same period. ▪ All QARR measures of access to care improved between 2007 and 2010.
Goal 3: To continue to improve the quality of care	✓	▪ State measures met or exceeded national measures in 2010 NCQA QARR, and state 2010 scores largely exceeded state 2007 scores.
Goal 4: Expanded Health Care Coverage	✓	▪ FHPlus and FHP-PAP combined enrollment increased by 11.6 percent between October 2009 and June 2012
Waiver Requirement: Budget Neutrality	✓	▪ The budget neutrality analysis for the period FFY 2009-2010 through FFY 2011-2012 shows that the Partnership Plan Waiver accrued projected savings to both the State and federal Medicaid programs of approximately $6.5 billion.

Building on these key accomplishments, the State is taking further steps to improve access, quality and cost efficiency in the Medicaid Program as described in the sections that follow.

3.2. Next Steps

Projects related to the following programs are in the initial implementation phase. Therefore, more detailed analysis of program activities, performance and progress is not available at this time.

- Medicaid redesign ongoing implementation.
- Managed long term care for dual eligibles.
- Hospital-Medical Homes to Improve Primary Care Quality, Continuity and Coordination.

- The Preventable Readmissions Demonstration.

As part of the waiver extension process the Department plans to continue monitoring the success of the Partnership Plan Demonstration on measures of access, quality and cost.

3.2.1. Medicaid Redesign Ongoing Implementation

Governor Cuomo created the Medicaid Redesign Team (MRT) in January 2011 with the express purpose of putting together a multi-year action plan that would improve patient outcomes and lower program costs. After months of work the team finalized the action plan and the State is now implementing that plan. To achieve fiscal discipline, the MRT recommended a new multi-year Medicaid Global Spending Cap. The cap, which applies to the State share of Medicaid spending controlled by the Department of Health, is now State law.

The plan's second major tenet is that the primary way to improve patient outcomes and lower costs is effective care management. The MRT made the historic recommendation that the State phase-out the uncoordinated FFS program and replace it with a new system of *care management for all*. This new system will rely on a variety of health plans, new models of care and integrated delivery systems that will eventually provide fully-integrated managed care for all Medicaid members. It will take New York State between three to five years to fully implement the State's care management vision. While New York State has administered a managed care program for more than twenty years many of the State's highest need/highest cost populations have been excluded.

In addition to contracting with health plans, the MRT also recommended that the State invest in provider level care management strategies such as Patient Centered Medical Homes (PCMHs) and Health Homes. While full capitation can help better align incentives so as to reward value over volume, there is a clear need to drive provider level cooperation and meaningful improvement in service provision at the point of care. New York State is now on a path to ensure that all Medicaid members enjoy the benefits of high quality primary care through nationally accredited PCMHs and that every high need/high cost Medicaid member is enrolled in a Health Home.

The State's vision for a new proposed MRT waiver amendment is to reinvest federal dollars that will prepare the State for the ACA requirements as well as maximize the value of key ACA provisions. Health care reform must be about improving quality, improving health and reducing per capita costs. The State believes that the proposed MRT waiver amendment will allow New York State to address all three goals in a coordinated fashion while also fulfilling the promise laid out in the ACA. The requested extension to the Partnership Plan Demonstration will provide the venue to support the implementation of the proposed MRT amendment.

3.2.2. Managed Long Term Care for Dual Eligibles

Critical to advancing one of the MRT's primary objectives is the creation of a managed long term care (MLTC) Demonstration for dual eligible Medicaid recipients, 21 years old and

older, who are in need of home and community based care for more than 120 days. To achieve these objectives, the Department developed an MLTC mandatory enrollment process. Stakeholders from every sector including consumers have been engaged in this effort. Lessons learned from Partnership Plan Demonstrations of county by county mandatory Medicaid Managed Care enrollment over the last decade are essential for carrying out this endeavor. This transition is expected to facilitate:

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

The Department is initially targeting FFS Personal Care Program recipients residing in New York City for MLTC enrollment.

The program will also target new recipients in need of community based long term care. Implementation will occur first in local jurisdictions that have sufficient choice of managed long term care plans. While individual voluntary choice of an MLTC plan is preferred, the Department has the authority to assign persons who do not make a choice of plans. Specific populations and programs, such as the NHTD waiver, the TBI waiver and Assisted Living Program participants will be transitioned into the MLTC plans once appropriate waiver services are incorporated into the MLTC model.

3.2.3. Hospital-Medical Homes to Improve Primary Care Quality, Continuity and Coordination

The Hospital-Medical Home (H-MH) Demonstration is designed to improve primary care quality, continuity and coordination with other providers that Medicaid patients receive at hospital outpatient departments and primary care settings that are used to train resident physicians. The Department is finalizing the review process and a funding allocation methodology for making awards.

3.2.4. Potential Preventable Readmissions

The Potential Preventable Readmissions (PPR) Demonstration is designed to provide competitive grants to hospitals and/or collaborations of hospitals and other providers to develop strategies to reduce the rate of preventable readmissions related to medical or behavioral health conditions. To date the Department has developed an outline for a Request for Applications (RFA) and will begin the internal department approval process. The Department anticipates announcing the RFA in the spring of 2013.

Attachment I

MEDICAID MANAGED CARE QARR/NATIONAL BENCHMARK COMPARISON 2007 & 2010

Medicaid Managed Care QARR/National Benchmark Comparison 2007 & 2010

Eighteen Medicaid Managed Care plans submitted 2010 QARR data in June 2011. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for QARR 2007 and 2010 are displayed in the following table and compared with the NCQA HEDIS National benchmark measures for 2010 Medicaid HMOs in the NCQA The State of Health Care Quality 2011. As indicated by **green** shading, NYS Medicaid Managed Care average exceeded the national benchmarks for 39 of 42 measures (**gray** cells indicate that national benchmarks were not available). **Yellow** shading indicated NYS' average was equal to national benchmarks, while **blue** shading indicated NYS' average was below national benchmarks. Medicaid plans submitted 2011 data in June 2012. Data is being finalized and NCQA's report with national benchmarks for 2011 data is expected in October 2012. 2007 data was taken from the March 2009 Partnership Plan Request for Extension).

Measure	2007 NYS Medicaid Managed Care Average	2010 NYS Medicaid Managed Care (MMC) Average	National HEDIS 2010 Medicaid HMO Average*	2010 MMC Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	88	92	88	✓
Children and Adolescents' Access to PCPs Ages 12-24 months	95	96	96	
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	90	93	88	✓
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	93	95	90	✓
ADHD Continuation	59	64	44	✓
ADHD Initiation	53	58	38	✓
Adolescents' Assessment or Counseling or Education- Substance Use		60		
Adolescents' Assessment or Counseling or Education- Depression	53	52		
Adolescents' Assessment or Counseling or Education- Sexual Health	73	60		
Adolescents' Assessment or Counseling or Education- Tobacco Use	76	64		
Adults' Access to Care Age 20-44 Yrs	80	82		
Adults' Access to Care Age 45-64 Yrs	87	89		
Adults' Access to Care Age 65 and over	88	89		
Adult BMI Assessment (ABA)		70	42	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	77	84	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	60	70	45	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	29	35	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	46	52	51	✓
Drug Therapy in Rheumatoid Arthritis	74	76	70	✓
Use of Appropriate Asthma Medications (Ages 12-50)		88	86	✓
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers		77		
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers		76		
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers		76		
Use of Appropriate Asthma Medications (Ages 5-11)		92	92	
Use of Appropriate Asthma Medications (Ages 5-50)		90	88	✓
Use of Imaging Studies for Low Back Pain	81	79	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	27	27	24	✓

Measure	2007 NYS Medicaid Managed Care Average	2010 NYS Medicaid Managed Care (MMC) Average	National HEDIS 2010 Medicaid HMO Average*	2010 MMC Measures Above the National Average
Cervical Cancer Screening		72	67	✓
Chlamydia Screening (Ages 16-20)	53	67	55	✓
Chlamydia Screening (Ages 16-24)		68	62	✓
Chlamydia Screening (Ages 21-24)	60	69	58	✓
Annual Dental Visit(Ages 2-18)		54		
Annual Dental Visit(Ages 2-21)	48	53		
Frequency of Ongoing Prenatal Care 81-100%		74	61	✓
Controlling High Blood Pressure (Ages 18-85)		67	56	✓
HIV/AIDS Comprehensive Care- Engaged in Care		80		
HIV/AIDS Comprehensive Care- Syphilis Screening Rate		58		
HIV/AIDS Comprehensive Care- Viral Load Monitoring		58		
HBreast Cancer Screening	68	68	51	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	85	91	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	65	67	68	
Annual Monitoring for Patients on Persistent Medications- Combined	84	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	91	94	90	✓
Annual Monitoring for Patients on Persistent Medications- Diuretics	84	90	86	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	77	85	82	✓
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	50	66	65	✓
Appropriate Testing for Pharyngitis	73	84	65	✓
Postpartum Care		73	64	✓
Timeliness of Prenatal Care		90	84	✓
Use of Spirometry Testing for COPD	40	46	31	✓
Appropriate Treatment for URI	89	91	87	✓
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	81	80	72	✓
Adolescent Well-Care Visits	58	56	48	✓
5 or More Well-Child Visits in the First 15 Months of Life	79	77	76	✓
Weight Assessment for Children and Adolescents		65	37	✓
Weight Counseling for Nutrition for Children and Adolescents		71	46	✓
Weight Counseling for Physical Activity for Children and Adolescents		58	37	✓

SS - sample size less than 30

N/A - not applicable to the product

**National benchmarks from NCQA's 2011 State of Health Care Quality report*

Attachment II

FAMILY HEALTH PLUS QARR/NATIONAL BENCHMARK COMPARISON 2010

Family Health Plus QARR/National Benchmark Comparison 2010

The NYSDOH provided IPRO with Family Health Plus (FHPlus) data disaggregated from the full Medicaid Managed Care plan QARR data. IPRO constructed the following table to represent a comparison of the national HEDIS quality measures to the FHPlus data for the same time frame; 2010. As indicated in the final column of the table below, FHPlus was above the national quality metric for almost 85 percent of the measures (i.e., 21/25 measures).[12] Impressively, for several of these measures FHPlus was largely improved over the HEDIS measures. For example, the Adult BMI measure indicates that nationally Medicaid HMOs are only at 42 percent while FHPlus is at 70 percent. This large difference is also evident with COPD, breast cancer screening, and ambulatory follow-up for mental illness. For the few measures that are not above the national metric, NYS was within four percentage points with the exception of adolescent well-care visits at a seven percent difference. It is clear that there are areas for which NYS is performing well above the nation on many measures and might now focus on those few measures where there is room for improvement within FHPlus for the state.

As indicated by **green** shading, FHPlus measures exceeded 21 of the 25 comparable HEDIS National Benchmarks (**gray** cells indicate that national benchmarks were not available). **Blue** shading indicated NYS' average was below national benchmarks.

Measure	2010 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2010 Medicaid HMO Average*	FHPlus Measures Above the National Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	NA	88	
Children and Adolescents' Access to PCPs Ages 12-24 months	NA	96	
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	NA	88	
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	NA	90	
ADHD Continuation	NA	44	
ADHD Initiation	NA	38	
Adolescents' Assessment or Counseling or Education- Substance Use	NA		
Adolescents' Assessment or Counseling or Education- Depression	NA		
Adolescents' Assessment or Counseling or Education- Sexual Health	NA		
Adolescents' Assessment or Counseling or Education- Tobacco Use	NA		
Adults' Access to Care Age 20-44 Yrs	NA		
Adults' Access to Care Age 45-64 Yrs	NA		
Adults' Access to Care Age 65 and over	NA		
Adult BMI Assessment (ABA)	70	42	✓
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	83	64	✓
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	70	45	✓
Antidepressant Medication Management-180 Day Effective Phase Treatment	38	34	✓
Antidepressant Medication Management-84 Day Acute Phase Treatment	54	51	✓

[12] The HEDIS data was taken from the NCQA *The State of Health Care Quality 2011*; specifically, the Medicaid HMO section which represents data from 2010.

Measure	2010 NYS Family Health Plus (FHPlus) Managed Care Average	National HEDIS 2010 Medicaid HMO Average*	FHPlus Measures Above the National Average
Drug Therapy in Rheumatoid Arthritis	76	70	✓
Use of Appropriate Asthma Medications (Ages 12-50)	90	86	✓
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers	80		
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers	NA		
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers	NA		
Use of Appropriate Asthma Medications (Ages 5-11)	NA	92	
Use of Appropriate Asthma Medications (Ages 5-50)	NA	88	
Use of Imaging Studies for Low Back Pain	78	76	✓
Avoidance of Antibiotics for Adults with Acute Bronchitis	28	24	✓
Cervical Cancer Screening	75	67	✓
Chlamydia Screening (Ages 16-20)	NA	55	
Chlamydia Screening (Ages 16-24)	66	62	✓
Chlamydia Screening (Ages 21-24)	NA	58	
Annual Dental Visit(Ages 2-18)	NA		
Annual Dental Visit(Ages 2-21)	43		
Frequency of Ongoing Prenatal Care 81-100%	77	61	✓
Controlling High Blood Pressure (Ages 18-85)	68	56	✓
HIV/AIDS Comprehensive Care- Engaged in Care	84		
HIV/AIDS Comprehensive Care- Syphilis Screening Rate	51		
HIV/AIDS Comprehensive Care- Viral Load Monitoring	53		
HBreast Cancer Screening	73	51	✓
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	90	86	✓
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	64	68	
Annual Monitoring for Patients on Persistent Medications- Combined	89	84	✓
Annual Monitoring for Patients on Persistent Medications- Digoxin	89	90	
Annual Monitoring for Patients on Persistent Medications- Diuretics	88	86	✓
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	79	82	
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	75	65	✓
Appropriate Testing for Pharyngitis	NA	65	
Postpartum Care	77	64	✓
Timeliness of Prenatal Care	92	84	✓
Use of Spirometry Testing for COPD	55	31	✓
Appropriate Treatment for URI	NA	87	
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	NA	72	
Adolescent Well-Care Visits	41	48	
5 or More Well-Child Visits in the First 15 Months of Life	NA	76	
Weight Assessment for Children and Adolescents	NA	37	
Weight Counseling for Nutrition for Children and Adolescents	NA	46	
Weight Counseling for Physical Activity for Children and Adolescents	NA	37	

SS - sample size less than 30

N/A - not applicable to the product

**National benchmarks from NCQA's 2011 State of Health Care Quality report*

Attachment III

NEW YORK STATE DEPARTMENT OF HEALTH
COMPREHENSIVE MCO OPERATIONAL SURVEY QUESTIONS
ATTACHMENT L-7

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

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

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

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

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

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

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

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

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

73. When more information is needed to render a determination, does the MCO request necessary information prior to making an adverse determination or upholding an appeal?	4903.5(c) 4905.11 4408-a(3)(c) 98-2.9(b) MMC/FHP Contract App F.1 (2)(a) [42CFR 438.210 (b)(2)(ii)] F.1 (3)(c)(ii) F.2(4)(a)(iii)(B) F.2(10)
74. Does the MCO notify enrollees and providers when services are authorized?	4903.2 4903.3 MMC/FHP Contract App F.1(2)(iv)
75. **Medicaid Advantage Only:** Upon issuing an Organization Determination and Notice of Action, does the MCO offer enrollees a choice of Medicare or MMC appeal processes?	MA Advantage Contract App F.1 (2)(c)
76. Do providers have the ability to request timely reconsideration of a UR adverse determination of a service they recommended?	4903.6 4903.5
77. Does the enrollee have the ability to file standard appeals of adverse determinations?	4904.3 4903.5 MMC/FHP Contract App F.2(3)(a)(i), (ii), (iii) and (iv) F.2(10)
78. Does the enrollee and/or the enrollee=s health care provider have the opportunity to engage in an expedited appeal?	4904.2 (a) and (b) 4903.5(b) 98-2.9 (e)(f) 98-1.14 (c) MMC/FHP Contract App F.2(3), (4), (10)
79. **Medicaid Only:** Does the enrollee have the ability to review their case file and present evidence to support his/her appeal?	MMC/FHP Contract App F.2(3)(a)(iv)
80. Does the MCO adequately cover emergency services?	4902.1(c),(h) 4903.4 4903.5 4904.1 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(2)
81. Does the MCO adequately cover the provision of post-stabilization care and inpatient admissions resulting from an ER visit? b) How does the MCO facilitate the transfer of patients from non-participating to participating hospitals after stabilization?	4902.1(d) 4902.1(h) 4903.3 4903.6 4905.11 4905.13 98-1.13(a) MMC/FHP Contract App G(3), (4)

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

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

94. **For all applicable MCOs, including Medicaid only with less than 10,000 enrollees:** Does the MCO have provisions for in-service training programs for investigative, claims, quality, UM and other personnel with periodic refreshers?	98-1.21(b)(9) MMC/FHP Contract Section 23.1 (42 CFR Part 438.608)
95. Does the MCO have a Fraud and Abuse Awareness program?	98-1.21(b)(13)
96. Does the MCO have a fraud and abuse detection manual that is available to its employees?	98-1.21(b)(14) Section 1902(a) of the Social Security Act
97. If the MCO accepts paper claim forms, other than standardized federal claim forms such as the HCFA1500, do such forms include appropriate c warning statement against fraudulent acts?	98-1.22(a), (b)

Attachment IV

NEW YORK STATE PARTNERSHIP PLAN
BUDGET NEUTRALITY IMPACT
OCTOBER 2009 THROUGH SEPTEMBER 2012,
NYSDOH, SEPTEMBER 6, 2012.

New York State Partnership Plan

Projected 1115 Waiver Budget Neutrality Impact Through December 2013

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,426,169,462
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,370,065,165
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271
Demonstration Group 10 - MLTC Adult Age 18-64 Duals					$247,394,784
Demonstration Group 11 - MLTC age 65+ Duals					$2,554,212,091
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$23,949,611,226**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Group 1 - TANF Children under age 1 through 20		$5,006,727,158	$2,714,708,527	$2,722,636,616	$5,935,822,630
Demonstration Group 2 - TANF Adults 21-64		$2,891,489,419	$1,575,447,496	$1,567,158,701	$3,416,017,313
Demonstration Group 5 - Safety Net Adults		$5,947,064,577	$3,499,710,446	$3,596,498,109	$8,302,164,325
Demonstration Group 6 - FHP Adults w/Children up to 150%		$910,895,137	$503,870,306	$509,844,937	$1,126,650,488
Demonstration Group 7 - FHP Adults without Children up to 100%		$327,279,755	$168,015,728	$171,374,962	$383,180,812
Demonstration Group 6A - FHP Adults w/Children @ 160%		$0	$0	$0	$0
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$3,699,108	$3,699,108
Demonstration Group 10 - MLTC Adult Age 18-64 Duals					$249,276,515
Demonstration Group 11 - MLTC age 65+ Duals					$2,561,508,288
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)				$2,600,000	$14,650,000
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)				$2,600,000	$14,650,000

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)				$0	$133,400,000
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)				$0	$5,000,000
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,792,015,405**