New York State
Federal-State Health Reform Partnership
Final Report

NYS Department of Health
6-30-2014

Table of Contents

Primary References:

1. **F-SHRP Annual and Quarterly Reports - 2008-2014**
2. **F-SHRP Phase-out Plan, November 27, 2013**
3. **F-SHRP Transition Report, April - June 2013**
4. **IPRO Interim Evaluation Report, March 20, 2014**

Attachments:

(1) Exclusions and Exemptions from MMMC
(2) Exclusions and Exemptions from MLTC
(3) Budget Neutrality –separate document

New York State's Federal-State Health Reform Partnership Final Report

Please Note:

Rockefeller Institute of Government – State University of New York is conducting a comprehensive final evaluation of the Federal-State Health Reform Partnership and will be addressing many of the sections below in more quantitative and qualitative detail.

I. Executive Summary

The Federal-State Health Reform Partnership (F-SHRP) demonstration was approved by Centers for Medicare & Medicaid Services (CMS) on September 29, 2006. The F-SHRP demonstration provided federal financial support for a health reform program in New York that addressed the state's need to modernize its acute and long-term care infrastructure, increase capacity in primary and ambulatory care, and make investments in health information technology. The demonstration also allowed the state to enroll certain Medicaid populations into managed care on a mandatory basis: aged, blind and disabled individuals statewide, and children, caretaker relatives, and pregnant women in selected counties.

New York State's Federal-State Health Reform Partnership Medicaid Section lll5 Demonstration (11-W-00234/2) expired on March 31, 2014. This document is the Final Report for the F-SHRP demonstration as required by Special Terms and Conditions (STC) Number 50, explaining the disposition of the populations remaining in the F-SHRP, the Designated State Health Programs (DSHPs), the 12-month continuous eligibility groups, health system reforms, and the closeout costs associated with terminating the demonstration.

The populations that were included in the F-SHRP consist of Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) recipients. With the expiration of F-SHRP, these populations have transitioned into the New York State's Partnership Plan Medicaid Section 1115 Demonstration (11-W-00114/2). The eligibility and benefits for these populations were equal to those afforded them while under the F-SHRP Demonstration. As of November 2012, Mandatory Medicaid Managed Care programs are operating in all counties of the state, including New York City.

On November 27, 2013, an F-SHRP Phase-Out Plan was submitted. The focus was on transitioning F-SHRP populations into the Partnership Plan and addressing continuation or expiration of other F-SHRP components. The Phase-Out Plan has been implemented in accordance with STC requirements. The disposition of the populations in the F-SHRP, Designated State Health Programs continue to be under discussion with CMS, the12 month continuous eligibility were successfully transitioned to the 1115 Partnership Plan. The closeout costs associated with terminating the demonstration are addressed in this final report.

The New York State Department of Health (Department) recently submitted a completed application to CMS to request an extension of the Partnership Plan. This request is to extend the authority to continue existing programs, which include those transitioned from F-SHRP and to incorporate new health care reform initiatives as negotiated with CMS.

II. Introduction

Under F-SHRP, the federal government invested up to $1.5 billion over the life of the Demonstration to: focus on health care reform initiatives; promote the efficient operation of the state's health care system;

consolidate and right-size the state's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the use of e-prescribing; foster the implementation of electronic medical records and regional health information organizations; and expand ambulatory and primary care services.

The primary goals of the F-SHRP Demonstration were to improve the cost effectiveness and quality of the state's health care system and promote increased access to and coordination of care in appropriate clinical settings. To achieve these goals, the key activities of the Demonstration were as follows:

- Consolidate and "right-size" the state's health care system by reducing excess capacity in the acute care system
- Shift emphasis in long-term care from institutional-based to community-based settings
- Expand the adoption of advanced Health Information Technology (HIT)
- Expand and improve ambulatory and primary care infrastructure
- Expand managed care to additional populations and counties in the Medicaid program

This waiver program had its origins in the Partnership Plan, which sought to improve the economy, efficiency and quality of care, by requiring families and children to enroll in managed care entities to receive services.

III. General Background

In 2004, the state was presented with significant reform opportunities including the aging of New York's population, the continued shift in care from institutional to outpatient settings, and the quality and efficiency advantages that are available through health information technology. The state created the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) capital grant program to invest an anticipated one billion dollars over a four-year period, to effectively reform and reconfigure New York's health care delivery system. In 2005, the state asked the federal government to partner with its HEAL NY initiative to implement reform projects that would improve the quality of care and result in long term savings for both the state and federal governments. The F-SHRP was then approved for an initial five year period beginning in 2006 with a termination date of September 30, 2011. On April 29, 2011 CMS approved an extension of the F-SHRP for an additional two and a half years, setting a termination date of March 31, 2014. The populations, which consisted of Mainstream Medicaid Managed Care and Managed Long Term Care, have transitioned into the Partnership Plan Medicaid Section 1115 Demonstration.

In January 2011, Governor Andrew M. Cuomo created the Medicaid Redesign Team (MRT) to address quality issues and underlying healthcare costs in New York's Medicaid program. One of the recommendations of the MRT was an amendment to the F-SHRP Waiver. It included authority to mandatorily enroll participants in the Recipient Restriction Program, approved on July 29, 2011. CMS subsequently approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012 incorporating additional changes resulting from recommendations of the MRT. The September 30, 2011 and March 30, 2012 amendments provided authority to the state to require mandatory managed care enrollment of populations that were previously exempt, or excluded from mandatory managed care. Whereas, the August 31, 2012 amendment provided the state the authority to require individuals who received community-based long term care services in excess of 120 days to enroll into managed care.

In 2012, New York added an initiative to the Demonstration to improve service delivery and coordination of long-term care services and supports for individuals through a managed care model. Under the Managed Long Term Care Program (MLTC), eligible individuals in need of more than 120 days of

community-based long term care services were enrolled with managed care providers to receive Long Term Services and Supports (LTSS), as well as other ancillary services.

In 2013 New York had two amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment the Long Term Home Health Care Program (LTHHCP) participants are being transitioned from New York's 1915(c) Waiver into the 1115 Demonstration and into managed care. The second amendment eliminated the exclusions from Mainstream Medicaid Managed Care (MMMC) for both foster care children placed by local social service agencies and individuals participating in the Medicaid Buy-In Program for the Working Disabled.

A. Rightsizing New York's Acute Care System

In April 2005, the New York State legislature declared that it was in the interest of the State to undertake an independent review of health care capacity and resources in the State to ensure that the supply of general hospital and nursing home facilities was best configured to appropriately respond to community needs for quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability. Accordingly, the legislature established the Commission on Health Care Facilities in the 21st Century (The Commission) as an independent commission led by Stephen Berger. The Commission was charged with examining the supply of general hospital and nursing home facilities, and recommending changes that would result in a more coherent, streamlined health care system in the State of New York. New York's acute care infrastructure was outdated and oversized and many existing facilities were highly leveraged with debt. The migration of health care services to the outpatient setting added to the significant excess capacity that exists in the State.

Among other activities and recommendations, the Berger Commission evaluated each hospital and nursing home in the State over the course of 18 months. Its acute care recommendations affected 57 acute care facilities, or about 25% of the State's hospitals. Recommendations included 48 acute care reconfiguration, affiliation, and conversion arrangements, and nine facility closures. Collectively, the recommendations were expected to reduce inpatient capacity by approximately 4,200 beds, or 7 percent of the State's supply. These recommendations were aimed at reducing Medicaid inpatient hospital costs.

The goal of the F-SHRP Demonstration was to place an increased emphasis on ensuring that as acute care capacity was right-sized more services would be rendered in appropriate and cost effective clinical settings. Right-sizing the institutional infrastructure was also expected to result in reduced inpatient utilization by reducing pressure to fill empty beds. Under this Demonstration, the Department hoped to retire and restructure hospital debt, fund operating costs necessary to downsize or close facilities, and convert unneeded acute care facilities to alternate delivery models. The Demonstration was expected to expand the availability of ambulatory and primary care services, ensuring that individuals continued to have access to health care providers and services as the acute care sector was restructured.

B. New Mandatory Mainstream Managed Care Enrollment

Under the Partnership Plan Demonstration (11-W-00114/2), the state has the authority to require mandatory mainstream managed care enrollment for any of the beneficiaries described in Table 1 (page 6) except those that reside in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, or Yates counties. Under this F-SHRP Demonstration, any recipient in the eligibility groups listed in Table 1 on page 6 below who live in those 14 counties were required to enroll in managed care plans.

C. Reforming New York's Long-Term Care System

The growth of non-institutional alternatives for long-term care services, advances in medical technology, overall improvement in the health of potential consumers and caregivers, and increasing preference for less restrictive health care alternatives were contributing to decreasing demand for traditional long term facility care. Nursing home occupancy continued to drop in most areas of the State to unprecedented levels. While occupancy had dropped, admissions and discharges had grown, with virtually all growth in the short-stay rehabilitation categories of less than 90 day stays. Consequently, the average length of stay had diminished by over 40 percent.

The Berger Commission's recommendations for downsizing or closing nursing homes included eliminating approximately 3,000 beds, which represented about 3 percent of the State's supply. Consistent with the Commission's recommendations, the F-SHRP Demonstration placed an increased emphasis on shifting long-term care from institutional-based to community-based settings. In addition to rightsizing activity in the long-term care sector, it was hoped that the Demonstration would support implementation of a single point of entry (SPOE) system, home modification and housing accessibility initiatives, and expand telehomecare services, all designed to respond to changing long-term care needs for the future.

D. Health Information Technology (HIT)

Numerous studies demonstrated the potential savings that could be achieved through expanding HIT adoption and utilization in the nation's fragmented delivery system. Greater use of HIT applications could reduce duplicative care, lower health care administration costs, and minimize errors in care. However, moving forward on major HIT initiatives required significant financial investments. New York enacted the HEAL NY program to, among other activities, expand the use of e-prescribing, develop and expand the use of electronic medical records, and facilitate the development, implementation and application of interoperable health information exchange across care settings throughout New York.

HEAL NY made grants to acute and long-term care facilities that demonstrated a commitment to investing in the restructuring and reconfiguration of their facilities to improve the delivery of quality care to patients. Funded projects included those that sought to expand the adoption and use of HIT applications in New York and promote interoperable health information exchange across care settings throughout the State.

E. Populations Affected

Under the F-SHRP Demonstration, implementation of mandatory enrollment of the Social Security Insurance (SSI) population was accelerated and expanded to also incorporate those individuals with Serious and Persistent Mental Illness (SPMI).

The Mandatory Managed Care Program operated by New York State provided Medicaid state plan benefits through comprehensive Managed Care Organizations (MCOs) to those recipients eligible under the state plan as noted below.

1. Mandatory Mainstream Managed Care (MMMC)

Under this Demonstration, beneficiaries residing in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties who met the criteria listed in Table 1 on page 6 below were required to enroll in managed care plans.

Table 1: Eligibility Groups Affected by County-Specific MMMC Enrollment

State Plan Mandatory and Optional Groups	Eligibility Criteria
Pregnant women and children under age 1 (demonstration population 1 and demonstration population 2)	Income up to 200% of the federal poverty level (FPL)
Children ages 1 through 5 (demonstration population 1)	Income up to 133% FPL
Children ages 6 through 18 (demonstration population 1)	Income up to 133% FPL
Children ages 19 through 20 (demonstration population 1)	Income at or below the monthly income standard (determined annually
Parents and caretaker relatives (demonstration population 2)	Income at or below the monthly income standard (determined annually)

The state also had authority to expand mandatory enrollment into MMMC to all individuals identified in Table 2 except those otherwise excluded or exempted. Refer to **Attachment 1**: Exclusions and Exemptions from MMMC.

Table 2: Eligibility Groups Affected by MMMC Enrollment Requirement

State Plan Mandatory and Optional Groups	Eligibility Criteria
Adults and children (age 0 through 64) receiving Supplemental Security Income (SSI) payments or otherwise disabled (demonstration population 3 and demonstration population 4)	Income at or below the monthly income standard
Adults (age 65 and above) (demonstration population 5 and demonstration population 6)	Income at or below the monthly income standard

2. Managed Long Term Care

MLTC provided a limited set of Medicaid state plan benefits, including long-term services and supports through a managed care delivery system, to individuals eligible through the state plan who require more than 120 days of community based long term care services.

The state had authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3, except those otherwise excluded or exempted. Refer to **Attachment 2:** Exclusions and Exemptions from MLTC.

Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional groups	FPL and/or other qualifying criteria	Expenditure and Eligibility group reporting
Adults age 65 and above (demonstration population 8)	Income at or below SSI level	Demonstration population 8/MLTC
Adults/children ages 18 through 64 (demonstration population 7)	Income at or below SSI level	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Adults age 65 and above (demonstration population 8)	Income at or below the monthly income standard, or with spend-down to monthly income standard	Demonstration population 8/MLTC adults 65 and above – Non-Duals
Adults/children ages 18 through 64 blind and disabled (demonstration population 7)	Income at or below the monthly income standard, or with spend-down to monthly income standard	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Ages 16 through 64 Medicaid Buy-In for Working People with Disabilities (demonstration population 7)	Income up to 250% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Parents and caretaker relatives 21 through 64 (demonstration population 7)	Income at or below the monthly income standard, or with spend- down to monthly income standard	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Children ages 18 through 20 (demonstration population 7)	Income at or below the monthly income standard or with spend-down	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Pregnant Women (demonstration population 7)	Income up to 200% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Poverty Level Children ages 18 through 20 (demonstration population 7)	Income up to 133% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Foster Children ages 18 through 20 (demonstration population 7)	In foster care on the date of eighteenth birthday	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Demonstration Eligible Groups	**FPL and/or other qualifying criteria**	**Expenditure and Eligibility group reporting**
Community Long Term Services and Supports Population	Income based on higher income standard to community settings for long-term services and supports pursuant to STC 17	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals Demonstration population 8/MLTC adults 65 and above – Non-Duals

IV. Implementation of the Demonstration

F-SHRP Waiver

The goal of implementation was to improve the health care status of low-income New Yorkers by improving access to care and improving the quality of health services delivered while managing costs.

A. F-SHRP Waiver Amendments

The following waiver amendments were implemented to build and expand the original initiatives of the F-SHRP Demonstration:

- The state created HEAL NY capital grant program to invest an anticipated one billion dollars over a four-year period, to effectively reform and reconfigure New York's health care delivery system. In 2005, the state asked the federal government to partner with its HEAL NY initiative to implement reform projects that would improve the quality of care and result in long term savings for both the state and federal governments.

- In 2007, revisions were made to Chapter 58 of the New York State Social Services Law 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. Effective January 1, 2014, adults eligible under the Modified Adjusted Gross Income category became eligible for continuous coverage. This proposal provided stability and continuity of coverage and care to certain adults in the same way that it had for children on Medicaid.

- CMS provided approval for the mandatory enrollment of dual eligible recipients, 21 years of age or older receiving more than 120 days of community based long term care services, into a Managed Long Term Care Plan (MLTCP) on August 31, 2012. The initiative offered three (3) models of MLTCPs: partially capitated; the Program of All-Inclusive Care for the Elderly (PACE); and, Medicaid Advantage Plus (MAP). Both PACE and MAP included Medicare and Medicaid covered services in the benefit package and required the participant to be nursing home eligible; partially capitated plans included only Medicaid covered benefits.

  In order to ensure a smooth transition of the thousands of Medicaid recipients who were previously accessing services through the State's fee-for-service programs, such as the Medicaid Personal Care Program, the Department opted to phase-in the mandate geographically.

- The Department received CMS approval of the Special Terms and Conditions (STCs) for enrollment of individuals in the 1915c Long Term Home Health Care Program (LTHHCP), which offers home based care to individuals who would otherwise be admitted to a nursing home. Dually eligible LTHHCP participants over age 21 were required to enroll in a MLTC plan based on a phase-in schedule approved by CMS. Dually eligible LTHHCP participants aged 18 through 20 could choose to enroll in a MLTC plan which has been approved to enroll individuals aged 18 and older, and dually eligible individuals aged 21, and under and non-duals of any age, could voluntarily enroll in a MMMC plan.

- CMS granted the Department authorization for MMMC enrollment of individuals in foster care who were placed in the community directly by the local district social services. This did not extend to individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution. In addition, the Department received CMS authorization for managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities Program.

B. Benefit Changes/Other Program Changes

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

- Home Delivered Meals and Medical Social Services: Effective April 1, 2013, these two services were added to the Medicaid managed care benefit package for enrollees who have transitioned to a MMMC plan from LTHHCP and were receiving home delivered meals under the LTHHCP. This addition to the benefit package prevented the loss of access to this service for LTHHCP participants upon MMMC enrollment and reduced the risk of failure for these specific enrollees to remain in the community.

- Pharmacy Network for Specialty Drugs: Effective April 1, 2013, the benefit required managed care organizations (MCO) to permit each enrollee to fill any mail order covered prescription at any mail order or non-mail order retail pharmacy in the MCO's network. If the MCO had designated a specific pharmacy or pharmacies for filling prescriptions for a particular drug or drugs, the enrollee could fill such prescriptions at any other pharmacy in the MCO's network provided that the pharmacy agreed to a comparable price of the pharmacy designated by the MCO.

- The Department received authorization from CMS regarding the addition of Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC) to the Medicaid managed care benefit package. These programs were designed to assist individuals to live more independently in the community or to eliminate the need for residential health care services. Individuals who were in receipt of these services received 90 days of transitional care with their current care plan, or until the MCO authorized an alternate care plan, whichever was later. This addition to the benefit package prevented the loss of access to this service for MMMC enrollees who transitioned from fee-for-service Medicaid and reduced the risk of failure for these specific enrollees to remain in the community.

- The Department received CMS approval to include Directly Observed Therapy for Tuberculosis (TB/DOT) in the Medicaid managed care benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

V. Operationalizing the Demonstration

- Right sizing acute care infrastructure
- Reforming long-term care
- Improvement in primary/ambulatory care

Demonstration Initiatives

A. Managed Care

Medicaid Managed Care Programs offer enrollees the opportunity to select a managed care organization whose focus is on preventive health care. The MCO partners with the enrollee's primary care provider to provide primary care case management (PCCM) for the purpose of better coordinating patient care, helping enrollees navigate the medical delivery system and attending to the enrollee's overall health and well-being. The state's original MMC program has enrolled three distinct populations into MCOs as part of the Demonstration: Temporary Assistance for Needy Families (TANF) children under age 1 to age 20; TANF adults age 21 through 64. The Medicaid Managed Care (MMC) program accomplishments in the area of coverage and access included increased enrollment, expansion of mandatory enrollment, policy changes to increase access to and continuity of care and meeting standards for primary care practitioner to enrollee ratios. The state's goal of geographic expansion of mandatory MMC to all counties of the state for TANF and SN populations was accomplished in November 2012. In 2013, the state legislature eliminated all previous exclusions or exemptions from mandatory enrollment into MMC.

The MMC program accomplishments include: exceeding national standards for quality outcomes, Managed Care Organizations engaged in the required annual performance improvement projects, indications of enrollee satisfaction, activities to support informed choice and to engage stakeholders, and an increase in the number of Managed Care Organizations receiving quality incentive payments. Overall, Medicaid beneficiaries enrolled in managed care report satisfaction with their care and experiences.

B. Managed Long Term Care

Managed long-term care is a system that streamlines the delivery of long-term services to people who are chronically ill or disabled and require more than 120 days of community-based long-term care services. As part of its overall strategy to better coordinate care for high need Medicaid beneficiaries, New York has mandated that dual eligible Medicare and Medicaid recipients who are in need of home and community based care for more than 120 days enroll in a Managed Long Term Care Plan. The program goals were: to improve care coordination for Medicaid's highest risk/ highest cost population, to improve patient safety and quality of care for beneficiaries, to reduce preventable acute hospital and nursing home admissions, and to improve overall satisfaction, safety and quality of life for consumers.

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

This initiative offered beneficiaries a choice of three (3) models of MLTC plans: partially capitated; the Program of All Inclusive Care for the Elderly (PACE); and, Medicaid Advantage Plus (MAP). Both PACE and MAP included Medicare and Medicaid covered services in the benefit package that required the participant to be nursing home eligible; partially capitated plans included only Medicaid covered benefits. Recipients were required to choose a plan to receive services. If no choice was made, the recipient was enrolled into a partially capitated plan.

C. HEAL Grants

The Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) legislation amended the Public Authorities Law (1680-J) and the Public Health Law (2818) to authorize the Dormitory Authority of the State of New York and the Department of Health to award up to $1.5 billion in capital grants for improvements in the operation and efficiency of the health care delivery system within the state. Through 24 separate phases, or rounds of grants, HEAL NY awarded $3 Billion in grant funds. The first awards were made in the spring of 2006, and the last awards were made in spring of 2014.

Goals of HEAL NY

The purpose of the HEAL NY program was to improve the quality, stability and efficiency of health care services in New York State. The principal goals of the program included programs that will promote the efficient operation of the state's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional- based to community-based settings; expand the use of e-prescribing, electronic medical records, and regional health information organizations; and improve ambulatory and primary care provision.

The Centers for Medicare and Medicaid Services (CMS), under the 1115 Medicaid, Federal-State Health Reform Partnership (F-SHRP Waiver), agreed to furnish DOH with $1.5 billion over five years to support implementation of health system restructuring as supported by HEAL NY, and to assist in Medicaid fraud recovery. These F-SHRP funds have served as a Federal match for HEAL NY dollars, thus enabling the Department and Dormitory Authority of the State of New York (DASNY) to award some $3 billion for support of capital restructuring/rightsizing projects, regional planning, expansion of primary and community-based care, and promotion of health information technology (HIT).

HEAL Grant Spending Summary:

Eighty percent of 505 contractors spent 100 percent of their funds. More than 95 percent of contractors spent between 75 and 100 percent of their grant funding, with fewer than 5 percent spending 74 percent or less. Throughout the HEAL NY program history, unclaimed funds were repurposed and used to make additional awards.

The following table summarizes life to date expenditures for the HEAL NY program:

Fund	Total Appropriations Available for the Program	Life to Date Expended	Percent Spent
HEAL Bond	656,000,000	655,402,823	**99.91%**
HEAL Hard Dollar	779,000,000	778,525,204	**99.94%**
F-SHRP	1,500,000,000	1,365,863,344	**91.06%**
Roswell	175,000,000	175,000,000	**100.00%**
Total	**3,110,000,000**	**2,974,791,370**	**95.65%**

Federal Funds were unable to be used to match state projects including Phase 1, Roswell Park Cancer Institute, Phase 9 and Phase 19 planning grants, NYS Division of Budget spending reductions in 2011-12, and interest charges on late payments. A table of the various phases of HEAL is presented below on page 13.

HEAL NY Award Information:

Regional Allocation of funds. When appropriate, consideration of statewide geographic distribution of funds was included in awards determination. The following displays the total program amounts awarded in each of the ten NYS economic development regions.

Capital Region: $158.4million (Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer, Warren, Washington counties)

Central New York: $133.7million (Cayuga, Cortland, Madison, Onondaga, Oswego counties)

Finger Lakes: $115.2 million (Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates counties)

Long Island: $302.7 million (Nassau, Suffolk counties)

Mid-Hudson: $407 million (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester counties)

Mohawk Valley: $116.8 million (Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie counties)

New York City: $1.254 billion (Bronx, Kings, New York, Richmond, Queens counties)

North Country: $130.5 million (Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence counties)

Southern Tier: $96.2 million (Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins counties)

Western New York: $317.3 million (Allegany, Cattaraugus, Chautauqua, Erie, Niagara counties)

Project Objectives, Outcomes and Deliverables:

Program outcomes data is still being collected. While the project spending was completed by Mid-March of 2014, there remained roughly 65 contracts that had a contract end date of March 30, 2014. These projects have an additional 60 days to submit final quarterly progress. An all-inclusive review of project objectives, deliverables and outcomes will be completed in the near future.

A summary of the 24 rounds or phases of all awarded HEAL NY grants is presented in the following table:

HEAL Awards All Phases - 2006-2014

HEAL Phase	Eligible Projects	Total Amount (in Millions)	Awards Announced	Number of Awards	Brief Description
1	**Health Information Technology**	**$53**	May-06	**26**	The first round of Health IT grant projects. Funded interconnectivity for multiple providers on a regional basis.
2	**Capital Restructuring**	**$268**	Nov-06	**53**	The first round of capital restructuring grants. These projects were reviewed, scored and announced before the commission mandates were published.
3	**Health Information Technology**	**$53**	Canceled 8/07	**0**	This was an extension of Phase 1 in concept. This round was canceled under The Health Department's Office of Health Information Technology and Transformation. Phase 3 funds were rolled into Phase 5.
4	**Implementation of Berger Commission Mandates**	**$550**	**Four Rounds** 1) 9/28/07 2) 1/1708 3) 3/27/2008 4) 9/30/08	**49**	This Phase limited the eligible applicant pool to the facilities which were identified in the Commission's Report which became mandated activities. Grants were negotiated with the help of the Berger team with an emphasis on financial need and compliance with the mandate.
5	**Health Information Technology**	**$105**	Apr-08	**21**	This phase launched of the new statewide Health IT initiative. Goals include the building of a statewide health information network (SHINY) using regional health information organizations (RHIOs) and local health collaborations (CHITAs). Contracts are managed directly by OHITT.
6	**Expanding Primary Care**	**$100**	Sep-08	**79**	This phase enhanced and expanded primary care services in the community. It included a range of eligible applicants and only allowed $20 million to directly be awarded to hospitals.

7	**Capital Restructuring (Round #2)**	**$149**	Sep-08	**26**	This funded Berger Coverage Partners and Berger "Look-alikes" and included primary support to closures and mergers which were not identified in the Berger Commission's final report.
8	**Residential Health Care Facility Rightsizing**	**$30**	Sep-08	**10**	Grants to Nursing Homes supported activities which resulted in the reduction of RHCF beds and expansion community based services. Complied with 2818 Section 3.
9	**Regional Health Planning**	**$8**	Feb-09	**19**	Local Healthcare Planning Grants, which included $1M for the Finger Lakes Health Systems Agency.
10	**Health Information Technology**	**$100**	Sep-09	**11**	The goal of this phase was to improve care coordination and management through a patient centered medical home model supported by an interoperable health information infrastructure. Included funding for the New York eHealth Collaborative.
11	**Capital Restructuring (Round #3)**	**$174**	Sep-09	**26**	This phase assisted hospitals to voluntarily downsize, consolidate services and initiate changes in governance or merge for operational efficiencies.
12	**Alternative Long Care Initiatives**	**$172**	Sep-09	**19**	The goal assisted communities in developing viable alternatives to RHCF care for long term care populations while downsizing RHCF beds.

HEAL Phase	Eligible Projects	Total Amount (in Millions)	Awards Announced	Number of Awards	Brief Description
14-Q1	**Expanding Access in Queens - Round #1**	**$16**	Feb-09	**9**	These were emergency grants awarded to increase access in Queens responding to the healthcare need due to the closure of St. John's Queens and Mary Immaculate Hospitals and St. Dominic's Health Center.
14-Q2	**Expanding Access in Queens - Round #2**	**$30**	Sep-09	**12**	This phase was for additional funds to hospitals and D&TCs for projects that meet distinct health care needs in the borough of Queens.
14, 14DL, 14DH	**Individual Facility Awards**	**$105**	Sep-09	**15**	This block of discretionary awards were made to help address specific problems and issues experienced by various facilities across NYS. Some funds were used to complete pending Berger mandated changes and in addition, five awards were made to LTC facilities.
15	**Medicaid Transition Funding –$50 million**	**$50**	Sep-10	**17**	This phase supported capital projects to aid hospitals to implement DOH approved transition plans intended to restructure and improve financial operations and provide for continued financial viability in response to changes in Medicaid payments.
16	**Ambulatory Care in Lower Manhattan**	**$13**	Apr-10	**5**	This phase addressed service needs arising from the reduction of outpatient and ambulatory services resulting from the closure of St. Vincent's Catholic Medical Center due to their financial situation and associated bankruptcy proceedings.

17	**Health IT in Expanded Care Coordination**	**$117**	Sep-10	**14**	This phase of Health IT grants built upon previous funding initiatives (HEAL 1, 5 and 10) by furthering the implementation and effective use of interoperable health information infrastructure and participation in the Statewide Collaborative Process.
18	**Mental Health Services**	**$38**	Sep-10	**19**	Capital grants targeted projects to improve inpatient mental health facilities and Article 31 mental health clinics, especially capital improvements and innovations to service delivery to address problems associated with multiple inpatient stays.
19	**Facility Specific Reconfiguration Non Competitive**	**$190**	Sep-10	**32**	This block of non-competitive awards addressed unmet needs and help address specific problems and issues experienced by various facilities across NYS.
20	**Long Term Care Initiatives #2**	**$151**	Sep-10	**9**	These grants assisted in developing viable alternatives to RHCFs while maintaining critical access based on community need, and/or promoting access to aging in place by supporting Adult Care Facilities in transitioning to Enhanced or Special Needs Assisted Living Residence Licensure.
21	**Restructuring Initiatives in Medicaid Redesign**	**$300**	Jun-12	**40**	These grants assisted hospitals and nursing homes implement improve primary and community based care, eliminate excess capacity and reduce over-reliance on in-patient care. These grants helped implement recommendations from the Medicaid Redesign Team.
22	**Electronic Health Record Adoption**	**$38**	Oct-12	**2**	These grants promoted Electronic health record adoption and implementation support services for behavioral health and mental health providers.
CD	**Commissioner's Discretionary Awards**	**$275**	Fall 2013-Spring2014	**24**	Commissioners' Discretionary awards addressed unmet needs and helped address specific problems and issues experienced by various facilities across NYS.
Total (Total dollars excludes Phase #3)		**$ 3,032**		**537**	**Total HEAL Projects**

D. Designated State Health Programs (DSHPs)

The current Designated State Health Programs (DSHPs) consist of Health Care Reform Act programs, State Office on Aging programs, Office of Children and Family Services-Committees on Special Education direct care programs, and State Department of Health-Early Intervention Program Services. Transitioning DSHPs to support new Partnership Plan programs is under discussion with CMS. Subject to the conditions outlined in the Special Terms & Conditions, FFP was claimed for expenditures made for the following DSHPs during the demonstration approval period:

a) Health Care Reform Act programs –

- Healthy New York
- AIDS Drug Assistance
- Tobacco Use Prevention and Control
- Health Workforce Retraining
- Recruitment and Retention of Health Care Workers

- Telemedicine Demonstration
- Pay for Performance Initiatives

b) State Office on Aging programs –

- Community Services for the Elderly
- Expanded In-Home Services to the Elderly

c) Office of Children and Family Services - Committees on Special Education direct care programs

d) State Department of Health – Early Intervention Program Services

Monitoring the Waiver

The Department had extensive protocols in place to monitor waiver activities including provider billing, consumer complaints, enrollment, and consumer satisfaction.

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on MRT #1458 (care management population and benefit expansion, access to services and consumer rights) including expansion of the Medicaid managed care benefit package to include: Adult Day Health Care, AIDS Adult Day Health Care, and Directly Observed Therapy for Tuberculosis.

The Department employed a multi-faceted approach to ensuring accountability and improving the quality of care provided to plan enrollees through strategic monitoring activities.

Quality

The following activities highlight the Department's monitoring efforts:

- Progress was evaluated by review of data that reflects: health plan quality performance, access to covered services, extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care.

The Department assesses the program through analysis of the quality and appropriateness of care and services delivered to enrollees, and by monitoring MCO activities on an on-going or periodic basis. The national measures used in this approach are largely based on the following assessment tools:

- Quality Assurance Reporting Requirements (QARR) – a set of measures based on The National Committee for Quality Assurance's (NCQA).
- Healthcare Effectiveness Data and Information Set (HEDIS).
- The Medicaid Encounter Data System (MEDS).
- Prevention Quality Indicators (PQIs)-measures developed by the Agency for Healthcare Research and Quality (AHRQ), Semi-Annual Assessment of Members (SAAM) data sets.
- Consumer Assessment of Health Care Provider Systems (CAHPS®) Survey – a survey instrument that asks health plan members about experiences with access to care, health care providers and health plans.
- The Department's evaluation includes State-specific measures. State specific sources of data include the Department's Statewide Planning and Research Cooperative System (SPARCS),

data reporting from New York Medicaid Choice (NYMC), the State's contracted Managed Care enrollment broker, surveys conducted by its External Quality Review agent, IPRO, and the results of quality improvement activities.

External Quality Review Surveys and Technical Reports

IPRO, New York's External Quality Review Organization, conducted multiple surveys of each MCO and prepared a Plan-Specific Report for each. The following outlines the survey and reporting process:

- Reports are completed every three years.
- Reports include information on trends in plan enrollment, provider network characteristics, QARR performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies and other on-site survey findings, focused clinical study findings and financial data.
- Reports are updated annually for a subset of this information focusing on strengths and weaknesses.

Monitoring of Provider Networks

On a quarterly basis, MCOs submitted updated information on their contracted provider network to the Department. As part of these quarterly reports, MCOs provide information on the number of Medicaid enrollees empanelled to each network Primary Care Physician (PCP).

In addition, any material change in network composition must be reported to the state 45 days prior to the change. Provider network reports are used to monitor compliance with access standards, including travel time and distance, network capacity, panel size, and provider turnover.

Performance Improvement Projects (PIPs)

The Department required MMC and MLTC plans to conduct one Performance Improvement Project each year. The Department encouraged health plans to participate in collaborative quality improvement initiatives with other health plans to ensure quality outcomes.

Outreach

The Department, Maximus and the local departments of social services (LDSS) provided education and outreach in the areas of enrollment and health plan selection to Medicaid eligibles that were not enrolled in managed care.

Progress of Mandatory Managed Care

As of November 2012, Mandatory Medicaid Managed Care programs were operating in all counties of the state, including New York City. The Department staff provided technical support to both county workers and providers in all counties. The counties opting to utilize the assistance of the enrollment broker also received support from Maximus staff. There are four million Medicaid beneficiaries enrolled in managed care programs.

Progress of Managed Long Term Care

From September 2012 through September 2013, enrollment in the MLTC program has increased by 89 percent. There were about 110,401 people enrolled in the State's Medicaid Managed Long Term Care program as of September 2013.

Innovative Activities

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

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

- In 2009, the state increased physicians' fees by 80% over the 2007 levels.
- Additionally, in 2012 the state awarded $2 million in grants under the Doctors Across New York (DANY) Physician Loan Repayment and Practice Support program, which assists in the training and placement of physicians in rural and inner city areas where a shortage of health care providers has been identified.

As part of its waiver amendment request, New York has requested $250 million in order to broaden the DANY's program and expand the Primary Care Service Corp, which focuses on recruiting non-physician primary care providers to underserviced areas as well as to support other key workforce recruiting and retention programs for underserved areas. In the near term, the Department believes these efforts will make a substantial contribution to closing the nearly 1,100 primary care physician gap as well as gaps in other primary care and some specialty physician occupations.

Accomplishments

A. Access and Coverage

Expansion of mandatory enrollment coverage to previously exempted populations and an increase in access, continuity of care and meeting standards for primary care practitioner to enrollee ratios are accomplishments under this category. The Demonstration has significantly expanded coverage to previously under insured and uninsured populations.

B. Cost Savings

From a cost effective standpoint, MMMC and MLTC have been highly successful in maintaining budget neutrality and reducing overall cost savings while increasing access, and offering more benefits to increasingly expanding populations.

C. Quality

Accomplishments in the area of quality include member satisfaction surveys being completed, continuity of care for all services provided under the plan of care transition from FFS to managed care, the

introduction of a standardized assessment and activities to support informed choice and engage stakeholders.

- **Member Satisfaction Surveys Being Completed**

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

- **Introduction of a Standardized Assessment**

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

- **National Standards**

New York exceeds the national standards for quality outcomes. New York has met or exceeded 89 percent of the national QARR benchmarks and 87 percent of the 2007 measures.

- **Multifaceted Quality Strategies**

The Department's Office of Quality and Patient Safety, February 27, 2014, has cited the multifaceted strategy the Department uses to improve quality. These include:

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

- **Other**

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

D. Activities to Support Informed Choice and Engage Stakeholders

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

stakeholders, providers and Local Department of Social Services staff to ensure accuracy of information shared.

E. Self-Directed Options

To minimize disruption and promote continuity for members receiving Consumer Directed Personal Assistance Service (CDPAS) a policy for the transition of CDPAS into MLTC and the MCO benefit package was created. Self-direction gives individuals and families greater control over the services they receive, how they receive them and who provides them; and clear direction to both MLTC and MCO plans support its success. Additional education was developed and shared with MLTC Plans addressing Consumer Directed Personal Assistance Services and its use.

F. HEAL Grants

The New York State Dormitory Authority awarded three billion dollars for supports of capital restructuring/right sizing projects, regional planning expansion of primary community based care and promotion of health information technology.

G. Additional Program Accomplishments:

The primary goals of the F-SHRP Demonstration were to improve the cost effectiveness, and quality of the State's healthcare system and promote increased access to and coordination of care in appropriate clinical settings.

Overall, the Demonstration has been successful in meeting these goals and implementing key initiatives. The following are highlights of some of the more notable accomplishments:

- New York State engaged in a reconfiguration of its health care delivery system. As a result, approximately one-fourth of all hospitals in the state have been reconfigured; some closed, others merged, and others eliminated excess beds and redundant services.
- The State consistently exceeded the required amount of fraud and abuse recoveries in 2008, 2009, and 2010.
- Mandatory enrollment of SSI and SSI-related Medicaid enrollees in Medicaid managed care, including those with serious mental illnesses, was implemented.
- On September 30, 2008 Governor Paterson announced awards for: health information technology (electronic health records); primary care infrastructure; capital restructuring; and, residential health care facility rightsizing.
- In September 2012, MLTCP availability was expanded by approving 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority for new partially capitated plans.
- A standardized process was established for MLTCPs to enter into agreements with entities for the provision of Care Management Services.
- A study protocol was created with an External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirements related to transition of care.
- Information was made available to participants selecting plans to include a Consumer Guide for Plans. This Consumer Guide will be available statewide.
- Data gathering systems were developed to meet special terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915(c) LTHHCP.
- Improvements were submitted to network reporting guidelines for all MLTCs.
- A transition plan to expand mandatory enrollment to remainder of the state.

- Social Day Care utilization and plan contract monitoring continues.
- Incorporation of community based LTSS continue to be incorporated into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
- MLTCP capacity was expanded in all mandatory counties and building capacity for future counties.
- Continuity of care for MLTC transition.
- Network capacity, delivery systems and coordination of care are monitored.
- A mechanism was established for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.
- Network reporting guidelines were improved for all MLTCs.

F. Issues and Problems

- Hurricane Sandy had a devastating impact on New York State's health resources and the aftermath of the storm continues to affect health care needs and outcomes. It was necessary to pause the implementation and processing of some program activities as a result of disruptions caused by Hurricane Sandy, which occurred in November 2012. Currently, in some instances, there are still disruptions that the state continues to resolve and rectify. Both beneficiaries and providers experienced situations that needed to be addressed to avoid jeopardizing the delivery of services as well as addressing the safety, health and welfare of beneficiaries.
- An electronic reporting system for reporting critical incidents has been implemented and will continue to be refined as needed. The system will be continued to be monitored to ensure that it captures critical incident reports.
- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, NYS DOH, the Attorney General's Office and the Office of the Medicaid Inspector General are cooperating in ongoing audits and investigations. Focused activities are being expanded on an ongoing basis as issues are identified.

VI. Transition Plan

Transition of Mainstream Managed Care (MMC) Populations from the F-SHRP to the Partnership Plan

The Department transitioned the MMC populations and counties in the F-SHRP Demonstration into the Partnership Plan Demonstration. This transition simplifies the review and management process, while maintaining all current Waiver requirements. Whenever changes were made to the managed care program by the State and/or CMS, the State was required to include the same Special Terms and Conditions into both waivers. The delivery of services to the enrolled populations was the same in both waivers. The populations approved benefit packages and all Special Terms and Conditions pertaining to the provision of services for the enrolled populations were the same.

There was no disruption to the enrolled population. As a result, transitioning the enrolled populations into the Partnership Plan upon the termination of the F-SHRP was appropriate, efficient and logical. This was the original intention once the initial F-SHRP expired.

Transition of Managed Long Term Care (MLTC) Populations from the F-SHRP to the Partnership Plan

The Department transitioned the MLTC populations and counties in the F-SHRP Demonstration into the Partnership Plan Demonstration. As with the MMMC population, the transition was seamless and there were no disruptions in service to the enrolled populations.

Designated State Health Plans (DSHP)

CMS is currently working with the State in defining the use and purpose of DSHP dollars and finalizing DSHP claiming protocols and tracking procedures.

Continuous Eligibility Period

An amendment was submitted and approved by CMS to continue 12-month continuous coverage. Per CMS approval, all MAGI eligibility groups transitioned into the Partnership Plan are eligible to receive 12-month continuous coverage, effective January 1, 2014.

Native Americans

Under the State's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. This exemption from mandatory enrollment for Native Americans will be continued. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued.

VII. Impact of the Demonstration

New York State, through establishment of a Medicaid Redesign Team, consisting of stakeholders representing virtually every sector of the health care delivery system, including consumers, has proposed sweeping health care reforms that will lead to improved health outcomes as well as health care savings in years to come. Some of these reforms have been realized in the F-SHRP Demonstration and will continue under New York's Partnership Plan Demonstration.

Beneficiary Impact

A. Managed Care

Increased enrollment in managed care along with the expansion of mandatory enrollment has increased access and coverage for beneficiaries. Policies to maintain continuity of care and meeting standards for primary care practitioner to enrollee ratios have provided a greater quality of care for beneficiaries.

B. Managed Long Term Care

Increased access to managed long term care for Medicaid enrollees in need of long term supports and services (LTSS) has had the following impact on MLTC beneficiaries:

- Improvement of patient safety and quality of care for consumers;
- Reduction of preventable acute hospital and nursing home admissions; and
- Improvement of patient satisfaction and quality of life for consumers.

VIII. Programmatic Outcomes and Findings

- Cost effectiveness and maintenance of budget neutrality.
- Exceeding national standards for quality outcomes.
- Activities to support informed choice and stakeholder engagement.
- Increase in percentage of MCOs receiving incentive payments.
- Increased enrollment.
- Increased access to care.
- Increased continuity of care.
- Increased beneficiary satisfaction.
- Expansion of coverage to previously excluded groups.
- Introduction of standardized assessment.

IX. Budget Neutrality and Cost Efficiencies Findings

Budget Neutrality

Budget Neutrality (BN) is a requirement of Section 1115 waivers which limits federal funding to the amount that would have occurred absent of the waiver. The analysis compares without waiver expenditure limits to with waiver expenditures.

1. For the calculated budget neutrality for each year of the demonstration, and on a cumulative basis, see attached file with actual expenditures reported thru 3/31/11 for each demonstration year.

2. For estimated final budget neutrality see the attached file which reflects estimated final expenditures by demonstration year for the full F-SHRP demonstration period.

3. For expenditure estimates for the demonstration based on historical data, see the attached file, which reflects projected expenditures by demonstration year for the period 4/1/11 to 3/31/14.

4. For the methodology for determining expenditure estimates, see expenditure estimates for demonstration populations trended from the most current period with final 21 months of lag payments. Expenditures estimates for DSHPs reflect estimates of projected spending that take into account actual expenditures to date and any limits that may apply per STCs – in this case $3B through 3/31/14.

The PMPM and trend rates from the last formal renewal are reflected in the attached PMPM table.

Cost Efficiencies

Not applicable - it is the Department's understanding that this section pertains to 1915 waiver, and not the 1115 waiver.

X. Recommendations

New York looks forward to continuing to implement Medicaid Redesign Initiatives and to phase in populations and services under the Partnership Plan. The state is looking to finalize DSHP funding agreements in Partnership Plan renewal.

XI. Conclusions

New York has fully implemented Managed Care and phased in previously exempted populations. New services, new eligible groups and new budgeting methodologies for managed long term care now provides greater access to health care for low income New Yorkers.

The F-SHRP demonstration operated separately from New York's comprehensive section 1115 demonstration (The Partnership Plan). In order to obtain federal funding, New York met a series of established performance milestones, and generated sufficient federal savings which offset the federal investment.

This savings resulted from the state reducing excess capacity in its acute care hospital industry, shifting emphasis in long-term health care services from an institutional to community-based setting with the President's New Freedom Initiative by reducing nursing home excess capacity, providing worker retraining, investing in HIT initiatives including e-prescribing, electronic medical records and regional health information organizations , and reorienting New York's health care system away from inpatient facilities to outpatient and primary-care focused delivery systems, including pay-for-performance initiatives.

During the FSHRP demonstration, the federal government provided funding up to $300 million per year, totaling $1.5 billion to the state for specific designated expenditures. The federal funding allowed New York to invest state funds in to health reform programs that addressed the state's need to modernize its acute and long-term care infrastructure, increase capacity in primary and ambulatory care, and make investments in health information technology. The demonstration also allowed the state to enroll certain Medicaid populations into managed care on a mandatory basis: aged, blind and disabled individuals statewide, and children, caretaker relatives, and pregnant women in selected counties.

New York State has experienced great success with the Medicaid Section 1115 Waiver. Through F-SHRP, the state has realized improvements in access, quality and cost effectiveness. The state will

continue its successful partnership with CMS to incorporate several new initiatives into the Partnership Plan. The 1115 Waiver F-SHRP Demonstration has well-prepared New York to undertake a major reform of its health care service delivery system. New York's Medicaid Redesign Team Action Plan builds on the many successful components of the F-SHRP and Partnership Plan Demonstrations.

In the coming years, the state plans to continue its successful partnership with CMS to implement the following new initiatives:

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

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

Attachment 1: Exclusions and Exemptions from MMMC (STC 18)

Notwithstanding the eligibility criteria in STC 16(b) of the F-SHRP Special Terms and Conditions, certain individuals cannot receive benefits through the MMMC program (i.e. are excluded from participation) while others may request an exemption from receiving benefits through the MMMC program (i.e. may be exempted from participation). Tables 1:1 and 1:2 list those individuals either excluded or exempted from MMMC.

Table 1:1: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the Family Planning Expansion Program
Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a state Office of Mental Health (OMH) facility)
Individuals with a "county of fiscal responsibility" code of 98 (individuals in an Office of People with Developmental Disabilities (OPWDD) facility or treatment center)
Individuals under 65 years of age (screened and requiring treatment) in the Centers for Disease Control and Prevention's (breast, cervical, colorectal, and/or prostate) Early Detection Program, and needing treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage
Individuals eligible for Emergency Medicaid.

Table 1:2: **Individuals Who May Be Exempted from MMMC**

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 any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs (exemption is limited to six months)
Individuals designated as participating in OPWDD sponsored programs.
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area (exemption is limited to six months)
Individuals with a developmental or physical disability receiving services through a Medicaid Home and Community Based Services (HCBS) Waiver authorized under section 1915(c) of the Act.
Residents of alcohol/substance abuse Long Term Residential Treatment Programs.
Native Americans.
Individuals with a "county of fiscal responsibility code of 98" (OPWDD in Medicaid Management Information Systems) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

Attachment 2: Exclusions and Exemptions from MLTC (STC 19)

Notwithstanding the eligibility criteria in STC 16 of the F-SHRP Special Terms and Conditions, certain individuals cannot receive benefits through the MLTC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MLTC program (i.e. may be exempted from participation). Tables 2:1 and 2:2 lists those individuals either excluded or exempted from MLTC.

Table 2.1: **Individuals Excluded from MLTC**

Residents of psychiatric facilities
Residents of Residential Health Care Facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a state Office of Mental Health facility)

Individuals with a "county of fiscal responsibility" code of 98 (individuals in an OPWDD facility or treatment center)
Individuals eligible for the Family Planning Expansion Program
Individuals under 65 years of age who are screened through the Centers for Disease Control and Prevention's Early Detection Program and need treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse Long Term Residential Treatment Programs
Individuals eligible for Emergency Medicaid
Individuals in the OPWDD HCBS 1915(c) Waiver program
Individuals in the following 1915(c) Waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP) in certain counties. (New York is using a phased in approach to transition LTHHCP individuals into the MLTC program. There are six phases (see **Attachment 3**- "Attachment C of F-SHRP Waiver")
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

Table 2.2: **Individuals Who May Be Exempted From MLTC**

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid Buy-In for the Working Disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

Federal - State Health Reform Partnership
Actual Costs Through March 31, 2011 - DY4 Actuals 21 Month Lag Final
Extension through 2014

Groups to be Included in the Demonstration	DY 1 (10/01/06 - 09/30/07) Actual	DY 2 (10/01/07 - 09/30/08) Actual	DY 3 (10/01/08 - 09/30/09 Actual	DY 4 (10/1/09 - 9/30/10) Actual	DY 5 (10/1/10 - 3/31/11) Actual	DY 6 (4/1/11 - 3/31/12) Projected	DY 7 (4/1/12 - 3/31/13) Projected	DY 8 (4/1/13 - 3/31/14) Projected	Full Demonstration Period
Without Waiver									
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$74,205,296	$253,872,674	$334,430,349	$414,815,337	$239,802,796	$544,361,378	$594,330,588	$651,790,556	$3,107,608,974
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$35,180,438	$111,195,397	$160,979,221	$214,698,744	$126,787,422	$260,885,727	$305,826,321	$334,767,657	$1,550,320,927
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$6,813,524,052	$5,923,775,716	$5,605,439,540	$5,385,789,164	$2,841,157,566	$4,843,425,289	$5,040,917,954	$8,926,172,481	$45,380,201,762
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$830,759,022	$2,270,724,236	$3,398,057,992	$4,342,757,874	$2,585,985,210	$6,032,136,992	$6,908,041,018	$3,889,940,199	$30,258,402,543
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$222,205,966	$163,717,812	$160,076,250	$171,081,672	$91,494,819	$149,090,947	$142,357,617	$392,116,627	$1,492,141,710
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$60,600,194	$173,756,116	$236,925,000	$299,624,894	$177,917,010	$412,271,069	$468,565,821	$261,975,123	$2,091,635,227
Demonstration Group 7 – Non Duals 18-64						$0	$233,691,291	$85,737,316	$319,428,606
Demonstration Group 8 – Non Duals 65+						$0	$62,159,385	$22,310,307	$84,469,692
W/O Waiver Total	**$8,036,474,967**	**$8,897,041,951**	**$9,895,908,352**	**$10,828,767,686**	**$6,063,144,823**	**$12,242,171,402**	**$13,755,889,995**	**$14,564,810,265**	**$84,284,209,441**
With Waiver									
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$41,943,140	$130,509,759	$160,465,088	$177,404,747	$74,728,987	$241,641,042	$262,345,473	$286,061,767	$1,375,100,002
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$27,926,591	$84,400,273	$117,867,951	$146,624,422	$67,444,741	$177,494,934	$207,326,005	$226,068,147	$1,055,153,065
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$6,771,231,995	$6,352,131,819	$6,101,041,487	$5,609,323,113	$1,844,323,814	$4,961,633,040	$5,326,834,797	$8,004,190,653	$44,970,710,717
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$548,195,127	$1,700,934,347	$2,402,760,736	$2,770,899,040	$1,211,469,426	$3,935,772,899	$4,246,923,918	$2,253,175,067	$19,070,130,559
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$231,248,905	$194,954,514	$196,434,562	$193,467,456	$52,558,028	$222,038,396	$237,153,242	$437,889,104	$1,765,744,208
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$43,085,276	$133,556,332	$176,503,700	$204,091,650	$101,563,996	$289,116,793	$311,973,545	$165,515,330	$1,425,406,622
Demonstration Group 7 – Non Duals 18-64							$197,034,128	$73,039,262	$270,073,390
Demonstration Group 8 – Non Duals 65+							$52,628,303	$19,509,306	$72,137,610
Designated State Health Programs	$74,849,675	$317,971,598	$361,117,274	$361,369,720	$335,807,682	$430,069,725	$745,876,000	$372,938,000	$2,999,999,674
With Waiver Total	**$7,738,480,708**	**$8,914,458,642**	**$9,516,190,798**	**$9,463,180,147**	**$3,687,896,674**	**$10,257,766,829**	**$11,588,095,411**	**$11,838,386,636**	**$73,004,455,847**
Expenditures (Over)/Under Cap	**$297,994,259**	**($17,416,691)**	**$379,717,553**	**$1,365,587,539**	**$2,375,248,149**	**$1,984,404,573**	**$2,167,794,583**	**$2,726,423,629**	**$11,279,753,594**