Federal-State Health Reform Partnership
Section 1115 Quarterly Report
Demonstration Year: 7 (10/1/2012 – 9/30/2013)
Federal Fiscal Quarter: 2 (01-01-2013 – 03/31/2013)

I. Introduction

On September 29, 2006, New York State received Centers for Medicaid and Medicare Services (CMS) approval to join in a partnership to reform and restructure the state's health care delivery system. To accomplish the reform and restructuring, CMS approved a five-year 1115 demonstration entitled, Federal-State Health Reform Partnership (F-SHRP). The waiver was effective October 1, 2006 through September 30, 2011. On March 31, 2011, CMS approved a three year extension of the F-SHRP Demonstration for the period April 1, 2011 through March 31, 2014. An amendment to the F-SHRP waiver, approved on July 29, 2011 included authority to mandatorily enroll participants in the Recipient Restriction Program, one of the recommendations of the Governor's Medicaid Redesign Team (MRT). CMS approved subsequent waiver amendments on September 30, 2011, March 30, 2012, August 31, 2012 and November 19, 2012 incorporating additional changes resulting from recommendations of the MRT.

Under F-SHRP, the federal government will invest up to $1.5 billion over the life of the Demonstration in agreed upon reform initiatives. The primary focus of these initiatives is to 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.

In accordance with Section VII, paragraph 46 and Attachment B of the Special Terms and Conditions (STCs), this quarterly report outlines Demonstration activity for the second quarter of Demonstration year seven (01/1/2013 – 3/31/2013).

II. Enrollment

Second Quarter

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments
Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)	84,186	1,306	3,863
Population 2 – TANF Adults aged 21 through 64 ("new" MC enrollment)	30,249	556	1,939
Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)	64,082	1,018	328
Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)	238,047	7,706	2,041
Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)	4,118	491	89
Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)	43588	2,771	1,152

Explanation of Populations:

- Population 1 – TANF child 1 through 20 ('new' MC Enrollment)
- Population 2 – TANF Adults 21 through 64 ('new' MC Enrollment)
- Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)
- Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)
- Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)
- Population 6 - Aged or Disabled Elderly (SSI 65+ New MC)

F-SHRP Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in current Demonstration Year[1]	29,534

Reasons for voluntary disenrollments include: enrollment in another plan, approved enrollee request to qualify as either exempt or excluded, relocation to residence outside county of enrollment and Local Departments of Social Services (LDSS) approval to disenroll based upon good cause.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in current Demonstration Year[1]	19,033

Reasons for involuntary disenrollments include: loss of Medicaid eligibility, eligibility transfers between Family Health Plus (FHPlus) and Medicaid, inappropriate enrollment or death.

III. Outreach/Innovative Activities

New York State Department of Health (the Department), Maximus and the local departments of social services (LDSS) continue to provide education and outreach in the areas of enrollment and health plan selection to Medicaid eligibles that are not enrolled in managed care.

A. Progress of Mandatory Managed Care Expansion

As of November 2012, mandatory Medicaid managed care programs are operating in all counties of the state, including New York City. During this quarter, staff continued to provide technical support to both county staff and providers in all counties. The counties opting to utilize the assistance of the enrollment broker also received support from Maximus staff.

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.1 million. Currently, 2.2 million are enrolled in a managed care plan, including eligible SSI recipients.

The MRT changes implemented during the reporting period had a significant impact on the work of New York Medicaid Choice (NYMC). During the reporting period, the following

benefits were transitioned into Medicaid managed care: Consumer Directed Personal Assistance Program (CDPAP) and Orthodontia for children with severe malocclusions.

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, thirteen (13) Medicaid offices and 18 Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 74% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 15 consumers per work session. A work session covers a half day of work activities.

A total of 2,651 presentations were scheduled by NYMC. Of these, 678 or 26% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

C. New York State (outside of NYC) Outreach Activities

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on the following systems and program changes:

- MRT #1458, including expansion of managed care enrollment to include: Long Term Home Health Care Program recipients, and children in foster care placed in the community directly by the LDSS; and expansion of benefits to include medical social services and home delivered meals.

- Enrollment center progress on the Health Care Eligibility and Assessment Renewal Tool (HEART tool). The HEART tool is used by the Enrollment Center to do Medicaid eligibility renewals.

Several Medicaid updates were published and Managed Care Technical Advisory Group conference calls were held to update the counties on changes to the program as a result of the MRT roll-out.

IV. F-SHRP Waiver

A. F-SHRP Waiver Amendments

Negotiations with CMS continued during the quarter to finalize the Special Terms and Conditions (STCs) for enrollment of individuals in the Long Term Home Health Care Program (LTHHCP), 1915(c) waiver program offering home based care to individuals who would otherwise be admitted to a nursing home. Dually eligible LTHHCP participants over age 21 will be required to enroll in a MLTC plan based on a phase-in schedule approved by CMS. Dually eligible LTHHCP participants aged 18 through 20 may choose to enroll in a MLTC plan approved to enroll individuals aged 18 and older, and dually eligible individuals aged 21 and under and non-duals of any age may voluntarily enroll in a MMMC plan.

The Department was also awaiting CMS authorization to enroll individuals in foster care who are placed in the community directly by LDSS. This does 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 was awaiting authorization to enroll individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

B. Twelve Month Continuous Coverage

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. This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Twelve months continuous coverage will be effective January 1, 2014 with the implementation of the New York Health Insurance Exchange.

C. Managed Long Term Care Program

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 offers 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 include Medicare and Medicaid covered services in the benefit package and require the participant to be nursing home eligible; partially capitated plans include only Medicaid covered benefits. Recipients must choose a plan to receive services. If no choice is made, the recipient is enrolled into a partially capitated plan.

The mandatory enrollment process began in New York County in June 2012 with announcement letters notifying recipients of fee for service personal care services (of at least 120 days and 120 days of Medicaid eligibility) that the Medicaid program was changing, the recipients then received a mandatory notice and materials to start the choice period. Recipients eligible were given sixty (60) days to choose a plan. The enrollment process has followed the enrollment plan submitted with the Partnership Plan amendment, by New York City borough (Bronx, Brooklyn, Queens and Staten Island) through December 2012. The population seeking services is now directed by Health Resources Administration (HRA) case workers to New York Medicaid Choice (NYMC), the New York State enrollment broker, which provides information and counseling to consumers, facilitates enrollment, educates plans and supports the state with data gathering.

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services and a supportive transition from the previous, fragmented, fee-for-service process to coordinated managed care.

1. Accomplishments

- Mandatory enrollment process initiated and continuing in all five boroughs. Due to the length of the prior authorization and Medicaid eligibility periods, additional cohorts from all NYC counties will continue to be identified for the enrollment process; the anticipated time frame to transition all personal care cases in the five boroughs is June 2013.

- Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Care Program (CDPCP) can now receive that benefit through a MLTCP and are included in the mandatory.

enrollment population. This was made effective in November of 2012. (See separate section below).

- Completed systemic process to identify recipients receiving Private Duty Nursing and/or Adult Care Health Care services and include these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population can be identified and will be transitioned when CMS approval is received.

- Expanded MLTCP availability by approving 16 service area expansions, 8 new lines of business for operational MLTCPs, and 5 new certificates of authority for new partially capitated plans.

- Developed, in consultation with local officials and NYMC, processes for Nassau, Suffolk and Westchester local social services districts to commence notification to participants in January 2013.

- Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued to plans, Care Management Administrative Services Contract Statement and Certification, Standard Clauses for Care Management Administrative Services Contract, and Care Management Administrative Services Contract Guidelines for MLTC Plans, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the managed long term care process.

- New York's Enrollment Broker, NYMC conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency.

- Expanded the scope of the transition of community based services to include Certified Home Health Agency care, Private Duty Nursing and Adult Day Health Care services in mandatory counties beginning in February 2013.

- Expanded the geographic transition region to include Nassau, Suffolk and Westchester counties in February 2013 with CMS approval.

- Continued to develop reporting mechanisms with Enrollment Broker and Computer Sciences Corporation to assure information is gathered as required as transition moves forward.

- Expanded MLTCP availability by approving 7 service area expansions, 1 new line of business for operational MLTCPs, and 3 new certificates of authority for new partially capitated plans.

- Expanded Department's complaint hotline staffing and developed and implemented a new standardized database for tracking complaints and resolution.

2. Significant Program Developments

- Initial mandatory enrollment process completed in NYC.
- Mandatory initiative moving into Nassau, Suffolk and Westchester counties.
- Continued incorporation of community based long term services and supports (LTSSs) into the MLTC benefit package – CDPAP, private duty nurse (PDN), adult day health care (ADHC), and CHHA.
- Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
- Continuity of care assured through transition period.
- Monitoring of network capacity, delivery systems and coordination of care.
- Development of data gathering systems to meet terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915 c Long Term Home Health Care Program.
- Created study protocol with External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirement related to transition of care.
- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.

3. 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 auto-assignments in New York City during November due to disruptions caused by Hurricane Sandy. This resulted in delays in issuing announcement and mandatory enrollment notices to targeted consumers during November; however schedules were back on track by December of 2013.
- NYMC, the Department's enrollment broker, had to redeploy systems and resources due to storm damage at their main facility.
- The Department's ability to systemically identify certain transition populations was delayed.

4. Summary of Self Directed Options

To minimize disruption and promote continuity for members receiving Consumer Directed Personal Assistance Services (CDPAS) a policy for the transition of CDPAS into MLTC and the Managed Care Organization (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 a clear direction to both the MLTC plans and MCOs supports its success.

This policy document was created in conjunction with a CDPAS Workgroup reflective of numerous stakeholders that met a number of times to discuss issues and develop policies for this new benefit:

- **Contracting During the Transition Period.** For the period October 1 2012-September 30, 2013 (Transition Period), Health Plans were required to contract with Fiscal Intermediaries (FIs) that currently have a contract or memorandum of understanding (MOU) with a LDSS and currently provide fiscal intermediary services to the health plan's member(s). The rate of payment must be at least the Fee for Service (FFS) rate of payment provided for in the contract or MOU between the FI and the LDSS. The MLTC/MCO is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the MLTC/MCO maintains two (2) FIs for each county. To adequately meet the needs of members who are newly assessed and considered eligible to receive CDPAS, the MLTC/MCO may also include in the MLTC/MCO's network FIs that do not have a contract or MOU with the LDSS.

- **Consumer Continuity of Care and Choice During the Transition Period.** The Department provided a list of Fiscal Intermediaries (FIs) currently providing FI services to FFS and MCO's enrolled members. To promote and maintain consumer choice, members may, during the Transition Period, change to any FI in the county that has a contract with the MCO.

  If, at the time of transition, an FI serves less than five (5) members in a county, MLTC/MCOs may encourage the members to use an alternative FI to minimize the number of FIs an MLTC/ MCO must have under contract. However, during the transition period, the expectation is that a member is not required to transition to a different consumer directed personal assistant due to the lack of an MLTC/MCO/FI contract. MLTC/ MCOs are prohibited from coercing or threatening the member or the worker to change FIs.

- **Network Adequacy During the Transition Period**. An MLTC/ MCO that does not have members participating in CDPAS in a particular LDSS must have at least two (2) FI contracts. This will ensure that members will have the option to participate in CDPAS.

- **FI Contracting and Network Adequacy After the Transition Period.** Beginning October 1, 2013, MLTC/MCOs may contract with two (2) FIs to cover members in multiple counties.

- **Model FI Contract and Department of Health Review.** The Department supports the use of the MLTC/MCO/FI model contract developed by the parties.

However, each MLTC/MCO/FI may negotiate the terms of the model contract, except that no agreement may contain provisions that would be considered management functions under 10 NYCRR. 98-1.11 or a provider agreement per 10 NYCRR 98-1 and the Provider Contract Guidelines without the express written approval of the Department. The MCO were required to submit to the Department the name(s) of the contracted FIs for each county prior to October 1, 2012 and the fourth quarter of each year thereafter, or upon request of the Department.

- **Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative.** Each member prior to receiving CDPAS must sign a consumer acknowledgement of the roles and responsibilities of the MLTC/MCO and the member. The Department has provided a sample acknowledgment form with the minimum requirements for its use by the MLTC/MCO.

- Transition of Consumer Direct Services continues throughout the mandatory counties.

- Department is preparing guidelines to share with all MLTCs regarding Consumer Direct Services to supplement existing educational materials shared previously.

5. Required Quarterly Reporting

- **Critical incidents:** The most significant critical incident for the reporting period was Hurricane Sandy. In order to assure ongoing connection to members the Department required Plans: to provide working phone numbers available 24/7 and alternate working email addresses; to make member service representatives available beyond office hours; to perform outreach to members to assess their safety and location; and to authorize out of network coverage for services to assure that members could continue services in alternative locations due to evacuations. In addition NYMC had to make adjustments due to being evacuated from their workplace such as shifting consumer representative phone lines, delaying mandatory mailings, and creating alternate access to systems. During recovery, Plans, the Department, the HRA and NYMC have continued to identify issues (i.e. mailing addresses; out of service area members) to assure ongoing continuity. Also during this time the Department, in partnership with NYMC is developing the critical incident reporting structure. Due to Hurricane Sandy, additional time is needed and the completed system will be build by April 15, 2013.

  The system continues to be refined to capture critical incidences.

- **Grievance and appeals:** The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter:

Period: 10/01/12 – 12/31/12			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	2294	2294	100%
# Standard/Expedited	564	219	39%
Total for this period:	2858	2513	88%

Appeals	
Total appeals filed for this period:	
Total for this period:	221

Period: 01/01/13 – 03/31/13			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	2712	2712	100%
# Standard/Expedited	730	689	94%
Total for this period:	3442	3401	99%

Appeals	
Total appeals filed for this period:	
Total for this period:	407

- **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 15,382, with 721 individuals who did not qualify to enroll in an MLTC plan.

- **Referrals and 30 days assessment:** This was the first quarter for Plans to report to the enrollment broker (New York Medicaid Choice) the number of individuals they received referral on from outside NYMC and the time frame in which assessments were completed. The establishment of the reporting system and training of Plans to assure data completeness and quality is an ongoing effort. This quarter there were 1,604 reported referrals with 1,362 dates of assessment within the 30 day time frame. This represents an 85% rate of assessment completion based on data elements submitted. The remaining 242 reported referrals had errors in the data that resulted in an inability to calculate a date for assessment. NYMC is reaching out to plans to improve the data reporting. The State will review the finalized data to determine if actions need to be taken.

- **Consistency of reporting has improved over the last quarter of 2012, but data discrepancies indicate that continued education and refining instructions is necessary.** Raw data shows total assessments conducted

by MLTC plans during the period is 3,379. Of those, only 1,504 were conducted within the 30 day time frame, 1,875 were not. This represents less than 50% compliance with the base timeframes, a significant drop from the 85% reported previously. However it appears that there are a variety of errors in plan reporting, and steps are being taken with NYMC to increase education and advise plans that the state will be taking actions if improvements are not seen immediately.

- **Referrals outside enrollment broker:** 6,580 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Referrals outside enrollment broker (consumers who were referred but did not qualify for the 30 day age calculation because of bad dates in date field):** 158 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Rebalancing efforts:** Due to delay in reporting of the current assessment data from SAAM (Semi-Annual Assessment of Members), the following data reflects activities prior to implementation of mandatory enrollment. This is statewide data for managed long term care plans, therefore a subset of individuals enrolled during that period (1,108 out of 58,846).

For the January – June 2012 reporting period, the MLTC population had 1,108 people admitted to a nursing home during the same time period.

For the 1,108 people, percent break out by reason(s):

Therapy/Rehab	59
Respite	4
Permanent Placement	34
Unsafe home	5.7
Other	2.9

For July - December 2012. There were 1,227 nursing home admissions (out of 78,269). Admitted to a nursing home during this time period:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30
Unsafe home	6.4
Other	3

- **Total complaints, grievances/appeals by type of issue:**

Reason for Grievance	Total
Dissatisfaction with quality of home care (other than lateness or absences)	
# Same Day	364
# Standard	155
# Expedited	3
Home care aides late/absent on scheduled day of service	
# Same Day	132
# Standard	28
# Expedited	0
Dissatisfaction with quality of day care	
# Same Day	5
# Standard	1
# Expedited	0
Dissatisfaction with quality of other covered services	
# Same Day	90

Reason for Grievance	Total
# Standard	34
# Expedited	1
Dissatisfaction with transportation	
# Same Day	1878
# Standard	213
# Expedited	0
Travel time to services too long	
# Same Day	3
# Standard	3
# Expedited	0
Wait too long to get appointment or service	
# Same Day	10
# Standard	3
# Expedited	0
Waiting time too long in provider's office	
# Same Day	1
# Standard	0
# Expedited	0

Reason for Grievance	Total
Dissatisfaction with care management	
# Same Day	44
# Standard	47
# Expedited	1
Dissatisfaction with member services and plan operations	
# Same Day	47
# Standard	54
# Expedited	0
Dissatisfied with choice of providers in network	
# Same Day	7
# Standard	1
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	
# Same Day	0
# Standard	4
# Expedited	0
Language translation services not available	
# Same Day	9
# Standard	1
# Expedited	0

Reason for Grievance	Total
Hearing/vision needs not accommodated	
# Same Day	0
# Standard	0
# Expedited	0
Disenrollment issues	
# Same Day	2
# Standard	3
# Expedited	0
Enrollment issues	
# Same Day	0
# Standard	2
# Expedited	0
Plan staff rude or abusive	
# Same Day	4
# Standard	2
# Expedited	0
Provider staff rude or abusive	
# Same Day	12
# Standard	3
# Expedited	0

Reason for Grievance	Total
Violation of other enrollee rights	
# Same Day	0
# Standard	0
# Expedited	0
Denial of expedited appeal	
# Same Day	0
# Standard	0
# Expedited	0
Other:	
# Same Day	104
# Standard	52
# Expedited	1
Total for this period:	
# Same Day	2710
# Standard	596
# Expedited	6

Reason for Appeal	Total
Denial or limited authorization of service including amount, type or level of service	
# of Standard Filed	166
# of Expedited Filed	0
Reduction, suspension or termination of previously authorized service	
# of Standard Filed	50
# of Expedited Filed	2

Reason for Appeal	Total
Denial in whole or part of payment for service	
# of Standard Filed	2
# of Expedited Filed	0
Other	
# of Standard Filed	1
# of Expedited Filed	0
Total appeals filed for this period:	
# of Standard Filed	219
# of Expedited Filed	2

Reason for Complaints	Total
Billing provider questions on coverage or payer	62
Dissatisfaction with quality of home care	14
Care not adequate to support client in home	9
Difficulty obtaining DME	6

V. Operational/Policy Developments/Issues

A. Mandatory Enrollment of the SSI Population

The state expanded mandatory managed care enrollment under the F-SHRP demonstration to 14 counties with managed care capacity and to SSI and SSI-related Medicaid beneficiaries statewide. As of November 2012, mandatory Medicaid managed care programs are operating in every county of the state, including New York City. Lewis, Jefferson, Warren and St. Lawrence counties implemented mandatory programs on October 1, 2012 and the last voluntary county (Chemung) began its mandatory program on November 1.

B. Health Plans

1. Changes to Certificates of Authority:

   - Amerigroup New York, LLC. had an address change on February 19, 2013.
   - Amida Care, Inc. was approved for a HIV Special Needs Plan in Queens County, effective February 19, 2013.

2. Routine surveillance activity for the quarter included operational surveys for the following plans:

   - New York State Catholic Health Plan, Inc. Follow up survey was conducted on January 18, 2013. No deficiencies were cited.

- Affinity Health Plan, Inc. Follow up survey was conducted on February 27, 2013 to February 28, 2013. A Statement of Deficiency was issued.
- VNS Choice. Survey was conducted on March 13, 2013 to March 15, 2013. A Statement of Deficiency was issued.
- Amerigroup New York, LLC. Follow up survey was conducted on March 20, 2013 to March 22, 2013. A Statement of Deficiency was issued.

Beginning in the second quarter of 2011, the Department has delegated the member services survey to its agent, IPRO. No problems were found with access to health plan telephone lines.

VI. Consumer Issues

Complaints

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 4,840 total reported complaints/action appeals, MMMC plans reported 622 complaints and action appeals from their SSI enrollees. This compares to 642 SSI complaints/action appeals from last quarter. The top 5 categories of complaints reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Balance Billing	19%
Dissatisfaction with quality of care	12%
Reimbursement/billing disputes	11%
Access to non-covered services	10%
Dissatisfaction with provider services	10%

VII. Successful Achievement of Milestones

A. Employer Sponsored Health Insurance (ESHI) Initiative

FHPlus Premium Assistance Program

The FHPlus Premium Assistance Program (PAP), for individuals who are eligible for FHPlus and have access to cost effective health insurance went into effect on January 1, 2008. Total enrollment as of March 31, 2013 is 3078 individuals.

Enrollment in ESHI Through FHPlus PAP	New Enrollment 1/01/13-3/31/13	Total Enrollment March 31, 2013
FHPlus Adults with children	**111**	**711**
FHPlus Adults without children	**346**	**2367**
Total	**457**	**3,078**

Age group for reporting Quarter 1/01/13 – 3/31/13	Number of Enrollees
19-44	2,615
45-64	463

B. Family Health Plus Buy-in Program

Development Activities

The United Federation of Teachers (UFT) contracted with New York State and the NYS Office of Children and Family Services to provide all 25,000 of their child care providers with access to health insurance through the FHPlus Employer Buy-In. UFT will partner with the Health Insurance Plan of New York to provide a network of services to their members. The child care workers are licensed and registered home child care providers in New York City and provide services to low-income families. During this quarter, a total of 1,077 unsubsidized UFT members were enrolled in the FHPlus Buy-In Program. For child care workers who are eligible for Medicaid or FHPlus, the premium will be paid through the state.

Civil Service Employees Association (CSEA) also received legislative authority and appropriations to provide health insurance coverage through the FHPlus Employer Buy-In Program. CSEA is actively seeking a plan to provide coverage to their member population.

FidelisCare, present in almost every county of the state, is seeking to contract with a vendor, U.S. Fire and Unified Life, to provide family planning services so that FidelisCare can participate in the FHPlus Employer Buy-in program. As a Catholic health plan, FidelisCare does not provide these services. U.S. Fire and Unified Life is working with the state to complete the necessary steps to be approved as a vendor for family planning with FidelisCare for the FHPlus Employer Buy-In program.

The Department continues to receive inquiries from small employers about the FHPlus Buy-in Program. However, many of these inquiries are from counties where there is no health insurance plan participation and no additional enrollments have been made.

Information on the FHPlus Employer Buy-in program for both managed care plans and potential employers is available on the Department website at:

http://www.nyhealth.gov/health_care/managed_care/family_health_plus_employer_buy-in/index.htm.

VIII. Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY)

During the quarter, the following events and activities occurred within the HEAL NY grant program.

A. Phase 1: Health Information Technology ($52.9 million)

In May 2006, 26 awards were announced. All awardees have fully-executed contracts (one MOU) in place with the Department. Twenty-four projects have been completed, with 18 fully spent. Two contracts were left incomplete.

B. Phase 2: Capital Restructuring Initiatives ($267.7 million)

In May 2006, 26 awards were announced. All awardees have fully-executed contracts (one MOU) in place with the Department. Twenty-four projects have been completed, with 18 fully spent. Two contracts were left incomplete.

C. Phase 3: Health Information Technology ($52.8 million)

The Department rebid the $53 million in Phase 3 HEAL NY funds for health information technology projects as part of Phase 5.

D. Phase 4: Berger Implementation ($550 million)

Between September 2007 and September 2008, 49 awards were announced in four rounds. Forty-three projects have been completed, with 36 fully spent. Four projects expect to fully spend. Two projects never went forward.

E. Phase 5: Health Information Technology: Advancing Interoperability and Community Wide Electronic Health Record Adoption ($105 million)

In April 2008, 19 awards were announced. All of these contracts have been fully executed and are being managed by the Office of Health Information Technology.

F. Phase 6: Primary Care Infrastructure ($100 million)

In September 2008, 79 awards were announced. Seventy five contracts were fully executed. Sixty-five projects have been completed, with 40 fully spent. Eleven projects are still active. Four projects never went forward (awards were either withdrawn or rescinded)..

G. Phase 7: Capital Restructuring Initiatives #2 ($150 million)

In September 2008, 26 awards were announced. Twenty-three contracts were fully executed. Seventeen projects have been completed, with 13 fully spent. One award was declined, another contract was rescinded due to significant changes to the scope of the contract and a third was never executed.

H. Phase 8: Residential Health Care Facility (RHCF) Rightsizing Demonstration Program ($30 million).

In September 2008, ten awards were announced. Contracts were developed in the HEAL NY unit in conjunction with the Office of Long Term Care. All contracts were fully executed, but one was rescinded for lack of progress. Five projects have completed their expenditures. Four are still active.

I. Phase 9: Local Health Planning Initiatives ($7 million)

In February 2009, a total of 18 awards were announced. Contracts were developed in the Workforce Development Unit and the Office of Rural Health. All projects have been completed, with 11 fully spent.

J. Phase 10: Health Information Technology - Improving Care Coordination and Management through a Patient Centered Medical Home Model Supported by an Interoperable Health Information Infrastructure ($60 million)

In September 2009, nine awards were announced. All of the contracts are fully executed and are being managed by the Office of Health Information Technology.

K. Phase 11: Capital Restructuring Initiatives #3 ($175 million)

In September 2009, 25 awards were announced. One facility, Saint Vincent's Catholic Medical Center has closed and will never go to contract. Eleven projects have been completed, with seven fully spent. Thirteen projects are still active.

L. Phase 12: Alternative Long Term Care Initiatives ($175 million)

In September 2009, 19 awards were announced. Thirteen projects have been completed, with nine fully spent. Six projects are still active.

M. Phase 13: Primary Care Initiatives

This pool of grant money was initially intended for primary care, but subsequently a decision was made not to issue a Request for Grant Application (RGA) for that purpose. No grants were ever made under Phase 13.

N. Phase 14: Discretionary Awards

Finger Lakes Health System: On June 3, 2008, $1,000,000 was awarded to the Department to support local health planning activities. This project has been completed.

Queens Expanding Access Grants: On February 17, 2009, a $15,950,000 grant was awarded to nine facilities in the New York City borough of Queens. The purpose of this grant is to address the public health need associated with the closures of St. John's Queens and Mary Immaculate Hospitals and St. Dominic's Health Center. Funding will be used to restore adequate access to primary care, inpatient care and emergency services. All projects are completed.

Oswego Health: On May 19, 2009, $17.8 million was awarded to support the operation of a diagnosis and treatment urgent care center at the site of the former A. L. Lee Hospital in Fulton, New York. This contract has been developed but is not fully executed. An additional $8.34 million was awarded to Oswego Hospital on September 4, 2009. This award is for primary care in Oswego County, particularly Central Square. This contract is completed.

Health Care Services In Queens: An RGA was issued on August 21, 2009 announcing the availability of $30 million for the support of health care services in Queens. Hospitals, diagnostic and treatment centers are eligible to apply, as are organizations eligible to apply for establishment as diagnostic and treatment centers. As of September 14, 2009, 25 applications had been received. Twelve awards totaling $30,052,135 were

announced September 25, 2009. All contracts are fully executed. Four projects have been completed and eight are still active.

P14 Discretionary: Thirteen awards were made on September 30, 2009; eight to hospitals and clinics totaling $57,340,000 and five to long term care facilities totaling $29,343,798. An additional award of $500,000 was made to Finger Lakes Health System to support research and analysis of local health care services. Two projects are inactive; one award was rescinded based on the facility's decision to not move forward with the project, the second did not go forward due to closure of the facility. Six projects have been completed and are fully spent. Five projects are still active.

O. Phase 15: Medicaid Transition Funding – ($50 million)

Seventy three applications were received by the May 24, 2010 deadline for submission. The selection of 17 award recipients was announced on September 2, 2010. Award letters to the awardees were mailed September 3, 2010. Funds will support capital projects which do the following: 1) help the financial viability of hospitals adversely affected by changes in Medicaid reimbursement enacted in the 2009-10 State Budget; and, 2) serve a large proportion of Medicaid beneficiaries and other underserved populations. One award will not go to contract and the funds will be repurposed. Five projects have completed, with four fully spent. Eleven projects are still active.

P. Phase 16: Urgent Care in Greenwich Village- ($14 million)

Grants to support an urgent care facility and other health care services in Greenwich Village for patients displaced by the closure of St. Vincent's Catholic Medical Center were made to 5 facilities. Projects will include an urgent care center providing round-the-clock care, seven days a week, to the Greenwich Village community and expansion of services at four well-established clinics in the St. Vincent's service area Two projects have completed and are fully spent. Three projects are still active.

Q. Phase 17: Health IT – Medical Home ($140 million)

New York State grants will provide fourteen awards to health care organizations within the state to improve the coordination of health care through the use of health information technology were announced September 10, 2010. The grants will support projects that continue to build health information technology infrastructure in New York State and include statewide collaborative and program evaluation components. Contracts are being managed by the Office of Health Information Technology.

R. Phase 18: Mental Health – ($30 million)

In September 2010, grants were awarded to 19 hospitals and clinics across New York State totaling $38.5 million to improve the coordination and delivery of inpatient and outpatient mental health services. One award will not go to contract Seven projects have been completed, with one fully spent. Eleven projects are still active.

S. Phase 19: Facility Specific Discretionary Awards- ($200 million)

In September 2010, grants were awarded to 32 health care facilities and agencies. An announcement for a continuous acceptance of applications for this series of grants remains posted to the Department website. One facility, Ira Davenport Memorial

Hospital, declined their award. Eighteen projects have been completed, with seventeen fully spent. Thirteen projects are still active.

T. Phase 20: Long Term Care Initiatives #2 – ($150 million)

In September 2010, grants were awarded to nine health care facilities and agencies in New York State to improve long-term care services and develop community-based alternatives to traditional nursing home care for older New Yorkers. All contracts are fully executed and still active.

U. Phase 21: Restructuring initiatives in Medicaid Redesign - ($450 million)

In November of 2011, the grant opportunity for $450 million under HEAL NY was announced. These funds represent the final major HEAL NY grants under New York State's existing Medicaid 1115 Waiver, which expires March 31, 2014.

In June 2012, grants totaling $301,280,229 were awarded to 40 hospitals and nursing homes. The Department of Health received a diverse group of applications from 99 facilities throughout the state. The awards were distributed equitably among the state's various health planning regions. The balance of the $450 million has been reserved to support additional, actionable projects, including, when developed, efforts to help develop a high-quality, financially secure and sustainable health system in Brooklyn.

One award was declined. Thirty-six contracts have been executed and the rest are being developed and processed by the HEAL NY Unit.

V. All Active Contracts

Letters were sent to 200 plus HEAL grantees with active contracts letting them know that they only had until December 31, 2013 to submit final payment claims. The date was moved up to allow claiming data to be entered into the new Statewide Financial System, and to ensure the proper claiming by DOH of federal funds by the end of HEAL/F-SHRP grant program.

W. We are in the process of repurposing any unclaimed funds from completed contracts

IX. Financial, Budget Neutrality Development Issues

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.

The *without waiver* amount is an estimated amount for persons eligible for the waiver using the initial per member per months (PMPMs) trended forward by trends included in the terms and conditions times the eligibles. The *with waiver* amount is equal to the actual expenditures for eligibles. The cost before the waiver (without waiver) must also be greater than the *with waiver* to have budget neutrality.

There is no allowance for Safety Net or Family Health Plus (members without children) expenditures; these must be funded with the savings.

All persons eligible for the waiver are included in the BN formula whether or not they are enrolled in managed care.

BN is calculated over the entire demonstration, not for each year of the demonstration. BN is a fluid calculation; many changes impact BN. Recipients transitioned from Fee for Service (FFS) to the Managed Care (MC) demographic mix of waiver eligibles changes over time, service utilization trends change, health plan capitation payments change, Medicaid fee schedules change, additional populations are made eligible through waiver amendments.

The current savings for the 1115 waiver is $51B (estimated through the proposed extension 12/31/13). However, this amount is overstated since CMS requires the amounts to match the CMS64, which has some time frames with little or no lag, therefore, understating the *with waiver* amounts. The actual savings amount is closer to **$35B**.

A. Quarterly Expenditure Report Using CMS-64 and Savings Estimate, Budget Neutrality and Savings Analysis **(See Attachment 1)**

B. Designated State Health Programs **(See Attachment 2)**

C. Reform Initiatives **(See Attachment 3)**

D. Hospital and Nursing Home Data **(See Attachment 4)**

X. Other

1. Integrated Programs:

   No Change.

2. Changes to Certificates of Authority:

   No Change.

3. Consumer Issues:

   No change.

4. FY2013 State Budget Changes to Medicaid:

   Under the FY2013 New York state budget, all previously existing exclusions or exemptions from mandatory enrollment into Medicaid managed care were eliminated. The commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits are in place. Two additional capitated programs were created within the Medicaid program: Fully Integrated Duals Coordination Organizations and DISCOs. The budget also provides the Commissioner of Health with the authority to include additional services in the Medicaid managed care plan benefit package.

XI. Transition Plan Updates

Attachment 5 contains the Department's updated Transition Plan indicating how New York State will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Federal-State Health Reform Partnership demonstration.

Attachments

Contact:
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Albany, NY 12237
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Submitted on: February 28, 2013

Federal - State Health Reform Partnership
Actual Costs Through March 31, 2011 FFY 08 Updated to 21 month lag
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	$335,158,575	$415,792,416	$239,802,796	$544,500,114	$606,218,508	$664,827,398	$3,134,377,777
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	$161,171,664	$214,944,753	$126,787,422	$260,696,655	$289,658,081	$317,069,886	$1,516,704,295
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	$5,380,061,232	$5,168,621,962	$2,841,157,566	$4,879,674,503	$5,082,430,780	$8,949,548,487	$45,038,794,298
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	$3,171,887,386	$4,195,753,282	$2,585,985,210	$5,995,887,778	$6,866,528,192	$3,866,564,193	$29,784,089,299
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	$174,213,750	$155,247,220	$91,494,819	$126,498,845	$116,680,610	$377,760,614	$1,427,819,635
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	$234,685,000	$296,320,668	$177,917,010	$434,863,171	$494,242,828	$276,331,136	$2,148,716,124
Demonstration Group 7 – Non Duals 18-64						$0	$233,691,291	$344,368,194	$578,059,485
Demonstration Group 8 – Non Duals 65+						$0	$62,159,385	$89,615,201	$151,774,586
W/O Waiver Total	$8,036,474,967	$8,897,041,951	$9,457,177,607	$10,446,680,301	$6,063,144,823	$12,242,121,066	$13,751,609,675	$14,886,085,109	$83,780,335,499
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	$110,711,363	$153,389,729	$74,728,987	$257,199,233	$284,749,509	$310,490,961	$1,363,722,682
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	$92,535,888	$138,057,589	$67,444,741	$182,837,248	$202,422,200	$220,721,405	$1,016,345,936
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	$3,639,685,043	$4,786,271,458	$1,844,318,724	$4,647,440,419	$4,773,363,516	$7,639,481,690	$40,453,924,663
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	$1,662,538,789	$2,497,718,794	$1,211,469,426	$4,304,193,758	$4,876,694,637	$2,716,660,181	$19,518,405,059
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	$122,008,234	$161,944,338	$52,558,144	$176,273,857	$169,511,061	$389,019,447	$1,497,518,500
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	$155,867,608	$198,327,040	$101,563,996	$329,137,844	$372,916,474	$207,740,573	$1,542,195,142
Demonstration Group 7 – Non Duals 18-64							$197,034,128	$293,365,831	$490,399,959
Demonstration Group 8 – Non Duals 65+							$52,628,303	$78,364,249	$130,992,552
Designated State Health Programs	$74,849,675	$317,971,598	$361,117,274	$361,369,720	$304,012,722	$632,200,000	$632,200,000	$316,100,000	$2,999,820,989
With Waiver Total	$7,738,480,708	$8,914,458,642	$6,144,464,200	$8,297,078,667	$3,656,096,740	$10,529,282,359	$11,561,519,828	$12,171,944,338	$69,013,325,483
Expenditures (Over)/Under Cap	$297,994,259	($17,416,691)	$3,312,713,407	$2,149,601,633	$2,407,048,083	$1,712,838,707	$2,190,089,846	$2,714,140,771	$14,767,010,016

Federal - State Health Reform Partnership
Budget Neutrality Analysis

Groups to be Included in the Demonstration	FFY 2007 DY1 PMPM	FFY 2008 DY2 PMPM	FFY 2009 DY3 PMPM	FFY 2010 DY4 PMPM	FFY 2011 DY5 PMPM	SFY 2012 DY6 PMPM	SFY 2013 DY7 PMPM	SFY 2014 DY8 PMPM
	WITHOUT WAIVER PMPMS							
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$482.15	$514.58	$549.19	$586.13	$625.56	$667.00	$711.00	$758.00
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$661.56	$705.21	$751.73	$801.33	$854.19	$909.00	$967.00	$1,029.00
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.	$1,746.00	$1,852.00	$1,966.00	$2,086.00	$2,214.00	$2,349.00	$2,493.00	$2,646.00
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.	$1,746.00	$1,852.00	$1,966.00	$2,086.00	$2,214.00	$2,349.00	$2,493.00	$2,646.00
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.	$1,126.00	$1,186.00	$1,250.00	$1,318.00	$1,389.00	$1,464.00	$1,542.00	$1,625.00
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.	$1,126.00	$1,186.00	$1,250.00	$1,318.00	$1,389.00	$1,464.00	$1,542.00	$1,625.00
Demonstration Group 7 – Non Duals 18-64							$8,873.37	$9,396.90
Demonstration Group 7 – Non Duals 65+							$8,111.89	$8,403.92

Groups to be Included in the Demonstration	DY 1 (10/1/06 - 9/30/07)	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)	DY 5 (10/1/10 - 3/31/11)	DY 6 (4/1/11 - 3/31/12)	DY 7 (4/1/12 - 3/31/13)	DY 8 (4/1/13 - 3/31/14)
	WITH WAIVER PMPMS							
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$272.53	$264.53	$181.41	$216.23	$194.94	$315.06	$333.97	$354.00
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$525.15	$535.27	$431.60	$514.69	$454.39	$637.52	$675.77	$716.32
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.	$1,735.16	$1,985.92	$1,330.03	$1,931.69	$1,437.20	$2,237.21	$2,341.40	$2,258.67
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.	$1,152.14	$1,387.28	$1,030.48	$1,241.79	$1,037.20	$1,686.25	$1,770.56	$1,859.09
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.	$1,171.82	$1,412.28	$875.42	$1,374.86	$797.90	$2,040.06	$2,240.18	$1,673.43
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.	$800.56	$911.61	$830.20	$882.14	$792.91	$1,108.07	$1,163.47	$1,221.64
Demonstration Group 7 – Non Duals 18-64							$7,481.48	$8,005.18
Demonstration Group 7 – Non Duals 65+							$6,868.07	$7,348.83

Federal - State Health Reform Partnership
Budget Neutrality Analysis

	MEMBER MONTHS							
Groups to be Included in the Demonstration	DY 1 (10/1/06 - 9/30/07)	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)	DY 5 (10/1/10 - 3/31/11)	DY 6 (4/1/11 - 3/31/12)	DY 7 (4/1/12 - 3/31/13)	DY 8 (4/1/13 - 3/31/14)
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	153,905	493,359	610,278	709,386	383,341	816,342	852,628	877,081
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	53,178	157,677	214,401	268,235	148,430	286,795	299,543	308,134
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.	3,902,362	3,198,583	2,736,552	2,477,767	1,283,269	2,077,341	2,038,681	3,382,293
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.	475,807	1,226,093	1,613,371	2,011,387	1,168,015	2,552,528	2,754,323	1,461,287
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.	197,341	138,042	139,371	117,790	65,871	86,406	75,668	232,468
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.	53,819	146,506	187,748	224,826	128,090	297,038	320,521	170,050
Demonstration Group 7 – Non Duals 18-64							26,336	36,647
Demonstration Group 7 – Non Duals 65+							7,663	10,664

Attachment 2

Federal-State Health Reform Partnership (F-SHRP)

Designated State Health Program Claim Sources

Demonstration Year 6 (October 1, 2011 - September 30, 2012)

Documented Cash Disbursements to Date

Agency/Program								
DOH	Claim Period	1-3/12 QER	7-9/12 QER					Total
AIDS Drug Assistance Program	10-12/11	$3,909,434						$3,909,434
	1-3/12		$0					$0
	4-6/12							$0
	7-9/12							$0
Healthy New York	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Tobacco Control Program	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Health Workforce Retraining	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Recruitment and Retention of Healthcare Workers	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Pay for Performance Demonstration	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Telemedicine Demonstration	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Early Intervention Services	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
SOFA								
Community Services for the Elderly	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Expanded In-Home Services to the Elderly Program	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0

OMRDD								
Residential and Community Support Services	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
OCFS								
Services to Special Education Children	10-12/11							$0
	1-3/12							$0
	4-6/12							$0
	7-9/12							$0
Total		$3,909,434	$0	$0	$0	$0	$0	$3,909,434
Federal Share		$1,954,717	$0	$0	$0	$0	$0	
Claims Reported to Date		$3,909,434	$3,909,434	$3,909,434	$3,909,434	$3,909,434	$3,909,434	
Federal Share		$1,954,717	$1,954,717	$1,954,717	$1,954,717	$1,954,717	$1,954,717	

New York State Department of Health

Federal-State Health Reform Partnership (F-SHRP)
Report of Reform Initiatives For the Period 01/01/13 - 03/31/13

Awards Under FFY 2007	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 2 Restructuring	$230,831,661		$230,831,661	$188,409,521		$188,409,521
Community Health Center Capital Program	$10,000,000		$10,000,000	$6,831,499	$29,914	$6,861,413
Displaced Worker Program	$12,614,885		$12,614,885	$11,618,214		$11,618,214
HEAL NY Phase 4: Implementation of Commission Mandates	$362,299,349		$362,299,349	$331,341,559	$570,443	$331,912,002
	$615,745,895	$0	$615,745,895	$538,200,793	$600,357	$538,801,150

Awards Under FFY 2008	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 4: Implementation of Commission Mandates	$187,700,651		$187,700,651	$179,443,997		$179,443,997
HEAL NY Phase 5: Health IT	$104,944,003		$104,944,003	$102,972,298	$306,259	$103,278,557
HEAL NY Phase 6: Primary Care Services	$99,885,522		$99,885,522	$79,913,786	$3,842,571	$83,756,357
HEAL NY Phase 7: Berger Lookalikes and coverage partners	$149,951,753		$149,951,753	$131,282,517	$5,334,650	$136,617,167
HEAL NY Phase 8: Nursing Home Rightsizing	$30,000,000		$30,000,000	$19,777,841	$827,126	$20,604,968
	$572,481,929	$0	$572,481,929	$513,390,439	$10,310,605	$523,701,045

Awards Under FFY 2009	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 10: Health IT	$99,914,713		$99,914,713	$55,290,209	$15,761,003	$71,051,212
HEAL NY Phase 11: Restructuring	$174,343,776		$174,343,776	$83,681,330	$18,636,066	$102,317,396
HEAL NY Phase 12: Long Term Care	$172,363,541		$172,363,541	$118,517,286	$16,202,501	$134,719,787
HEAL NY Phase 14(Q) - Targeted Hospitals, Queens	$15,950,000		$15,950,000	$15,011,782		$15,011,782
HEAL NY Phase 14(Q2) - Targeted Hospitals, Queens	$30,052,135		$30,052,135	$15,857,713	$3,196,003	$19,053,717
HEAL NY Phase 14(Os) - Targeted Hospitals, Oswego	$17,800,000		$17,800,000	$17,800,000		$17,800,000
HEAL NY Phase 14(D) - Targeted Hospitals, Discretionary	$87,183,798		$87,183,798	$49,459,713	$7,152,397	$56,612,110
	$597,607,963	$0	$597,607,963	$355,618,033	$60,947,970	$416,566,003

Awards Under FFY 2010	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 15 - Medicaid Transition Funding	$49,927,203		$49,927,203	$19,747,206	$4,043,108	$23,790,314
HEAL NY Phase 16 - Ambulatory Care Lower Manhattan	$14,000,000		$14,000,000	$5,878,267	$328,123	$6,206,390
HEAL NY Phase 17-Health IT in Expanded Care Coordination	$138,575,701		$138,575,701	$45,872,718	$11,367,510	$57,240,228
HEAL NY Phase 18- Mental Health Services	$38,501,949		$38,501,949	$11,559,985	$3,789,499	$15,349,485
HEAL NY Phase 19- Facility Specific Reconfiguration	$200,181,491		$200,181,491	$136,715,550	$20,319,171	$157,034,721
HEAL NY Phase 20 - Long Term Care Initiatives #2	$150,794,505		$150,794,505	$83,125,121	$23,414,424	$106,539,545
	$591,980,849	$0	$591,980,849	$302,898,847	$63,261,835	$366,160,682

Awards After FFY 2010	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase CD - Commissioner's Discretion (PHL Section 2818(6))	$47,157,680	$2,000,000	$49,157,680	$3,600,000	$40,100	$3,640,100
HEAL NY Phase 21 - Restructuring Initiatives in Medicaid Redesign	$295,683,549		$295,683,549	$33,005,414	$95,528,252.14	$128,533,666
	$342,841,229	$2,000,000	$344,841,229	$36,605,414	$95,568,352	$132,173,766

	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
Total All Health Reform Programs	**$2,720,657,865**	**$2,000,000**	**$2,722,657,865**	**$1,746,713,526**	**$230,689,120**	**$1,977,402,646**

Signed: Marybeth Hefner Date: 4/04/13

Name: Marybeth Hefner
Title: Deputy Director, Fiscal Management Group

New York State Medicaid
Inpatient and Nursing Home Information
FFS Expenditures, Eligible Months, Days and Discharges
January 1, 2013 through March 31, 2013

Q4: October 1, 2011 - September 30, 2012*

Inpatient Hospital	Medicaid Expenditures	Medicaid Discharges	Medicaid Cost Per Discharge	Medicaid Member months	Discharges PMPY
Medicaid FFS	$ 2,848,685,452	252,476	$ 11,283	12,358,573	0.25
Managed Care**	$ 4,314,201,837	518,543	$ 8,320	41,362,681	0.15
Total Medicaid	$ 7,162,887,289	771,019	$ 9,290	53,721,254	0.17
Nursing Home	Medicaid Expenditures	Medicaid Days	Medicaid Cost Per Day	Medicaid Member months	Days PMPY
Medicaid FFS	$ 6,279,933,713	29,200,157	$ 215	1,288,585	271.93
Managed Care**	$ 151,097,405	490,046	$ 308	41,781,872	0.14
Total Medicaid	$ 6,431,031,118	29,690,203	$ 217	43,070,457	8.27

***For discharges paid through March 2013**

**Managed care data includes an estimate for under-reporting of hospital encounter data

Managed care cost is a blended rate of plan paid claims and encounter proxy costs during the time period.

Managed care member months used for nursing home calculation include managed long-term care member months as the nursing home utilization for those members is in the managed care utilization.

Attachment 5

New York State

Federal-State Health Reform Partnership

Medicaid Section 1115 Demonstration

Transition Report

I. Introduction

On September 29, 2006, New York State received CMS approval to join in a partnership to reform and restructure the State's health care delivery system. To accomplish the reform and restructuring, CMS approved an 1115 demonstration entitled, Federal-State Health Reform Partnership (F-SHRP). The waiver was effective October 1, 2006 through September 30, 2011. On March 31, 2011, CMS approved a three year extension of the F-SHRP Demonstration for the period April 1, 2011 through March 31, 2014.

On January 1, 2014, New York will have made considerable progress in implementing the ACA. Specifically, New York will have expanded coverage, established an Alternative Benefit Plan, modified its eligibility system, and made changes to access to care and reforms to the payment and delivery system. The ACA expands Medicaid eligibility for individuals under the age of 65, with income at or below 133 percent of the Federal Poverty Level (FPL). In NYS, some of these individuals are currently eligible under New York's Partnership Plan 1115 Waiver.

II. Transition Plan

A. Seamless Transitions

i. **Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 regardless of disability status with income at or below 133 percent of the FPL;**

The populations transitioning to coverage under the ACA are currently covered under New York's Partnership Plan 1115 waiver. Although New York will transition individuals from the waiver to coverage under the ACA, the State intends to maintain the authority included in this waiver to mandatorily enroll individuals into managed care in the following counties: Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

Table 1: Individuals Enrolled in Medicaid Managed Care

Current State Plan Mandatory and Option Groups	Current FPL and/or other qualifying criteria
Pregnant women	Income up to 200%
Children under age 1	Income up to 200%
Children 1 through 5	Income up to 133%
Children 6 through 18	Income up to 133%
Children 19-20	Income at or below the monthly income standard
Parents and caretaker relatives	Income at or below the monthly income standard
Adults and children (0-64) receiving Supplemental Security Income payments or otherwise disabled	Income at or below the monthly income standard

Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

The Demonstration population of parents/caretakers with MAGI income between 138% and 150% of FPL will no longer be eligible for Medicaid. These individuals will be eligible for a tax credit under the ACA provided they do not have access to affordable coverage. The State will be seeking authority, through an amendment to the Partnership Plan waiver, for federal financial participation for an affordability wrap for those individuals who would have been eligible for the Demonstration prior to January 1, 2014 and are now able to purchase a Qualified Health Plan. The goal is to mitigate the increased costs for these individuals as they move from the Demonstration to the QHP. The State intends to implement an affordability wrap to pay the premium for the Qualified Health Plan for individuals in this income group who purchase a silver plan. 19 and 20 year olds living with parents with MAGI income between 138% and 150% FPL will have Medicaid coverage under MOE requirements.

Certain disabled adults and children and individuals age 65 and older will not transition to coverage under the ACA. For these individuals, as well as for those whose coverage will be transferred under the ACA, New York intends

to maintain the authority included in this waiver to mandatorily enroll individuals into managed care. For individuals determined eligible in the Exchange using MAGI rules, New York will provide 12 months of continuous coverage. In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 2, regardless of the delivery system through which they receive Medicaid benefits. Once the State begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility; for those individuals who are redetermined eligible consistent with ACA rules, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under MAGI rules, the individual is guaranteed a subsequent 12-month continuous eligibility period.

This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Authority for this population's eligibility during the 12 month continuous eligibility period is only in the 1115 waiver and therefore, individuals during this period would be eligible for expanded Medicaid levels and benchmark under the ACA, and are also subject to continuous coverage. The counties for which F-SHRP authorizes mandatory managed care are the same counties F-SHRP authorizes continuous coverage.

The Department is making the necessary system and program changes and expects implementation by January 1, 2014.

Table 2: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Social Security Act/Code of Federal Regulations Reference
Pregnant women aged 19 or older	1902(a)(10)(A)(i)(III) or (IV) and 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children up to age 19	1931 and 1925