Federal-State Health Reform Partnership (F-SHRP)
Section 1115 Quarterly Report
Demonstration Year: 7 (10/1/2012 – 9/30/2013)
Federal Fiscal Quarter: 4 (07-01-2013 – 09/30/2013)

I. Introduction

On September 29, 2006, New York State received approval from the Centers for Medicaid and Medicare Services (CMS) 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.

F-SHRP is due to expire March 31, 2014. The current populations, which consist of Mainstream Medicaid Managed Care (MMMC) and Managed Long Term Care (MLTC), will be transitioned into the Partnership Plan Medicaid Section 1115 Demonstration. The current Designated State Health Programs (DSHPs) under the F-SHRP Demonstration are under discussion with CMS. If extended, they will be modified to reflect agreements between CMS and the State and incorporated into the Partnership Plan.

Currently, a Phase Out Plan proposing the transition of the above mentioned populations to the Partnership Plan and addressing the continuation or expiration of the other F-SHRP components was submitted to CMS on November 27, 2013. Implementation of this Phase Out Plan is pending CMS' approval.

In accordance with Section VII, paragraph 49 and Attachment B of the Special Terms and Conditions (STCs), this annual/quarterly report outlines Demonstration activity for the fourth quarter (07/1/13 – 9/30/13) and Demonstration year seven (10/1/2012 – 9/30/2013).

II. Enrollment

Fourth Quarter

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments
Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)	88,829	1,508	3,941
Population 2 – TANF Adults aged 21 through 64 ("new" MC enrollment)	31,544	668	1,841
Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)	60,692	1,717	312
Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)	242,713	9,744	2,098
Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)	3,712	308	46
Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)	45,980	2,537	527

Demonstration Year Voluntary Disenrollment

Population Groups	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)	1,400	1,306	1,381	1,508
Population 2 – TANF Adults aged 21 through 64 ("new" MC enrollment)	646	556	636	668
Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)	1,057	1,081	1,262	1,717
Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)	7,808	7,706	8,857	9,744
Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)	687	491	611	308
Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)	4,088	2,771	3,244	2,537

Demonstration Year Involuntary Disenrollment

Population Groups	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)	4,008	3,863	3,932	3,941
Population 2 – TANF Adults aged 21 through 64 ("new" MC enrollment)	2,122	1,939	1,837	1,841

Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)	**411**	**328**	**391**	**312**
Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)	**2,316**	**2,041**	**2,566**	**2,098**
Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)	**69**	**89**	**56**	**46**
Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)	**695**	**1,152**	**541**	**527**

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	**62,007**

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	**37,121**

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).

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 17 Job Centers.

The Education and Enrollment Driven Referral (EED) process was responsible for 84% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 14 consumers per work session. A work session covers a half day of work activities.

A total of 2,649 presentations were scheduled by NYMC. Of these, 584 or 22% 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 MRT #1458, 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.

IV. F-SHRP Waiver

A. F-SHRP Waiver Amendments

The Department finalized and received CMS approval of 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 are 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.

CMS granted the Department authorization for MMMC enrollment of 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 received CMS authorization for managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

B. Benefit Changes/Other 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 the Long Term Home Health Care Program (LTHHCP) and were receiving home delivered meals under the LTHHCP. This addition to the benefit package will prevent the loss of access to this service for LTHHCP participants upon MMMC enrollment and may reduce the risk of failure for these specific enrollees to remain in the community.

Pharmacy Network for Specialty Drugs: Effective April 1, 2013, managed care organizations (MCO) must 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 has designated a specific pharmacy or pharmacies for filling prescriptions for a particular drug or drugs, the enrollee may fill such prescriptions at any other pharmacy in the MCO's network provided that the pharmacy agrees to a comparable price of the pharmacy designated by the MCO.

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

Directly Observed Therapy for Tuberculosis (TB/DOT): The Department received CMS approval to include 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.

C. 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 certain adults in the same way that it has for children on Medicaid. The adults covered under this proposal are those that are categorized under the Modified Adjusted Gross Income (MAGI) category, to potentially include pregnant women, parents/caretaker relatives, and other adults under age 65. Twelve months continuous coverage will be effective January 1, 2014 with the implementation of the New York Health Insurance Marketplace.

D. 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, FFS 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. The mandatory transition process for Personal Care Services in NYC counties was essentially completed as of September 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 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 (PDN) and/or Adult Day 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 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority since September 2012.

   - 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. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant.

- 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. The transition expanded to Rockland and Orange counties as of September 2013.

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

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

- Additional education was developed and shared with MLTC Plans addressing Consumer Directed Personal Assistance Services and its use.

- Entered into discussion to initiate a Member Services survey of all MLTC Plans on a semi-annual basis by the State's contractor to assure information shared with potential enrollees is accurate and helpful.

- Developed, with the Enrollment Broker, training for local social services in the transition process, identifying the districts ongoing role during the transition, establish clear communication mechanisms with MLTC plans, SDOH and stakeholders to ease transitions, addressing potential systemic issues and ensure informed choice by stakeholders and enrollees.

- Initiated activities for expansion of transition to Albany, Erie, Onondaga and Monroe counties in December 2013.

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 LTSS into the MLTC benefit package – CDPAP, 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 LTHHCP.
   - 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.
   - Established mechanism for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.
   - Improvement to network reporting guidelines for all MLTCs.
   - Initiated training for use of the mandatory Uniform Assessment System for New York State which will replace the Semi Annual Assessment of Members tool previously utilized by MLTC assessors.
   - Developed Guidelines for MLTC plans and the State's Enrollment Broker on Involuntary Disenrollment to assure appropriate notice and ongoing care as needed to support health and safety of enrollees in the community.
   - Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.
   - Enhanced monitoring of MLTC Provider Networks where deficiencies are identified and action taken.
   - Enhanced oversight of Social Day Care utilization and plan contract monitoring.

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 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.

- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, SDOH, 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.

4. Summary of 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 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 are required to contract with FIs that currently have a contract or 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 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 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.

- Posting of Consumer Direct Services guidelines to the Department of Health website for clarification.

5. Required Quarterly Reporting

   A. **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 to complete the system.

The system continues to be refined at this time, with an anticipated completion in Fall, 2013.

No critical incidents have come to the attention of the Department this quarter. We continue to work on a formal electronic structure that will be in place this quarter.

B. **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:	580

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

Grievances			
Period: 04/01/13 – 06/30/2013		**Resolved**	**Resolved %**
# Same Day	3427	3427	100%
# Standard/Expedited	751	715	95%
Total for this period:	4178	4142	99%

Appeals	
Total appeals filed for this period:	
Total for this period:	413

Period: 7/01/13 - 9/30/13			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	4275	4275	100%
# Standard/Expedited	1350	1357	101%
Total for this period:	5625	5632	100%

Appeals	
Total appeals filed for this period:	
Total for this period:	578

C. **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.

D. **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. For the quarter from July to September, the Department continues to track the data provided by NYMC and will continue to identify areas that need improvement.

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 3,491. Of those, only 1,598 were conducted within the 30 day time

frame, 1,899 were not. This represents less than 50% compliance with the base timeframes, however non compliance is appears to be isolated to certain plans. The State's enrollment broker NYMC has provided additional education regarding reporting and a steady improvement in quality and timelines is apparent. The Department issued notification that effective next quarter (July) plan specific remedial actions will be taken as indicated

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

F. **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.

G. **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:

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). For the 1,227 people, percent by reason of admission:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30

Unsafe home	6.4
Other	3

For the January - June 2013 reporting period, the MLTC population had 1,422 people admitted to a nursing home during the same time period.

For the 1,422 people, percent break out by reason(s):

Therapy/Rehab	64
Respite	3
Permanent Placement	27
Unsafe home	5.6
Other/Unknown	6

- **Total complaints, grievances/appeals by type of issue for the fourth quarter:**

Reason for Grievances	Total
Dissatisfaction with quality of home care (other than lateness or absences)	**921**
# Same Day	605
# Standard	315
# Expedited	1
Home care aides late/absent on scheduled day of service	**438**
# Same Day	314
# Standard	124
# Expedited	0
Dissatisfaction with quality of day care	**21**
# Same Day	9
# Standard	12
# Expedited	0
Dissatisfaction with quality of other covered services	**340**
# Same Day	271
# Standard	69
# Expedited	0
Dissatisfaction with transportation	**2991**
# Same Day	2611
# Standard	378
# Expedited	2

Travel time to services too long	**15**
# Same Day	8
# Standard	7
# Expedited	0
Wait too long to get appointment or service	**30**
# Same Day	12
# Standard	17
# Expedited	1
Waiting time too long in provider's office	**2**
# Same Day	2
# Standard	0
# Expedited	0
Dissatisfaction with care management	**138**
# Same Day	87
# Standard	51
# Expedited	0
Dissatisfaction with member services and plan operations	**73**
# Same Day	28
# Standard	45
# Expedited	0
Dissatisfied with choice of providers in network	**25**
# Same Day	18
# Standard	7
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**10**
# Same Day	5
# Standard	5
# Expedited	0
Language translation services not available	**8**
# Same Day	0
# Standard	8
# Expedited	0
Hearing/vision needs not accommodated	**8**
# Same Day	0
# Standard	7
# Expedited	1
Disenrollment issues	**175**
# Same Day	6
# Standard	169
# Expedited	0
Enrollment issues	**13**
# Same Day	8
# Standard	5
# Expedited	0
Plan staff rude or abusive	**34**

# Same Day	11
# Standard	23
# Expedited	0
Provider staff rude or abusive	**92**
# Same Day	56
# Standard	36
# Expedited	0
Violation of other enrollee rights	**4**
# Same Day	1
# Standard	3
# Expedited	0
Denial of expedited appeal	**1**
# Same Day	1
# Standard	0
# Expedited	0
Other:	**302**
# Same Day	225
# Standard	76
# Expedited	1
Total for this period:	**5616**
# Same Day	4275
# Standard	1335
# Expedited	6

Reason for Appeal	**Total**
Denial or limited authorization of service including amount, type or level of service	**400**
# of Standard Filed	343
# of Expedited Filed	57
Reduction, suspension or termination of previously authorized service	**60**
# of Standard Filed	54
# of Expedited Filed	6
Denial in whole or part of payment for service	**119**
# of Standard Filed	119
# of Expedited Filed	0
Failure to provide services in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon grievance or appeal of grievance in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon appeal of plan action in a timely manner	**0**
# of Standard Filed	0

# of Expedited Filed	0
Other	**0**
# of Standard Filed	0
# of Expedited Filed	0
Total appeals filed for this period:	**578**
# of Standard Filed	566
# of Expedited Filed	12

Fraud and Abuse Complaints Reported during Quarter	11

Reason for Complaints	Total
Subcontractor questions on coverage or payer	63
Dissatisfaction with home health care services	34
Dissatisfaction with dental services/treatment	17
Difficulty obtaining DME	17

- **Total complaints, grievances/appeals by type of issue for the year (October 1, 2012- September 30, 2013):**

Reason for Grievances	Total
Dissatisfaction with quality of home care (other than lateness or absences)	**2553**
# Same Day	1726
# Standard	819
# Expedited	6
Home care aides late/absent on scheduled day of service	**0**
# Same Day	0
# Standard	0
# Expedited	0
Dissatisfaction with quality of day care	**0**
# Same Day	0
# Standard	0
# Expedited	0
Dissatisfaction with quality of other covered services	**829**
# Same Day	610
# Standard	216
# Expedited	3
Dissatisfaction with transportation	**9353**
# Same Day	8339

# Standard	1012
# Expedited	2
Travel time to services too long	**34**
# Same Day	21
# Standard	13
# Expedited	0
Wait too long to get appointment or service	**88**
# Same Day	50
# Standard	36
# Expedited	2
Waiting time too long in provider's office	**8**
# Same Day	7
# Standard	1
# Expedited	0
Dissatisfaction with care management	**399**
# Same Day	225
# Standard	213
# Expedited	1
Dissatisfaction with member services and plan operations	**245**
# Same Day	112
# Standard	133
# Expedited	0
Dissatisfied with choice of providers in network	**72**
# Same Day	51
# Standard	21
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**21**
# Same Day	6
# Standard	15
# Expedited	0
Language translation services not available	**22**
# Same Day	11
# Standard	11
# Expedited	0
Hearing/vision needs not accommodated	**12**
# Same Day	2
# Standard	9
# Expedited	1
Disenrollment issues	**199**
# Same Day	11
# Standard	188
# Expedited	0
Enrollment issues	**23**
# Same Day	11
# Standard	12

# Expedited	0
Plan staff rude or abusive	**57**
# Same Day	22
# Standard	25
# Expedited	0
Provider staff rude or abusive	**169**
# Same Day	111
# Standard	58
# Expedited	0
Violation of other enrollee rights	**9**
# Same Day	4
# Standard	5
# Expedited	0
Denial of expedited appeal	**2**
# Same Day	1
# Standard	1
# Expedited	0
Other:	**831**
# Same Day	570
# Standard	259
# Expedited	2
Total for this period:	**15964**
# Same Day	12706
# Standard	3236
# Expedited	22

Reason for Appeal	**Total**
Denial or limited authorization of service including amount, type or level of service	**984**
# of Standard Filed	917
# of Expedited Filed	67
Reduction, suspension or termination of previously authorized service	**260**
# of Standard Filed	250
# of Expedited Filed	10
Denial in whole or part of payment for service	**188**
# of Standard Filed	188
# of Expedited Filed	0
Failure to provide services in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon grievance or appeal of grievance in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon appeal of plan action in a timely manner	**0**
# of Standard Filed	0

# of Expedited Filed	0
Other	**1**
# of Standard Filed	1
# of Expedited Filed	0
Total appeals filed for this period:	**1433**
# of Standard Filed	1407
# of Expedited Filed	26

Fraud and Abuse Complaints Reported during Quarter	21

Reason for Complaints	Total
Subcontractor questions on coverage or payer	167
Dissatisfaction with home health care services	128
Dissatisfaction with dental services/treatment	17
Access to covered services (including transportation)	54
Enrollment issues	17
Case management	15
Difficulty obtaining DME	32

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:

- Wellcare of New York, Inc. was previously approved for Medicaid Advantage Plus in Bronx, Kings, Queens and New York counties. However, this designation was omitted from the COA in a previous edit. The Medicaid Advantage Plus designation was put back on the COA effective May 1, 2013.

For the period of July 1, 2013 – September 30, 2013 there were no changes.

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

   - Amida Care, Inc. Survey was conducted May 21, 2013 to May 24, 2013. A Statement of Deficiency was issued. A plan of correction has not yet been received.

   - UnitedHealthcare of New York, Inc. Survey was conducted on April 22, 2013. No deficiencies were cited.

   - HealthFirst PHSP, Inc. Survey was conducted April 17, 2013 to April 18, 2013. No deficiencies were cited.

   - Metro Plus Health Plan, Inc. and Metro Plus Health Plan SNP, Inc. Surveys were conducted June 17, 2013 to June 21, 2013. Statements of Deficiency are pending.

3. Routine provider directory surveys were conducted for health plans in the first half of 2013 with the following results. Where deficiencies were found, plans were required to provide plans of corrections:

   - The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:

     Amerigroup New York, LLC.
     Amida Care, Inc.
     HealthFirst PHSP, Inc.
     Health Insurance Plan of Greater New York.
     Hudson Health Plan, Inc.
     Independent Health Association, Inc.
     Metro Plus Health Plan, Inc.
     Metro Plus Health Plan SNP, Inc.
     MVP Health Plan, Inc.
     Neighborhood Health Providers, Inc.
     New York State Catholic Health Plan, Inc.
     UnitedHealthcare of New York, Inc.
     VNS Choice
     Wellcare of New York, Inc.

Beginning in the second quarter of 2011, the Department has delegated the member services survey to its agent, IPRO. None have been identified with access to health plan telephone lines.

C. Health Participation

During FFY 2012/2013 there were several expansions, one health plan name change, one Certificate of Authority updated to reflect an address change, one correction to a

Certificate of Authority and two Certificates of Authority were updated to reflect a line of business being taken off plans' Certificates of Authority.

- The New York Presbyterian Community Health Plan, which has no members and exists for claims run out only, changed its name to New York Presbyterian Plan Management LLC., effective June 1, 2012.*
- 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.
- Amerigroup New York, LLC. was approved for expansion for the Medicaid Advantage program in Suffolk, and Westchester counties, effective February 19, 2013.
- Amerigroup New York, Inc. Medicaid managed care was removed from Orange county effective July 1, 2013.
- HealthNow New York, Inc. Medicaid managed care and Family Health Plus was removed from Genesee and Niagara counties effective July 1, 2013.
- UnitedHealthcare of New York, Inc. was approved for expansion into Albany, Chautauqua, Cheumg, Columbia, Essex, Genesee, Niagara, and St. Lawrence counties for Medicaid managed care and Family Health Plus effective September 1, 2013.
- Wellcare of New York, Inc. was previously approved for Medicaid Advantage Plus in Bronx, Kings, Queens and New York counties. However, this designation was omitted form the COA in a previous edit. The Medicaid Advantage Plus designation was put back on the COA effective May 1, 2013.

* Represents retroactive changes that were not reported on the fiscal year 2011/2012 annual report.

VI. Consumer Issues

A. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings The Medicaid

Managed Care Advisory Review Panel (MMCARP) meeting was held September 27, 2013. In addition to a program update and a review of the minutes from the previous meeting, the agenda included the following presentations: Update regarding the New York State of Health Exchange; Managed Long Term Care/FIDA Update; and Auto-Assignment Rates Carve-In.

B. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning meetings were held on April 18, May 16 and June 20, 2013. The April meeting included presentations on: updates on MMC and FHPlus rates; 2012 Quality Incentive payments; stop-loss advance; response to plan association and Milliman letter regarding administrative and CRG adjustments; primary care rate increase (PCRI); managed care efficiency adjustments; MLTC risk corridor calculation; uniform

assessment tool; FIDA update; update on new populations and benefits; patient centered medical home.

The May meeting included: updates on MMC and FHPlus rates; MLTC rates, transition rates and timing; reserves; FIDA update; implementation of elective C-section and Percutaneous Coronary Intervention (angioplasty) initiatives; Behavorial Health Organization (BHO) presentation; mental health/pharmacy workgroup update; and a presentation by food and nutrition services agency, God's Love We Deliver.

Presentations at the June meeting included: MEDS/MMCOR report; mainstream April 2013 rates; PCRI; stop-loss/risk pools; an update on MLTC rates/risk corridor settlement; update on FIDA; update on BHO; Hepatitis C; a discussion of the standardized pharmacy prior authorization form; and a presentation on the New York City school-located vaccination program.

The Managed Care Policy and Planning meetings were held on July 18, August 15 and September 19, 2013. The July meeting included presentations on: Finance and Rate Development, Average Acquisition Cost (AAC)/Cost of Dispensing (COD), OPWDD DISCO/FIDA Update, Discussion of Exchange/Medicaid Update, Behavioral Health Update, and Early Intervention/Fiscal Agent.

The August meeting agenda included: Finance and Rate Development, FIDA Update, Behavioral Health/HARP Update, OMIG Managed Care Review Activities, and Encounter Data Monitoring.

Presentations at the September meeting included: Emergency Preparedness, Finance and Rate Development, FIDA Update, New York City Flu Immunization Program, Behavioral Health/HARP, Discussion of Basic Benefit Information, Encounter Data Monitoring, and an Update on New York State of Health Exchange for the Medicaid/Child Health Plus Programs.

C. 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 **4,575** total reported complaints/action appeals, MMMC plans reported **618** 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
Reimbursement/Billing	11%
Pharmacy	6%
Non-Medical Provider or MCO Services	10%
Quality of Care	14%
Balance Billing	19%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	15
AIDS Adult Day Health Care	0
Appointment Availability - PCP	4
Appointment Availability - Specialist	3
Balance Billing	118
Communications/Physical Barrier	0
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	14
Dental or Orthodontia	35
Emergency Services	36
Eye Care	4
Family Planning	0
Home Health Care	5
Mental Health or Substance Abuse Services/ Treatment	4
Non-covered Services	23
Non-Permanent Residential Health Care Facility	1
Personal Care Services	21
Personal Emergency Response System	0
Pharmacy	40
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	61
Quality of Care	88
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	72
Specialist or Hospital Services	12
Transportation	9
Waiting Time Too Long at Office	2
All Other Complaints	50
Total	**618**

Medicaid Advantage plans reported **10** complaints and action appeals.

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 June 30, 2013 is 3077 individuals.

Enrollment in ESHI Through FHPlus PAP	New Enrollment 4/01/13-6/30/13	Total Enrollment 4/01/13-6/30/13
FHPlus Adults with children	64	750
FHPlus Adults without children	281	2327
Total	345	3077

Age group for reporting Quarter 4/01/13 – 6/30/13	Number of Enrollees
19-44	**2590**
45-64	**487**

For the period of July 1, 2013 – September 30, 2013 data is not available at this time.

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 has partnered with the Health Insurance Plan of New York (Emblem Health) 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 1,239 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.

Due to recent legislation, the FHPlus Buy-In Program will be ending December 31, 2013. UFT consumers who are enrolled in Emblem Health have been notified and will be assisted by the New York State of Health in selecting a new health insurance plan.

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

During the past year 99 contracts have completed their work. This brings the total number of HEAL projects completed to 348 of 519.

During the final quarter of the year, 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 November 2006, 53 awards were announced. Contracts were executed for 47 capital restructuring projects. 46 contract projects were completed, with 43 fully spent. Twelve projects were not completed (awards were either withdrawn or rescinded) and one is still active.

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-eight projects have been completed, with 43 fully spent. Seven 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. Six projects are still active.

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. Six projects have completed their expenditures. Three 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 12 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. Four contracts are fully spent.

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. Thirteen projects have been completed, with nine fully spent. Ten projects are still active.

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

In September 2009, 19 awards were announced. Fourteen projects have been completed, with ten fully spent. Five 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: A request for grant applications (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. Five projects have been completed, six are still active and one expired with no spending.

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. Four 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. Eight projects have been completed, with seven fully spent. Two 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. Six projects have completed, with five fully spent. Ten 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 five facilities. Projects will include an urgent care center providing around-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 and the funds will be repurposed. Ten projects have been completed, with eight fully spent. Eight 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. Twenty-one projects have been completed, with 20 fully spent. Ten 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. Three projects are completed and fully spent. Six projects are 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-nine contracts have been executed and nine are fully spent. Twenty-one projects are still active.

V. New Award

On March 12, 2013 a $2 million award was made to Kingsbrook Jewish Medical Center to fund a strategic organizational review to develop options to reconfigure operations and services.

On August 9, 2013 a $9.3 M award was made to Edward John Noble Hospital to work with Canton Potsdam Hospital t create a financially viable healthcare facility in Gouverneur, NY.

On August 29, 2013 a $9 M award was made to Brookhaven Memorial Hospital for expansion of cardiac catheterization services.

On September 17, 2013 Lake Erie Regional Health Systems was awarded an additional $1 M to their phase 21 project.

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)**
Updated information on the Designated State Health Programs will be submitted upon receipt.

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

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

X. Other

A. 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.

B. Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract

On June 21, 2013, the Department received CMS approval of the October 1, 2012 amendment to the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract. This amendment modifies the previously approved August 1, 2011 version of the model contract and includes contract language changes related to implementation of various

Medicaid Redesign Team initiatives, other programmatic changes and a one-year extension of the contract through February 28, 2014. The contract amendment was sent to MCOs for signature on June 27, 2013.

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

Federal - State Health Reform Partnership
Actual Costs Through March 31, 2011 FFY 09 Updated to 21 month lag
Extension through 2014

Attachment 1

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	$415,792,416	$239,802,796	$544,361,378	$594,427,284	$651,895,918	$3,108,788,111
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	$214,944,753	$126,787,422	$260,885,727	$305,694,809	$334,624,626	$1,550,292,392
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	$5,168,621,962	$2,841,157,566	$4,843,425,289	$5,040,917,954	$8,926,172,481	$45,163,034,560
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	$4,195,753,282	$2,585,985,210	$6,032,136,992	$6,908,041,018	$3,889,940,199	$30,111,397,951
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	$155,247,220	$91,494,819	$149,090,947	$142,357,617	$392,116,627	$1,476,307,258
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	$296,320,668	$177,917,010	$412,271,069	$468,565,821	$261,975,123	$2,088,331,001
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**	**$9,895,908,352**	**$10,446,680,301**	**$6,063,144,823**	**$12,242,171,402**	**$13,755,855,179**	**$14,890,708,369**	**$84,227,985,344**
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	$153,389,729	$74,728,987	$241,641,042	$262,388,156	$286,108,009	$1,351,173,910
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	$138,057,589	$67,444,741	$177,494,934	$207,236,850	$225,971,559	$1,046,400,488
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	$4,786,271,458	$1,844,323,814	$4,961,633,040	$5,326,834,797	$8,004,190,653	$44,147,659,063
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	$2,497,718,794	$1,211,469,426	$3,935,772,899	$4,246,923,918	$2,253,175,067	$18,796,950,313
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	$161,944,338	$52,558,028	$222,038,396	$237,153,242	$437,889,104	$1,734,221,090
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	$198,327,040	$101,563,996	$289,116,793	$311,973,545	$165,515,330	$1,419,642,012
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	$335,807,682	$392,406,473	$770,985,000	$385,492,500	$2,999,999,922
With Waiver Total	**$7,738,480,708**	**$8,914,458,642**	**$9,516,190,798**	**$8,297,078,667**	**$3,687,896,674**	**$10,220,103,577**	**$11,613,157,939**	**$12,130,072,301**	**$72,117,439,308**
Expenditures (Over)/Under Cap	**$297,994,259**	**($17,416,691)**	**$379,717,553**	**$2,149,601,633**	**$2,375,248,149**	**$2,022,067,825**	**$2,142,697,239**	**$2,760,636,068**	**$12,110,546,036**

Federal - State Health Reform Partnership
Budget Neutrality Analysis

Attachment 1

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	$263.51	$216.23	$194.94	$296.08	$313.84	$332.68
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$525.15	$535.27	$550.41	$514.69	$454.39	$618.44	$655.55	$694.88
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	$2,139.82	$1,931.69	$1,437.21	$2,406.33	$2,634.40	$2,372.70
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	$1,390.16	$1,241.79	$1,037.20	$1,532.65	$1,532.65	$1,532.65
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	$1,533.91	$1,374.86	$797.89	$2,180.31	$2,568.81	$1,814.69
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	$931.22	$882.14	$792.91	$1,026.67	$1,026.67	$1,026.67
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

Attachment 1

Groups to be Included in the Demonstration	MEMBER MONTHS							
	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	608,952	709,386	383,341	816,134	836,044	860,021
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	53,178	157,677	214,145	268,235	148,430	287,003	316,127	325,194
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	2,851,190	2,477,767	1,283,269	2,061,909	2,022,029	3,373,459
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	1,728,412	2,011,387	1,168,015	2,567,960	2,770,975	1,470,121
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	128,061	117,790	65,871	101,838	92,320	241,303
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	189,540	224,826	128,090	281,606	303,869	161,215
Demonstration Group 7 – Non Duals 18-64						0	26,336	36,647
Demonstration Group 7 – Non Duals 65+						0	7,663	10,664

Federal-State Health Reform Partnership (F-SHRP) Attachment 2
Designated State Health Program Claim Sources
Demonstration Year 7 (October 1, 2012 - September 30, 2013)
Documented Cash Disbursements to Date

Agency/Program	Claim Period	7-9/13 QER	Total
DOH			
AIDS Drug Assistance Program			
	10-12/12	$15,358,079	$15,358,079
Healthy New York	1-3/13	$4,359,823	$4,359,823
	4-6/13	$18,818,035	$18,818,035
	7-9/13		$0
	10-12/12	$822,562	$822,562
Tobacco Control Program	1-3/13	$2,481,861	$2,481,861
	4-6/13		$0
	7-9/13		$0
	10-12/12	$5,878,233	$5,878,233
Health Workforce Retraining	1-3/13	$9,349,215	$9,349,215
	4-6/13		$0
	7-9/13		$0
	10-12/12		$0
Recruitment and Retention of Healthcare Workers	1-3/13		$0
	4-6/13		$0
	7-9/13		$0
	10-12/12		$0
Pay for Performance Demonstration	1-3/13		$0
	4-6/13		$0
	7-9/13		$0
	10-12/12	$3,253,165	$3,253,165
Telemedicine Demonstration	1-3/13	$5,309,981	$5,309,981
	4-6/13		$0
	7-9/13		$0
	10-12/12		$0
Early Intervention Services	1-3/13		$0
	4-6/13		$0
	7-9/13		$0
	10-12/12	$11,249,943	$11,249,943
	1-3/13		$0
SOFA	4-6/13		$0
Community Services for the Elderly	7-9/13		$0
	10-12/12		$0
Expanded In-Home Services to the Elderly Prog	1-3/13		$0
	4-6/13		$0
	7-9/13		$0
	10-12/12		$0
	1-3/13		$0
	4-6/13		$0

OMRDD	7-9/13						$0
Residential and Community Support Services							
	10-12/12						$0
	1-3/13						$0
OCFS	4-6/13						$0
Services to Special Education Children	7-9/13						$0
	10-12/12						$0
	1-3/13						$0
Total	4-6/13						$0
	7-9/13						$0
Federal Share		$76,880,897			$0	$0	$76,880,897
Claims Reported to Date		$38,440,449	$0	$0	$0	$0	
Federal Share		$76,880,897	$76,880,897	$76,880,897	$76,880,897	$76,880,897	
CMS 64.9 Inc DSHP Waiver Claim		$38,440,449	$38,440,449	$38,440,449	$38,440,449	$38,440,449	
	10-12/12	**$36,561,982**					
	1-3/13	**$21,500,880**					
Federal Share Claim	**4-6/13**	**$18,818,035**					
	7-9/13						
	Total	**$76,880,897**					
		$38,440,448					

New York State Department of Health

Federal-State Health Reform Partnership (F-SHRP)
Report of Reform Initiatives For the Period 07/01/13 - 09/30/13

Attachment 3

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	$6,861,413	$2,170,611	$9,032,024
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	$331,912,002	$627,604	$332,539,606
	$615,745,895	$0	$615,745,895	$538,801,150	$2,798,215	$541,599,365

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	$103,278,557		$103,278,557
HEAL NY Phase 6: Primary Care Services	$99,885,522		$99,885,522	$85,564,482	$2,399,714	$87,964,196
HEAL NY Phase 7: Berger Lookalikes and coverage partners	$149,951,753		$149,951,753	$137,178,531	$886,964	$138,065,495
HEAL NY Phase 8: Nursing Home Rightsizing	$30,000,000		$30,000,000	$21,176,293		$21,176,293
	$572,481,929	$0	$572,481,929	$526,641,859	$3,286,678	$529,928,538

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	$71,963,148	$7,100,395	$79,063,544
HEAL NY Phase 11: Restructuring*	$174,343,776		$174,343,776	$106,484,809	$6,168,698	$112,653,508
HEAL NY Phase 12: Long Term Care*	$172,363,541		$172,363,541	$136,366,759	$3,622,482	$139,989,240
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	$20,294,220	$1,408,503	$21,702,723
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	$56,883,077	$1,040,316	$57,923,393
	$597,607,963	$0	$597,607,963	$424,803,794	$19,340,395	$444,144,189

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	$24,452,923	$4,956,069	$29,408,992
HEAL NY Phase 16 - Ambulatory Care Lower Manhattan	$14,000,000		$14,000,000	$6,763,719	$161,948	$6,925,667
HEAL NY Phase 17-Health IT in Expanded Care Coordination	$138,575,701		$138,575,701	$58,962,407	$17,373,886	$76,336,293
HEAL NY Phase 18- Mental Health Services	$38,501,949		$38,501,949	$17,490,538	$4,904,711	$22,395,249
HEAL NY Phase 19- Facility Specific Reconfiguration	$200,181,491		$200,181,491	$158,450,362	$4,979,332	$163,429,695
HEAL NY Phase 20 - Long Term Care Initiatives #2	$150,794,505		$150,794,505	$113,296,721	$22,324,921	$135,621,642
	$591,980,849	$0	$591,980,849	$379,416,670	$54,700,868	$434,117,538

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))	$50,157,680	$9,299,198	$59,456,878	$5,836,100	$6,832,207	$12,668,307
HEAL NY Phase 21 - Restructuring Initiatives in Medicaid Redesign	$295,683,549		$295,683,549	$140,065,973	$27,585,786.06	$167,651,759
	$345,841,229	$9,299,198	$355,140,427	$145,902,073	$34,417,993	$180,320,066

	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	**$2,723,657,865**	**$9,299,198**	**$2,732,957,063**	**$2,015,565,546**	**$114,544,149**	**$2,130,109,695**

**Corrected misidentified amounts for prior periods by $337,057 - under phase 11 & 12; originally reported on March 2013 report.*

Signed: MaryBeth Hefner Date: 10/30/13

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
July 1, 2013 through September 30, 2013

Q4: October 1, 2012 - March 31, 2013*

Inpatient Hospital	Medicaid Expenditures	Medicaid Discharges	Medicaid Cost Per Discharge	Medicaid Member months	Discharges PMPY
Medicaid FFS	$ 1,133,735,947	98,032	$ 11,565	5,684,824	0.21
Managed Care**	$ 2,115,038,398	254,446	$ 8,312	20,918,314	0.15
Total Medicaid	$ 3,248,774,345	352,478	$ 9,217	26,603,138	0.16
Nursing Home	Medicaid Expenditures	Medicaid Days	Medicaid Cost Per Day	Medicaid Member months	Days PMPY
Medicaid FFS	$ 3,102,546,592.85	14,226,578	$ 218	5,684,824	30.03
Managed Care**	$ 104,320,011.21	416,164	$ 251	21,288,239	0.23
Total Medicaid	$ 3,206,866,604.06	14,642,742	$ 219	26,973,063	6.51

*For discharges paid through September 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 Marketplace 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