NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

February 28, 2013

Jessica Woodard
Project Officer
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Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

Enclosed is the New York State Department of Health's 2013 first quarter Quarterly Report for the Section 1115 Federal-State Health Reform Partnership, covering the period October 1, 2012 through December 31, 2012.

Sincerely,

[redacted]

Gregory S. Allen, Director
Division of Program Development & Management
Office of Health Insurance Programs

Enclosure
cc: M. Melendez

**Federal-State Health Reform Partnership**
**Section 1115 Quarterly Report**
**Demonstration Year: 7 (10/1/2012 – 9/30/2013)**
**Federal Fiscal Quarter: 1 (10/1/2012 – 12/31/2012)**

## 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 first quarter of Demonstration year seven (10/1/2012 – 12/31/2012).

## II. Enrollment

First Quarter

| Population Groups | Current Enrollees | # Voluntary Disenrollments | # Involuntary Disenrollments |
|---|---|---|---|
| **Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)** | **81,588** | **1,400** | **4,008** |
| **Population 2 – TANF Adults aged 21-64 ("new" MC enrollment)** | **29,574** | **646** | **2,122** |
| **Population 3 – Disabled Adults and Children (SSI 0-64 Current MC)** | **65,519** | **1,057** | **411** |
| **Population 4 – Disabled Adults and Children (SSI 0-64 New MC)** | **232,248** | **7,808** | **2,316** |
| **Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)** | **4,171** | **687** | **69** |
| **Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)** | **42,328** | **4,088** | **695** |

**Explanation of Populations:**

- Population 1 – TANF child 1 – 20 ('new' MC Enrollment)
- Population 2 – TANF Adults 21 – 64 ('new' MC Enrollment)
- Population 3 – Disabled Adults and Children (SSI 0 – 64 Current MC)
- Population 4 – Disabled Adults and Children (SSI 0 – 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]** | **15,686** |

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]** | **9,621** |

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 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. See **Attachment 1**: NYS Medicaid Managed Care Map.

During this quarter, staff was involved in training for both county staff and providers in each of the counties preparing for implementation of mandatory programs. Chemung, Jefferson, Lewis, St. Lawrence and Warren counties chose to accept the assistance of the enrollment broker.

[1] Demonstration year to date: 10/01/2012 – 03/31/2013

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.5 million, of which almost 2.3 million are eligible for Medicaid managed care. Eleven percent or approximately 257,000 of the consumers eligible for Medicaid managed care are SSI recipients. 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 six (6) HIV/AIDS Services Administration (HASA) sites, thirteen (13) Medicaid offices and seventeen (17) Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 60% 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 2,580 presentations were scheduled by NYMC. Five hundred and eight (508) or 20% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

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

During the quarter, five counties implemented mandatory Medicaid managed care programs. At the request of counties, training was held with county staff to provide an overview of the Medicaid managed care program.

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

- MRT # 1458, including: orthodontics for children with severe handicapping malocclusions included in the benefit package of all Medicaid managed care plans as of October 1; and, Consumer Direct Personal Care Services (CDPAS) included in the benefit package effective November 1.
- Status of the 1115 waiver and implementation of new mandatory counties.
- 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

On November 19, 2012, CMS approved a waiver amendment authorizing the state to: establish the Managed Long-Term Care (MLTC) program; mandatorily enroll previously exempt or excluded populations into mainstream Medicaid managed care (MMMC); and, implement a housing disregard for certain individuals. The MLTC program expands mandatory Medicaid managed care enrollment to dually-eligible individuals age 21 or over who receive community-based long-term care services in excess of 120 days. It also provides dually-eligible individuals age 18 - 21, as well as nursing home eligible non-dual individuals age 18 and older, the option to enroll in the MLTC program. Individuals whose needs are similar to: 1) residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) facility; and 2) participants receiving services through a Medicaid home and community based waiver, including the Long Term Home Health Care Program, are no longer exempt from the MMMC program. In addition, the amendment authorizes the state to implement a recent state law change in which individuals discharged from a nursing facility who enroll in the MLTC program may qualify for a housing disregard, under which these individuals will qualify for Medicaid eligibility under a special income standard.

Negotiations continued during the quarter to authorize enrollment of individuals in the Long Term Home Health Care Program (LTHHCP), a 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. Dual eligible LTHHCP participants aged 18 through 20 may choose to enroll in an MLTC plan approved to enroll individuals aged 18 and older, and dual eligibles aged 21 and under and non-duals of any age may voluntarily enroll in a MMMC plan.

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.

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.

- 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; and 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 Human Resource Administration (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.

    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: | 221 |

c. **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 9,893, with 42 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.

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. **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 MLTC 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 |

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

| **Reason for Grievance** | |
|---|---|
| **Dissatisfaction with quality of home care (other than lateness or absences)** | **Total** |
| # Same Day | 372 |
| # Standard | 155 |
| # Expedited | 2 |
| **Home care aides late/absent on scheduled day of service** | |
| # Same Day | 213 |
| # Standard | 34 |
| # Expedited | 1 |
| **Dissatisfaction with quality of day care** | |
| # Same Day | 2 |
| # Standard | 7 |
| # Expedited | 0 |
| **Dissatisfaction with quality of other covered services** | |
| # Same Day | 126 |
| # Standard | 49 |
| # Expedited | 1 |
| **Dissatisfaction with transportation** | |
| # Same Day | 1334 |
| # Standard | 176 |
| # Expedited | 0 |
| **Travel time to services too long** | |
| # Same Day | 2 |
| # Standard | 1 |
| # Expedited | 0 |

| Reason for Grievance | |
|---|---|
| **Dissatisfaction with quality of home care (other than lateness or absences)** | **Total** |
| **Wait too long to get appointment or service** | |
| # Same Day | 8 |
| # Standard | 11 |
| # Expedited | 1 |
| **Waiting time too long in provider's office** | |
| # Same Day | 0 |
| # Standard | 1 |
| # Expedited | 0 |
| **Reason for Grievance** | **Total** |
| **Dissatisfaction with care management** | |
| # Same Day | 25 |
| # Standard | 38 |
| # Expedited | 0 |
| **Dissatisfaction with member services and plan operations** | |
| # Same Day | 23 |
| # Standard | 13 |
| # Expedited | 0 |
| **Dissatisfied with choice of providers in network** | |
| # Same Day | 14 |
| # Standard | 7 |
| # Expedited | 0 |
| **Misinformed about plan benefits or rules by marketing or other plan staff** | |
| # Same Day | 1 |
| # Standard | 3 |
| # Expedited | 0 |
| **Language translation services not available** | |
| # Same Day | 1 |
| # Standard | 1 |
| # Expedited | 0 |
| **Hearing/vision needs not accommodated** | |
| # Same Day | 1 |

| Reason for Grievance<br><br>Dissatisfaction with quality of home care (other than lateness or absences) | Total |
|---|---|
| # Standard | 0 |
| # Expedited | 0 |
| **Disenrollment issues** | |
| # Same Day | 0 |
| # Standard | 1 |
| # Expedited | 0 |
| **Enrollment issues** | |
| # Same Day | 0 |
| # Standard | 1 |
| # Expedited | 0 |
| **Plan staff rude or abusive** | |
| # Same Day | 4 |
| # Standard | 4 |
| **Reason for Grievance** | **Total** |
| # Expedited | 0 |
| **Provider staff rude or abusive** | |
| # Same Day | 32 |
| # Standard | 6 |
| # Expedited | 0 |
| **Violation of other enrollee rights** | |
| # Same Day | 1 |
| # Standard | 1 |
| # Expedited | 0 |
| Other: | |
| # Same Day | 135 |
| # Standard | 50 |
| # Expedited | 0 |
| **Total for this period:** | |
| # Same Day | 2294 |
| # Standard | 559 |
| # Expedited | 5 |

| Reason for Appeal<br><br>Denial or limited authorization of service including amount, type or level of service | Total |
|---|---|
| # of Standard Filed | 166 |

| Reason for Appeal | |
|---|---|
| # of Expedited Filed | 0 |
| Reduction, suspension or termination of previously authorized service | |
| # of Standard Filed | 50 |
| # of Expedited Filed | 2 |
| 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 |
|---|---|
| Access to covered services (includes transportation) | 54 |
| Home Care Quality | 48 |
| Enrollment Issues | 17 |
| Case Management | 15 |

## 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. Retroactive Changes to 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.

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

   - MVP Health Plan, Inc. Survey was conducted on October 9, 2012 to October 12, 2012. A Statement of Deficiency was issued. A plan of correction has been received but not yet accepted.

   - SCHC Total Care, Inc. Survey was conducted on October 11, 2012 to October 15, 2012. A Statement of Deficiency was issued. A plan of correction has been received and accepted. SCHC Total Care, Inc. also had a follow up survey on November 14, 2012 to November 15, 2012. A Statement of Deficiency was issued. A plan of correction has been received but not yet accepted.

   - Neighborhood Health Providers, Inc. Survey was conducted on November 23, 2012 to October 16, 2012. No deficiencies were cited.

   - HealthFirst PHSP, Inc. Survey was conducted on June 25, 2012 to June 28, 2012. A Statement of Deficiency was issued. A plan of correction has not yet been received.

   - Hudson Health Plan, Inc. Survey was conducted on December 11, 2012 to December 12, 2012. No deficiencies were cited.

3. Routine provider directory/participation surveys were conducted for health plans in the second half of 2012 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 Information Survey:

     HealthNow New York, Inc.

     MVP Health Plan, Inc.

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

     HealthNow New York, Inc.

     MVP Health Plan, Inc.

     Independent Health Association, Inc.

Routine member services surveys were conducted. 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 4,012 total reported complaints/action appeals, MMMC plans reported 642 complaints and action appeals from their SSI enrollees. This compares to 734 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 | 18% |
| Transportation | 17% |
| Quality of Care | 12% |
| Non-Medical Provider or MCO Services | 10% |
| All Other (Issue not captured by a defined category) | 6% |

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

| Category | Number of Complaints/Action Appeals Reported For SSI Enrollees |
|---|---|
| PCP Appointment Availability | 6 |
| Specialist Appointment Availability | 2 |
| Waiting Time Too Long at Office | 2 |
| Quality of Care | 79 |
| Denial of Clinical Treatment | 12 |
| Non-Medical Provider or MCO Services | 65 |
| Specialist or Hospital Services | 9 |
| Eye Care | 2 |
| Dental | 33 |
| Emergency Room | 20 |
| Mental Health/Substance Use | 1 |
| Long Term Services and Supports | 10 |
| Pharmacy | 34 |
| Non-covered Services | 17 |
| Family Planning | 0 |
| Communication/Physical Barrier | 1 |
| Advertising/Education/Outreach/Enrollment | 6 |
| Recipient Restriction/Plan Initiated Disenrollment | 6 |
| Reimbursement/Billing | 73 |
| Balance Billing | 116 |
| Transportation | 108 |
| All Other | 40 |
| Total | 642 |

## 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 December 31, 2012 is 3,132 individuals.

New York developed and tested a new software tool, the Health Insurance Premium Payment (HIPP) Calculator, designed to assist LDSS and New York Health Options with evaluating the cost-effectiveness of a third-party health insurance product to determine whether individuals ought to be enrolled in the FHP-PAP and to facilitate the issuance of premium payments. This standardization of cost-effectiveness analyses through HIPP will improve quality control statewide. To date, a full-day training has been provided to Enrollment Center and local district staff in 21 counties on how to use the tool.

| Enrollment in ESHI Through FHPlus PAP | New Enrollment 07/01/12-09/30/12 | Total Enrollment September 30, 2012 |
|---|---|---|
| FHPlus Adults with children | **107** | **722** |
| FHPlus Adults without children | **387** | **2,410** |
| **Total** | **494** | **3,132** |

| Age group for reporting Quarter 07/01/12-09/30/12 | Number of Enrollees |
|---|---|
| **19-44** | **2,619** |
| **45-64** | **513** |

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 897 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. Most of the 26 contract projects were completed with 16 fully spent. One contract is still active and two were projects cancelled due to project issues. We are in the process of repurposing any unclaimed funds.

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

In November 2006, 53 awards were announced. Contracts were executed for 47 capital restructuring projects. Forty contract projects were completed, 12 were not completed (awards were either withdrawn or rescinded) and one is still active. We are in the process of repurposing any unclaimed funds.

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. Of the 49 grant contracts, the status is as follows: 47 have been approved; one has been developed and is under review; and, one award will not go to contract due to lack of progress. Forty projects have completed their expenditures. We are in the process of repurposing any unclaimed funds.

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. Sixteen projects have completed their expenditures.

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

In September 2008, 79 awards were announced. Seventy three contracts are fully executed. The remaining six contracts are under review at the Office of State Comptroller (OSC) or the Department. Forty-four projects have completed their expenditures.

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

In September 2008, 26 awards were announced. Twenty-three contracts were fully executed. One award was declined, another contract was rescinded due to significant changes to the scope of the contract and a third was never executed. Twenty projects have completed their expenditures. We are in the process of repurposing any unclaimed funds.

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. Four projects have completed their expenditures. We are in the process of repurposing any unclaimed funds.

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 contracts have been fully executed. Sixteen contracts have completed their expenditures. We are in the process of repurposing any unclaimed funds.

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. One project is completed.

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

In September 2009, 25 awards were announced. Of these, 23 contracts are fully executed. One facility, Saint Vincent's Catholic Medical Center has closed and will never go to contract. The remaining contract is in the Department review process. Four projects are fully expended. We are in the process of repurposing any unclaimed funds.

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

In September 2009, 19 awards were announced. All contracts have been fully executed. Seven contracts are fully expended. We are in the process of repurposing any unclaimed funds.

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 contracts are fully executed. Four projects have completed their expenditures.

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 fully executed.

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 completed their expenditures.

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. Eleven contracts are fully executed and one award has been rescinded based on the facility's decision to not move forward with the project. Another project will not go forward due to closure of the facility. Five projects have completed their expenditures.

We are in the process of repurposing any unclaimed funds.

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. Sixteen contracts are fully executed. Two projects have completed their expenditures.

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. All five contracts are fully executed and two have completed their expenditures.

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. Ten contracts are fully executed and 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. Seventeen contracts are fully executed and one is in the approval process. Five projects have completed their expenditures.

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. The remaining 31 contracts are fully executed. Thirteen projects have completed their expenditures.

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.

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 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.

Twenty 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, instead of March 31, 2014. 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 the Department of federal funds by the end of HEAL/F-SHRP grant program.

## 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 2)**

B. Designated State Health Programs **(See Attachment 3)**

C. Reform Initiatives **(See Attachment 4)**

D. Hospital and Nursing Home Data **(See Attachment 5)**

## X. Other

1. Integrated Programs

The Medicaid Advantage program allows dually eligible individuals to voluntarily enroll in an approved Medicare Advantage plan that also has a Medicaid managed care product to receive most of their Medicare and Medicaid benefits. As of December 2012, 9,203 individuals in 24 upstate counties and New York City were enrolled in 13 Medicaid Advantage plans.

2. Changes to Certificates of Authority:

**No Changes.**

3. Consumer Issues

Medicaid Advantage plans reported a total of 20 complaints and action appeals as of November 2012.

## XI. Transition Plan Updates

There are no updates to the transition plan for this quarter. The Department continues to explore the necessary system and program changes needed to implement the Affordable Care Act.

## Attachments

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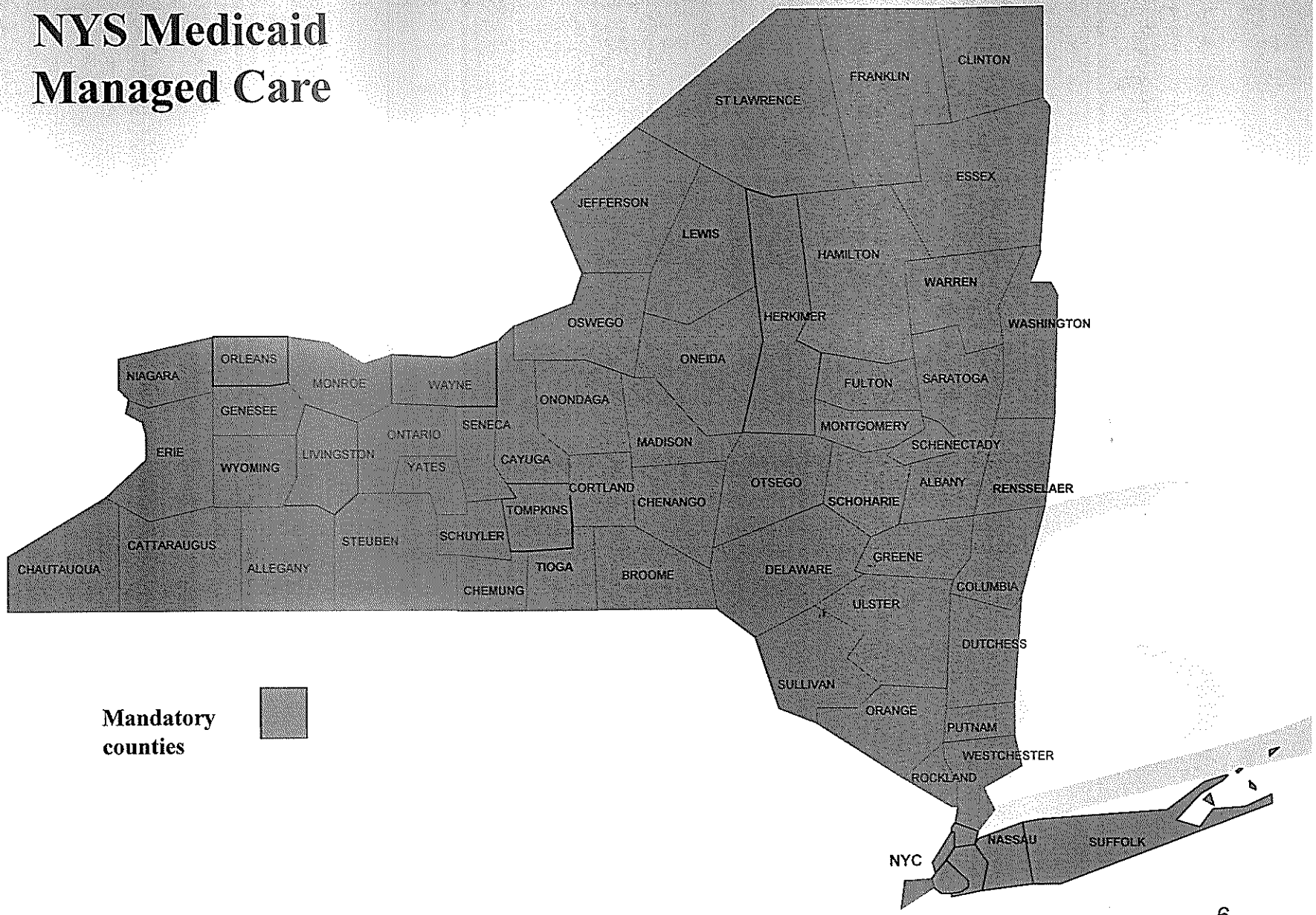
**Albany, NY 12237**
**Phone: 518-473-5876**
**Fax: 518-473-5508**

**Submitted on: February 28, 2013**

# NYS Medicaid Managed Care



# 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 3**

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 | Claim Period | 1-3/12 QER | 7-9/12 QER | Total |
|---|---|---|---|---|
| DOH | | | | |
| 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 10/1/12 - 12/31/12

| 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 | | $6,831,499 |
| 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 | $330,435,113 | $906,446 | $331,341,559 |
| | $615,745,895 | $0 | $615,745,895 | $537,294,347 | $906,446 | $538,200,793 |

| 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 | $179,236,561 | $207,436 | $179,443,997 |
| HEAL NY Phase 5: Health IT | $104,944,003 | | $104,944,003 | $102,196,641 | $775,657 | $102,972,298 |
| HEAL NY Phase 6: Primary Care Services | $99,885,522 | | $99,885,522 | $75,352,469 | $4,561,317 | $79,913,786 |
| HEAL NY Phase 7: Berger Lookalikes and coverage partners | $149,951,753 | | $149,951,753 | $123,998,273 | $7,284,244 | $131,282,517 |
| HEAL NY Phase 8: Nursing Home Rightsizing | $30,000,000 | | $30,000,000 | $19,289,445 | $488,397 | $19,777,841 |
| | $572,481,929 | $0 | $572,481,929 | $500,073,389 | $13,317,050 | $513,390,439 |

| 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 | $47,171,730 | $8,118,479 | $55,290,209 |
| HEAL NY Phase 11: Restructuring | $174,343,776 | | $174,343,776 | $62,803,263 | $20,878,068 | $83,681,330 |
| HEAL NY Phase 12: Long Term Care | $172,363,541 | | $172,363,541 | $107,419,799 | $11,097,488 | $118,517,286 |
| 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 | $12,642,657 | $3,215,056 | $15,857,713 |
| HEAL NY Phase 14(Os) - Targeted Hospitals, Oswego | $17,800,000 | | $17,800,000 | $17,631,345 | $168,655 | $17,800,000 |
| HEAL NY Phase 14(D) - Targeted Hospitals, Discretionary | $87,183,798 | | $87,183,798 | $47,988,032 | $1,471,680 | $49,459,713 |
| | $597,607,963 | $0 | $597,607,963 | $310,668,608 | $44,949,425 | $355,618,033 |

| 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 | $14,244,754 | $5,502,452 | $19,747,206 |
| HEAL NY Phase 16 - Ambulatory Care Lower Manhattan | $14,000,000 | | $14,000,000 | $2,462,890 | $3,415,377 | $5,878,267 |
| HEAL NY Phase 17-Health IT in Expanded Care Coordination | $138,575,701 | | $138,575,701 | $32,471,983 | $13,400,734 | $45,872,718 |
| HEAL NY Phase 18- Mental Health Services | $38,501,949 | | $38,501,949 | $9,877,786 | $1,682,199 | $11,559,985 |
| HEAL NY Phase 19- Facility Specific Reconfiguration | $200,181,491 | | $200,181,491 | $119,705,209 | $17,010,341 | $136,715,550 |
| HEAL NY Phase 20 - Long Term Care Initiatives #2 | $150,794,505 | | $150,794,505 | $64,874,582 | $18,250,538 | $83,125,121 |
| | $591,980,849 | $0 | $591,980,849 | $243,637,204 | $59,261,643 | $302,898,847 |

| 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)) | $8,957,680 | $38,200,000 | $47,157,680 | $3,600,000 | | $3,600,000 |
| HEAL NY Phase 21 - Restructuring Initiatives in Medicaid Redesign | $295,683,549 | | $295,683,549 | $0 | $33,005,413.52 | $33,005,414 |
| | $304,641,229 | $38,200,000 | $342,841,229 | $3,600,000 | $33,005,414 | $36,605,414 |

| | 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** | **$2,682,457,865** | **$38,200,000** | **$2,720,657,865** | **$1,595,273,548** | **$151,439,978** | **$1,746,713,526** |

Signed: [redacted] Date: 1/31/2013

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
## October 1, 2012 through December 31, 2012

**Q3: October 1, 2011 - June 30, 2012***

| **Inpatient Hospital** | Medicaid Expenditures | Medicaid Discharges | Medicaid Cost Per Discharge | Medicaid Member months | Discharges PMPY |
|---|---|---|---|---|---|
| Medicaid FFS | $ 2,181,729,117 | 195,681 | $ 11,149 | 9,395,113 | 0.25 |
| Managed Care** | $ 3,127,098,004 | 379,735 | $ 8,235 | 30,636,904 | 0.15 |
| Total Medicaid | $ 5,308,827,121 | 575,416 | $ 9,226 | 40,032,017 | 0.17 |
| **Nursing Home** | Medicaid Expenditures | Medicaid Days | Medicaid Cost Per Day | Medicaid Member months | Days PMPY |
| Medicaid FFS | $ 4,653,631,036 | 21,833,386 | $ 213 | 927,215 | 282.57 |
| Managed Care** | $ 119,053,340 | 407,641 | $ 292 | 30,930,012 | 0.16 |
| Total Medicaid | $ 4,772,684,376 | 22,241,027 | $ 215 | 31,857,227 | 8.38 |

***For discharges paid through December 2012**

**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.