New York's Reinvestment Strategy: Achieving the Triple Aim

OVERVIEW

New York's reinvestment strategy will ensure that the full breadth of the MRT recommendations and the ACA are successfully implemented. The reinvestment funds are essential given the fiscal challenges still facing New York State as the nation struggles to escape a weak economy. The following sections are New York's current thoughts on how to utilize the reinvestment funds. New York has identified thirteen new programs that if implemented as described in this document will ensure that the MRT action plan and the ACA are successfully implemented.

New York is interested in using the MRT waiver amendment resources to forge new relationships and partnerships between providers and stakeholders in order to improve health care delivery and overall population health. The state wants providers to work together across traditional "silos" and develop comprehensive proposals that will address core challenges that exist within specific communities. While the state will accept applications for waiver funding from single entities the state will provide enhanced consideration for proposals that are brought by multiple organizations in true partnership especially when those partnerships are formed as a result of regional health planning.

The state also seeks comprehensive applications from traditional and/or community-based integrated delivery systems and community-wide partnerships that will seek funding from multiple MRT waiver programs. Comprehensive applications will also be given enhanced consideration especially if they are tied to long term strategic plans and are well coordinated with other providers/stakeholders in the communities in which they serve.

MRT Reinvestment Program
Primary Care Expansion

BACKGROUND

Increasing access to high quality primary care services is essential in developing a community-based health care infrastructure which will ensure New York achieves the Triple Aim. As a result of the Affordable Care Act (ACA) and the initiatives of the Medicaid Redesign Team (MRT), New York State's health care system has made significant strides toward these aims. New York's health care delivery system and its financing are radically changing from the system of just a few years ago. The driving force behind the MRT's efforts is a growing Medicaid program in the state that has largely overinvested in expensive institutional care and underinvested in less costly primary and preventive care. A principal strategy of the MRT has been to promote integrated systems of care with a strong primary care foundation. The MRT Waiver Amendment presents a significant opportunity to accelerate progress toward this important objective.

New York State has the largest Medicaid program in the country with 26 percent of the State's population enrolled in Medicaid. At more than $50 billion a year, New York spends more than twice the national average on Medicaid on a per capita basis, and spending per enrollee is the second-highest in the nation. Moreover, increased Medicaid spending has not resulted in high quality of care. The state ranks 18^{h} out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. Hospital readmissions are a particularly costly problem for New York. A report issued by the New York State Health Foundation found hospital readmissions cost New York $3.7 billion per year, with nearly one in seven initial hospital stays resulting in a readmission.

There is broad consensus that to achieve the Triple Aim, high-quality, and accessible primary care must be available to all residents. The MRT has begun to strengthen and transform the health care safety net and taken a more community-based approach to health care by addressing health disparities as well as the social determinants of health – including socioeconomic status, education, food, and shelter.

A major challenge will be providing high-quality primary care to the surge of newly insured individuals thanks to the ACA. Already an estimated 2.3 million New Yorkers are "underserved" for primary care services due to mal-distribution of physicians in certain geographic areas. Primary care providers in many communities in New York State will need technical assistance and capacity building support to meet the goal of increasing access to high quality primary care. New York has invested heavily in improving primary care by providing incentive payments for providers to become Patient Centered Medical Homes (PCMHs).

While New York's accomplishments in this area have been impressive more needs to be done. An important subset of primary care providers - particularly smaller practices, practices in low income neighborhoods, practices that did not have the infrastructure to support seeking NCQA recognition requirements, or practices that have met initial NCQA recognition requirements but are seeking more challenging, higher recognition levels - often do not have the internal resources to plan or implement the changes associated with the patient centered model of care and integrated models of care. This presents a risk to the ability of these organizations to provide the best, most efficient, most coordinated care to their patients.

There is a substantial need for capital to expand primary care capacity in order to provide care for more people as newly insured individuals come into the marketplace. A key focus in restructuring will be building sustainable primary care capacity where it does not currently exist. It is also important to locate services in settings that are most accessible to the populations served. For example, co-locating primary care services in Emergency Departments, supportive housing or mental health programs increases the likelihood that they will be utilized. The shift in focus to primary care providers requires New York to not only invest in the preservation and expansion of primary care services but to integrate primary care into the overall health care system. Telemedicine also offers the possibility of providing needed services in underserved areas of the state.

There is also additional need for capital investment to build the technological infrastructure that networks will need to operate effectively. New technologies offer opportunities to improve the quality of the care provided, particularly with respect to care transitions, team based care and integration of services for complex populations. The increased connectivity available through data and information sharing such as Electronic Health Records offer tremendous opportunities to manage the continuum of a patient's care – from prevention to treatment, including self-management.

The state actively solicited the feedback of a multitude of partners and worked to ensure that primary care stakeholders in particular provided feedback on the types of primary care expansion initiatives that should be included in the MRT Waiver Amendment.

PROGRAM DESCRIPTION

New York State plans to invest $1.25 billion over the next five years to expand access to high-quality primary care. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Provide Needed Technical Assistance

New York State plans to allocate funds to quality improvement organizations/independent strategic planners to provide technical assistance to primary care providers and stakeholder collaborations as they develop plans to expand access to high quality primary care. The technical assistance modalities will be based on community/provider needs, however, should include gap analyses; learning collaboratives (including virtual learning collaboratives); on-site and virtual coaching; distance learning programs; self-guided training and practice coaching. Providers can also apply for technical assistance to aid them in applying for MRT waiver amendment funding. Specific examples of Technical Assistance that could be funded through this program include:

- **Financial and business planning for integrated systems of care:** Primary care providers becoming part of the integrated health care system confront a multitude of decisions that require a high degree of expertise (e.g., legal issues related to anti-trust regulations, risk-sharing payment models, severity adjustments, provider attribution, HIT and HIE, performance measurement, patient risk stratification, and many more). Many primary care providers need business, legal, and technical resources to re-evaluate their business and clinical models to fully participate in integrated systems of care. Many smaller practices will need assistance in the creation of a shared resource model for care team management services including high risk case management, patient/family self management, care transitions, medication management and reconciliation, and other important functions of the patient centered medical home.

- **Support Regional Extension Centers (RECs) toward universal adoption of EHRs, achievement of NCQA recognition, and full implementation of Health Information Exchange:** Two RECs in New York State– the New York e-Health Collaborative (NYeC) and New York City Regional Electronic Adoption Center for Health (NYC REACH) – assist primary care providers in the adoption, implementation, and meaningful use of ONC-certified EHR technology. The RECs have made a significant difference in the numbers of providers adopting EHRs and attaining NCQA PPC-PCMH Level 1 recognition and will continue to work toward universal achievement of PPC-PCMH Level 3 recognition. The type of hands-on assistance that the RECs provide will continue to be critical, particularly as providers with EHRs face the need to achieve higher standards to demonstrate their meaningful use.

To assist qualified providers, New York Medicaid will enter into agreements with the two RECs to supply Medicaid providers not included in RECs initial Office of the National Coordinator (ONC) contract funding with an array of EHR assistance services, including counseling and guidance in adopting, implementing, and meaningfully using an EHR system and how to use EHRs to measure and report on quality and outcomes per standardized state measures. In turn, the state will primarily rely on these two RECs to ensure the most effective use of funds and avoid duplication of efforts.

- **Support training and technical assistance on the use of data to improve quality and monitor performance:** Although there are some providers who have developed advanced skills for using data to improve quality and monitor their performance, many primary care providers require training and resources to learn how to use data to improve practice. Developing this capacity is critical as providers assume greater accountability for patient care, outcomes, and cost. The state will provide a pool of funds to support training and resources to support these activities.

- **Behavioral health integration:** There is lack of understanding on how to integrate behavioral health into primary care. There is a need for training and coordination across mental health, substance abuse and primary care providers on the care models and techniques used in these respective settings. The goal of this effort will be to establish a patient-centered approach to behavioral health issues and improving coordination of care, building on effective and evidence based models of integration.

2) Increasing Primary Care Provider Capacity and Accessibility: Capital Investment, Operational Assistance and HIT Assistance

Access to high quality primary care services requires capital to develop additional capacity and infrastructure. This is particularly important as more people obtain insurance coverage through the ACA. Beyond the need for new infrastructure there is also a need to increase access to services by locating primary care in targeted locations that increase the likelihood that patients will utilize them. Regional planning efforts will assist in this effort. Below is a description of three programs that will increase primary capacity and accessibility:

2a) Capital Investment: Expand Primary Care Infrastructure

Methods for capital deployment

Capital resources will be planned and distributed as part of the regional planning infrastructure New York is creating through the MRT process. Steps will be taken to ensure meaningful collaboration among community-based primary care providers and institutional providers. New York seeks to deploy capital funds through three different mechanisms.

- **Traditional asset based capital funding** – Primary care providers need up-front investment in order to participate fully in health system integration. Investment for "bricks and mortar" to develop capacity in areas most in need.
- **Debt relief/restructuring** – Primary care providers would benefit from balance sheet restructuring that would create more cash flow and allow them to pursue more effective capitalization. It will assist financially distressed providers to remain viable, and help facilitate opportunities for those that are more financially healthy, including taking on debt (at more favorable terms) to pursue primary care expansion opportunities.
- **Revolving Capital Fund** - New York State will create a permanent, revolving fund to leverage private sector investment and provide a source of affordable public/private financing for primary care providers. The Revolving Capital Fund would provide primary care providers with greater access to capital at reduced interest rates. Funds would be available to organizations providing community-based health care in underserved communities, including those providing primary care, mental health, dental, women's health services, and substance abuse services. Access to capital would revolve as the existing group of borrowers pay back their loans and the funds be redeployed to build more primary care capacity on an ongoing basis.

2b) Operational Assistance

Below are potential uses of funding to sustain and increase access to primary care services.

- **Preserve services that are at risk from hospital closures and restructuring:** The state will monitor the availability of primary care services and deploy resources to community health centers and other community-based primary care providers when capacity is at risk from hospital consolidations, mergers, restructuring, and closings.

- **Support the colocation of primary care services in Emergency Departments:** Locating primary care services in or near Emergency Departments should greatly enhance patient access to primary care medical homes and improve the coordination of care across care settings. The state will evaluate the state and federal regulatory barriers to these arrangements and provide the capital and operational funding to support their development.

- **Support the integration of behavioral health into integrated health systems:** New York will create demonstration projects that facilitate integration of behavioral health with community health centers, outpatient clinics and nursing homes, building on successful, evidence based models including but not limited to collaborative care. This will be critical for systems of care that serve the high number of patients with co-occurring mental health and substance abuse disorders and chronic health conditions.

- **Support telemedicine expansion and sustainability:** New systems of care are needed to evolve past all care being delivered in a traditional face-to-face physician and patient visit. Foremost among these models is the use of telemedicine to provide access to specialty services with significant provider shortages or distribution problems including child/adolescent psychiatry, hepatitis C, and others. Telemedicine can also be used to enhance access to primary and urgent care, reducing the need for more expensive institutional services including emergency room use. The state will provide incentive payments to promote broader use of telemedicine and address other regulatory hurdles to expand and sustain its use.

2c) Health IT Assistance

Primary care providers will require the Health IT infrastructure and software to be able to share patient information and data in real time with other partners in the heath care continuum. Providers and care-teams must have access to tools that support coordination (e.g., electronic alerts when a patient is seen in the Emergency Department and admitted or discharged from a hospital). Having ongoing access to and being able to use in-depth and high-quality data is critical to improving quality, monitoring performance, and coordinating care across care settings.

EHR adoption by primary care providers needs to dramatically increase. Currently, less than 5 percent of ambulatory practices are connected to the Statewide Health Information Network. Increasing the number of providers that are connected will also be critical to engage health plans to connect to and pay for the network.

- **Health IT Infrastructure** – There is still significant need to build health IT infrastructure, particularly to achieve health information exchange among providers including providers outside of current federal HIT incentive programs.
- **Support the Health IT Needs of Integrated Systems of Care:** Integrated systems of care need affordable software that allows all participating organizations to share a patient care plan across care settings. The state will provide funding to cover software-related costs to enable providers to become operational and integrated into the health care network. Funds will be synchronized with those requested under the health home program to leverage existing capabilities and the new Health Home capabilities.
- **Additional Support for Health Information Technology Infrastructure:** The New York eHealth Collaborative (NYeC) is a not-for-profit organization that is charged with developing the Statewide Health Information Network of New York (SHIN-NY) and assist healthcare providers in making the shift to electronic health records (EHR). The state will provide funding to NYeC, which will be matched by private health plan contributions, as part of a sustainability model that will fulfill the MRT vision that all New Yorkers experience the benefits of inter-operable EHRs.

IMPACT ON OVERALL MEDICAID SPENDING

Research has shown that patients who receive care through a PCMH get better care, and as a result, they have better health outcomes. With more effective care, there are fewer unnecessary inpatient and emergency room visits, resulting in an overall positive impact on spending.

A summary report of the key findings of prospective, controlled studies of patient centered medical home interventions was published by the Patient-Centered Primary Care Collaborative in November 2010. The review was conducted by Kevin Grumbach, MD, and Paul Gundy, MD, MPH, and entitled: "Outcomes of Implementing Patient Centered Medical Home Intervention: A review of the Evidence from Prospective Evaluation Studies in the United States". The findings of the literature review supports the contention that investing in primary care patient centered medical homes results in improved quality of care and patients experiences, as well as reductions in costly hospital and emergency department utilization.

Studies of integrated delivery system PCMH models demonstrate a 16 to 24 percent decrease in hospital admissions and a 29 to 39 percent decrease in emergency department visits, when comparing enrollees to controls. These studies were conducted at Group Health Cooperative of Puget Sound; Geisenger Health System ProvenHealth Navigator PCMH model; and HealthPartnerss Medical Group PCMH Model.

APPENDIX

A summary report of the key findings of prospective, controlled studies of patient centered medical home interventions was published by the Patient-Centered Primary Care Collaborative in November 2010. The review was conducted by Kevin Grumbach, MD, and Paul Gundy, MD, MPH, and entitled: "Outcomes of Implementing Patient Centered Medical Home Intervention: A review of the Evidence from Prospective Evaluation Studies in the United States."

Below is a summary of the key findings of the research they base these conclusions on. This summary is taken directly from their article.

Summary of Data on Cost Outcomes from Patient Centered Medical Home Interventions

A. Integrated Delivery System PCMH Models

1. **Group Health Cooperative of Puget Sound**
   - $10 PMPM reduction in total costs; total PMPM cost $488 for PCMH patients vs. $498 for control patients (p=.076).
   - 16% reduction in hospital admissions (p<.001); 5.1 admissions per 1,000 patients per month in PCMH patients vs. 5.4 in controls. $14 PMPM reduction in inpatient hospital costs relative to controls. 29% reduction in emergency department use (p<.001); 27 emergency department visits per 1,000 patients per month in PCMH patients vs. 39 in controls. $4 PMPM reduction in emergency department costs relative to controls.

2. **Geisinger Health System Proven Health Navigator PCMH Model**
   - 18% reduction in hospital admissions relative to controls: 257 admissions per 1,000 members per year in PCMH patients vs. 313 admissions per 1,000 members per year in controls (p<.01). Within PCMH cohort, admission rates decreased from 288 per 1,000 members per year at baseline to 257 during PCMH intervention period.
   - 7% reduction in total PMPM costs relative to controls (p=.21).

3. **Veterans Health Administration and VA Midwest Healthcare Network, Veterans Integrated Service Network 23 (VISN 23)**
   - For Chronic Disease Management model PCMH for high-risk patients with COPD, composite outcome for all hospitalizations or ED visits 27% lower in the CDM group (123.8 mean events per 100 patient-years) compared to the UC group (170.5 mean events per 100 patient years) (rate ratio 0.73; 0.56-0.90; p < 0.003). The cost of the CDM intervention was $650 per patient. The total mean ± SD per patient cost that included the cost of CDM in the CDM group was $4491 ± 4678 compared to $5084 ± 5060 representing a $593 per patient cost savings for the CDM program.
   - Comparable reductions in ED and hospitalizations were found for Veterans Health Administration PCMH interventions targeting other patients with chronic conditions.

4. **HealthPartners Medical Group BestCare PCMH Model**

   - 39% decrease in emergency department visits and 24% decrease in hospital admissions per enrollee between 2004 and 2009.
   - Overall costs for enrollees in HealthPartners Medical Group decreased from being equal to the state average in 2004 to 92% of the state average in 2008; in a state with costs already well below the national average.

5. **Intermountain Healthcare Medical Group Care Management Plus PCMH Model**

   - Reduced hospitalizations in PCMH group; by year 2 of follow-up, 31.8% of PCMH patients had been hospitalized at least once vs. 34.7% of control patients (p=.23). Among patients with diabetes, 30.5% of the PCMH group were hospitalized vs. 39.2% of controls (p=.01).
   - Net reduction in total costs was $640 per patient per year ($1,650 savings per year among highest risk patients).

B. Private Payer Sponsored PCMH Initiatives

1. **Blue Cross Blue Shield of South Carolina-Palmetto Primary Care Physicians**

   - 10.4% reduction in inpatient hospital days per 1,000 enrollees per year among PCMH patients, from 542.9 to 486.5. Inpatient days 36.3% lower among PCMH patients than among control patients. 12.4% reduction in emergency department visits per 1,000 enrollees per month among PCMH patients, from 21.4 to 18.8. Emergency department visits per 1,000 enrollees were 32.2% lower among PCMH patients than among control patients.
   - Total medical and pharmacy costs PMPM were 6.5% lower in the PCMH group than the control group.

2. **Blue Cross Blue Shield of North Dakota-MeritCare Health System**

   - Hospital admissions decreased by 6% and emergency department visits decreased by 24% in the PCMH group from 2003 to 2005, while increasing by 45% and 3%, respectively, in the control group. In 2005, PCMH patients had 13.02 annual inpatient admissions per 100 patients, compared with 17.65 admissions per 100 patients in the control group. PCMH patients had 20.31 annual emergency department visits per 100 members, compared with 25.00 among control patients.
   - In 2005, total costs per member per year were $530 lower than expected in the intervention group based on historical trends. Between 2003 and 2005, total annual expenditures per PCMH patient increased from $5,561 to $7,433, compared with a much larger increase among control patients from $5,868 in 2003 to $10,108 in 2005.

3. **Metropolitan Health Networks - Humana (Florida)**

   - Hospital days per 1,000 enrollees dropped by 4.6% in the PCMH group compared to an increase of 36% in the control group. Hospital admissions per 1,000 customers dropped by 3%, with readmissions 6% below Medicare benchmarks.
   - Emergency room expense rose by 4.5% for the PCMH group compared to an increase of 17.4% for the control group. Diagnostic imaging expense for the PCMH group decreased by 9.8% compared to an increase of 10.7% for the control group. Pharmacy expense increases were 6.5% for the PCMH group versus 14.5% for the control group.
   - Overall medical expense for the PCMH group rose by 5.2% compared to a 26.3% increase for the control group.

C. Medicaid Sponsored PCMH Initiatives

1. Community Care of North Carolina

- Cumulative savings of $974.5 million over 6 years (2003-2008). 40% decrease in hospitalizations for asthma and 16% lower emergency department visit rate.

2. Colorado Medicaid and SCHIP

- Median annual costs $785 for PCMH children compared with $1,000 for controls. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median annual costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

D. Other PCMH Programs

1. Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days.
- Annual net Medicare savings of $75,000 per PCMH care coordinator nurse deployed in a practice.

2. Genesee Health Plan (Michigan)

- 50% decrease in emergency department visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees 26.6% lower than competitors.

3. Erie County PCMH Model

- Decreased duplication of services and tests, lowered hospitalization rates, with an estimated savings of $1 million for every 1,000 enrollees.

4. Geriatric Resources for Assessment and Care of Elders

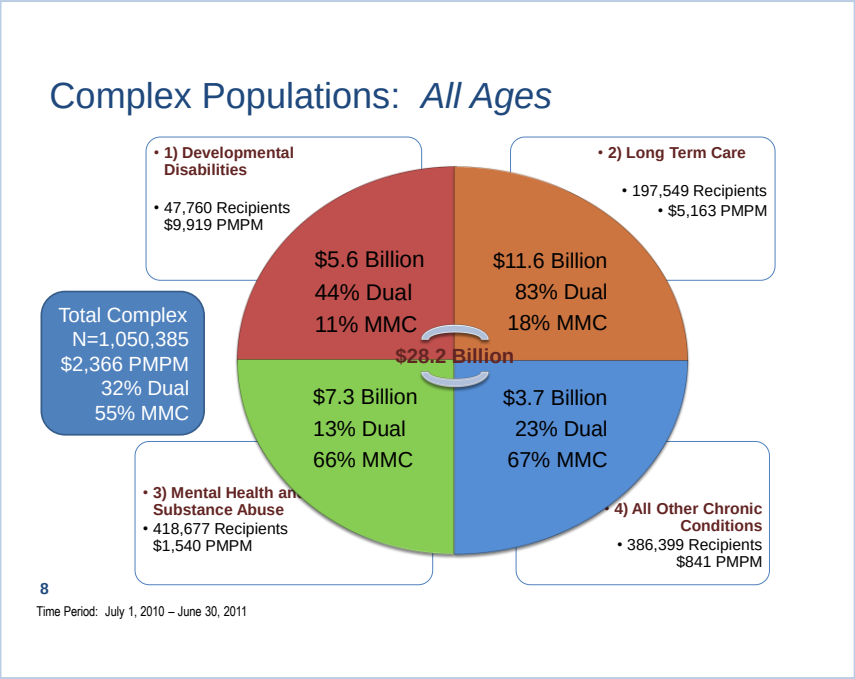
- Use of the emergency department significantly lower. The subgroup defined at the start of the study as having a high risk of hospitalization was found to have significantly lower hospitalization rates compared with high-risk usual care patients.

MRT Reinvestment Program
Health Home Development Fund

BACKGROUND

New York State has emerged as a national leader in the development of Health Homes consistent with the goals of the ACA. In rapid fashion, NYS has been rolling out comprehensive Health Home care management networks across the state with 35 Health Homes currently approved in 23 counties. Another 15 to 20 Health Homes are nearing approval in the remaining counties of the state. Unlike most states which chose to use Health Homes as simple case management funding inside of existing clinics or practitioner offices, New York took a much bolder approach. In New York each health home "network" is required to include a broad range of mandatory provider capacities including medical, behavioral health, HIV, housing and wrap around services all integrated with HIT capabilities and reporting through a single point of accountability for the patient.

There are 5.4 million Medicaid members and a little over one million of these Medicaid patients meet state and Federal Health Home criteria. New York categorized these members into four distinct groups shown below. New York's first wave of the Health Home initiative is focusing on implementing statewide Health Home services for members with behavioral health and/or chronic medical conditions. This group includes 805,000 members whose costs of care are approximately $11 billion per year.



In New York, Health Homes are envisioned as a permanent part of the state's considerable efforts to coordinate care for high need and high cost populations, consistent with the MRT's "care management for all" objective. New York seized upon the federal opportunity to implement a Health Home program as part of the broader goal of assuring that Medicaid members with high cost/high needs receive meaningful care coordination with a focused point of accountability at the provider level. In implementing the Health Home program, New York drew upon its significant experience with patient centered medical homes (PCMH), lessons learned from previous chronic illness management demonstrations, and investments in Health Information Technology (HIT) and Health Information Exchange (HIE).

Challenges to be addressed with waiver resources:

Despite this very aggressive and promising backdrop, Health Homes have encountered a number of serious challenges specifically with implementation. These obstacles include: difficulty locating the members identified as eligible for enrollment, an underprepared workforce, critical gaps in regional and provider HIT and HIE systems, and lack of funding for joint governance development and start up resources.

- **Member Engagement** – Health Home providers are being challenged to locate, engage and retain eligible members in care management. As provided for in the Health Home SPAs, Health Home providers will be reimbursed for outreach and engagement activities related to case finding for three months after a member is assigned to a Health Home. Reimbursement for outreach and engagement enables Health Homes to conduct outreach activities at the individual member level. Despite provision of the case finding fee, significant additional resources are being expended by Health Homes to find and engage these members. This is due to challenges in providing real time data on member addresses, the mobility of the population, and other critical population issues such as lack of trust, and understanding of what Health Homes can offer. To date, New York State has been unable to initiate a Health Home public education and awareness campaign to augment and support the individual outreach and engagement activities being conducted by the Health Homes. As a result, much understandable confusion still exists about what services Health Homes can provide and how they fit into the service delivery fabric in the state. A campaign targeted at communities at large that explains the purpose and role of Health Homes will provide a framework for Medicaid members to better understand the member level outreach and education efforts conducted by the Health Homes.

- **Workforce Training and Retraining** – New York State does not have an adequately prepared workforce to fully meet all the care management needs generated by the health home program. Health Homes are designed to utilize multidisciplinary teams of medical and behavioral health and other care providers led by a dedicated care manager to ensure that enrollees have timely access to the continuum of care needed.

While our Targeted Case Management (TCM) program offers a considerable care management workforce, retraining is necessary to focus on the more comprehensive and multidisciplinary nature of the Health Home care management job. Additionally, more care managers are needed and resources are lacking to properly train these new workers. This effort is mentioned here in the Health Home context but vendor selection and funding for this initiative would come from the MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform.

- **Clinical Connectivity** – Health Homes are currently struggling with accessing an infrastructure to share data necessary to provide comprehensive care management. While some advanced networks and promising regional capacities have been built with prior limited HIT funding, most Health Homes and the providers in them are struggling with key gaps in connectivity. Significant progress has been made in developing Regional Health Information Organizations (RHIOs) and this capacity can be leveraged – funding is need to fill critical gaps in provider connectivity and to develop capabilities needed by Health Homes that are not fully available such as a shared care management records and multi-party consent. While there has been significant progress in the establishment of New York's HIT/HIE infrastructure, additional funding is needed to build connectivity for mental health, substance abuse and other critical community providers. Additionally, funding is needed to fill critical gaps such as shared care management records and multi-party consent. The use of HIT and HIE is pivotal to allow sharing of member health information across the Health Home network and full health care continuum to facilitate breaking down the current "silos" of care and to improve quality of care by providing real time "actionable" data to clinicians and care managers. This integrated "just in time" data sharing system will be the vehicle to achieve community wide integrated care for those complex members served by Health Homes.

- **Joint Governance Support** – Providers are not fully prepared with the resources required to actuate the new governance models required to effectively form and operate Health Home care management entities. New York requires Health Homes to contractually or organizationally include a wide range of providers including hospitals, community-based health and behavioral health providers, and social services providers including housing. In order to meet this requirement, many Health Homes are developing joint governance organizations and capital dues structures to provide the necessary infrastructure for implementation and operation. These costs, together with costs associated with HIT and other operational expense, are resulting in the need for significant capital contributions from partnering organizations. This requirement for capital contribution and the associated concerns about individual provider ability to pay is distracting Health Homes from their core care management objective. Thus, the proper development of joint governance organizations requires one time technical assistance and start up assistance that is not achievable from within the current Health Home care management fees.

PROGRAM DESCRIPTION

New York State plans to invest $525 million over the next five years to fully deploy Health Homes across the state and ensure they can thrive long after waiver funds have been expended. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

Successful implementation of Health Homes will require significant additional funding to actuate the full potential of this extremely promising program. Waiver funds will be used on a one time basis to build the necessary infrastructure to address the challenges mentioned above. Stakeholder feedback provided suggestions for New York to use waiver funds in a number of ways to ensure successful, efficient implementation of Health Homes. The state received many constructive public comments, which have been incorporated into this request for waiver funding.

The Health Home Development Fund will be used to focus waiver resources on tangible and time limited health home implementation barriers to nurture Health Homes until they can be self-sufficient and rely exclusively on care management PMPMs and shared savings incentives. Health Home development funds will be disbursed through a competitive process structured around separate or combined health home development components. An assessment of individual and regional Health Home need for the funds will be made through the funding availability solicitation. In certain instances (e.g., Health Home IT funding), regional applications that involve multiple Health Homes collaborating on a single application may be required or strongly encouraged. Health Home waiver efforts that are supported by regional planning recommendations will be strongly considered for waiver funding. Health Home development funds will not duplicate funds made available through other waiver sources such as primary care expansion. Efforts on these separate proposals will be synchronized prior to the funding availability solicitation.

Health Home Development Fund components include:

1) Member Engagement and Public Education

Waiver funds will support the initiation of a public education campaign to explain the purpose and promise of Health Homes. The campaign will help potential members, providers and the public understand the valuable services offered through Health Homes and how this new service fits into overall service delivery framework in the community.

Conducting effective outreach and engagement of eligible Health Home individuals has been one of the most difficult challenges. Recommendations from several stakeholders suggest that waiver assistance in this education effort would be critical in assisting the care managers in engaging members and helping consumers understand the legitimacy (through a state level campaign) of what is being offered. Waiver funds would be spent for a population and program education campaign, not individual member level outreach, which is funded by the case finding fee. Funds would be used to create public service announcements, posters and other public awareness tools that would be used in the "hot spot" neighborhoods and locations where there are likely to be a high concentration of Health Home eligible individuals. The state would have an opportunity to create culturally and linguistically appropriate material which could also promote health literacy and reduce any engagement disparities. Funds also would be used to support care management agencies and other Health Home partners engaging in state approved outreach and patient engagement with direct street level marketing and consumer education activities focusing on Health Home eligible populations. New York State would also collaborate with patient advocacy groups and provider associations to further strengthen and expand outreach.

2) Staff Training and Retraining

Workforce waiver funds will support the development and rapid roll-out of care management staff training and retraining programs. These programs will leverage curricula that are already under development and will be aimed specifically at:

- Understanding the comprehensive focus of Health Home care management – including medical and behavioral health management;
- reducing communication challenges;
- enhancing cultural competence;
- increasing use of successful outreach and engagement and care management strategies; and
- promoting multidisciplinary care and holistic care coordination as part of a team.

Well trained care managers, in adequate numbers, are pivotal to the success of the Health Home program. Care managers in the health home will be the primary liaison with the enrollee, their family and each of their care providers. It is essential that this frontline staff have the most current skills needed to serve chronically ill patients and coordinate their care across settings.

Additional training will be focused on retraining of the large number of existing TCM case managers to fully develop their understanding of how Health Home care management will work, and how to more effectively "connect the dots" between the various components of care delivery and social supports through the Health Home architecture. This retraining is critical as previously many of these TCM programs were more limited in the focus of their case management activity. Vendor selection and funding for this initiative would come from the MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform.

3) Clinical Connectivity - Health Information Technology (HIT) Implementation

Waiver funds will support the elimination of prioritized gaps in HIT that are standing between Health Homes and the information they need to effectively manage high need patients. A key component of Health Home program success is "meaningful use" compliant HIT connected through Health Information Exchanges (HIE). As previously noted, resources to support the implementation of HIT and HIE have not been evenly distributed across the NYS health care and behavioral health care delivery system resulting in significant technology gaps. Further, all parties have been challenged to leverage existing community capabilities such as through RHIOs' HIE due to technical and steep upfront cost limitations. The ability of Health Homes to work is fully contingent upon access to real time data, yet the upfront costs to implement an appropriate technology solution are significant and resources within the programs are limited. Despite New York's past funding for HIT and HIE, one time waiver resources are critical to plug specific targeted gaps.

To that end, New York plans to use waiver funds for specific HIT initiatives that support local capacity to implement statewide system requirements and to support the development of a critically needed Health Home provider portal and quality management dashboard. Funds will also be focused on supporting smaller providers which have not been able to access previous HIT funding and associated resources.

The one time gap funding waiver program includes:

1) Working with New York eHealth Collaborative on the development of a compliant uniform care management platform accessible through the HIEs;
2) Developing a Statewide Health Home provider portal to share patient tracking, claims and encounter and quality data, and which includes a "Care Management Lite" platform for Health Homes not yet able to implement their own electronic care management software and is linked to the SHIN-NY;

3) Assisting RHIOs with platform transformation that will allow implementation of patient specific multi-provider consents to simplify data sharing among the multiple entities of the health home without violating HIPAA and other patient protections and to replace the single entity consent process currently in place in most state RHIOs;

4) Further standardizing and developing the needed interfaces for Health Homes to use data "push" and "pull" to access 'real time data', including patient alerts for hospital inpatient or emergency department visits and to share real time clinical and administrative data, pivotal information for effective care management;

5) Supporting providers participating in Health Homes with funds to establish joint/shared electronic health record (EHR) systems with the capability of reporting performance on evidence-based medicine guidelines for population management;

6) Developing a quality data center and utilization dashboard on the Health Home portal to share quality measures and data with providers and payees; and

7) Funding data analysis training and technical assistance for Health Homes;

4) Joint Governance Technical Assistance and Implementation Funds

Waiver funds will support technical assistance on joint governance models and the development of regional collaboration models for Health Homes. Waiver dollars will also be used to support targeted and limited start up for these new collaborative entities.

Health Homes are engaging in innovative forms of governance that support the ability for multiple providers to oversee and have responsibility for the Health Home services provided to a shared set of assigned Health Home patients. The need for the development of informed Health Home joint governance capacity and dollars to support start-up infrastructure is significant. The human resources required to manage rosters, assign patients, undertake quality management and finances, hire care managers and train staff is significant. Waiver funds would be used to offset or replace some of the cost of developing joint governance organizations and offset or replace the necessity for capital contributions from partner organizations to support one time implementation and readiness activities. Waiver funds also would be used to conduct Learning Collaboratives that foster best practices to assist in the development of future Health Home joint governance structures.

Supporting the effective development of new governance structures is one way Health Homes will help shape a responsive health care delivery system based on right care at the right time with joint accountability. In addition, these new joint structures will be uniquely positioned to support the needs of the whole care management and service delivery network and not simply the needs of a single provider.

IMPACT ON OVERALL MEDICAID SPENDING

Health Homes will save the state and the federal government Medicaid and Medicare dollars by targeting high risk and high cost patients for better care management and better overall care delivery. While return on investment (ROI) has often been difficult to quantify for care management programs, there is sufficient evidence in the medical literature to support the value of these programs.

John Hopkins Healthcare has reported an ROI of $3.65 for every $1 spent for an integrated care management program for high cost Medicaid enrollees affected by substance abuse and chronic disease. http://www.chcs.org/publications3960/publications_show.htm?doc_id=633674

In one reported study, health care costs averaged $4066 PMPM before institution of the program, $1492 PMPM after six months in the program and $1000 PMPM 12 months into the program. Overall, after calculating costs for the program, $2449 PMPM savings were achieved from prior experience.

AHRQ (http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt8.htm) has reported significant improvement in health care outcome metrics related to care management. While dollars were not specifically reported, it was noted that there was significant reduction in hospitalizations realized with some reported programs, a significant driver of savings. The Urban Institute (http://www.urban.org/uploadedpdf/412453-The-Potential-Savings-from-Enhanced-Chronic-Care-Management-Policies-Brief.pdf) also reports a number of care management programs documenting significant decreases in hospitalization rates (up to 24 percent) and emergency room usage (34 percent), both main drivers of savings.

Further, emerging evidence summarized by the federal Office for Management and Budget suggests that higher touch care management programs such as those being implemented by NYS under Health Homes, show promise in reducing avoidable expense.

While savings potential is apparent, the clear need to integrate care for our sickest patients has never been more evident. The most prevalent diagnoses at the top of the list of Health Home spending are mental health diagnosis, specifically schizophrenia and bipolar disorder. These patients die, on average, 25 years earlier than the average – most deaths due to treatable chronic medical conditions. Recent Johns Hopkins research suggests that people with serious mental illness —schizophrenia, bipolar disorder and disabling depression — are 2.6 times more likely to develop cancer than the general population. The study also found that patients with schizophrenia, when compared to the general population, were more than 4.5 times more likely to develop lung cancer, 3.5 times more likely to develop colorectal cancer and nearly three times more likely to develop breast cancer. People with bipolar disorder experienced similarly high risk for lung, colorectal and breast cancer. Experts speculate the number one contributor to this is smoking. Successful implementation of Health Homes will help these high cost/high need populations receive consistent high quality care and also reduce costs in the long run.

It is expected that the Health Home waiver reinvestment will be $150 million in the first two years and then will phase down during years 3-5. Health Home savings are expected to grow to over $180 million by year three of the waiver. New York is confident that at the end of the waiver period the state will have Health Homes that are stable and effective and as a result will be funded at normal FMAP levels and through shared savings.

MRT Reinvestment Program
New Care Models

BACKGROUND

New York State currently ranks 50th in avoidable hospital use and cost. Local collaboration and innovation are necessary to improve this troubling statistic and to move New York's health care outcomes from the bottom to the top. A New Care Model testing and development program will be set up with waiver funds to assertively tackle both cost and quality issues that affect New York's Medicaid program.

New York's health care system is often fragmented especially for our sickest patients and most of the fiscal incentives in the system are structured around the provision of additional volume (i.e., more admissions, days or visits). Only a small portion of the overall funding in the State's Medicaid program is set aside to promote quality. For instance, hospital systems that decide to seriously tackle unnecessary inpatient admissions and readmissions most often do so with potential peril to their bottom line. Outpatient clinics that invest in systems to track patients, provide more care intensity or perform home visits cannot find the extra resources to fund this important "extension" work. Additionally, almost no money is specifically tied to incentives for reducing or eliminating health disparities.

While some quality incentives do exist in the State's managed care program and some important quality gains have been made, much more work remains to be done especially for the state's most vulnerable patients. For instance, there are continued high rates of preventable events including avoidable hospitalizations and readmission, with the majority of readmissions (59 percent) being for medical conditions for persons with underlying mental health or substance abuse issues.

PROGRAM DESCRIPTION

New York State plans to invest $375 million over the next five years to launch new partnerships and test new models of care that could be expanded across the state and nation. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

This initiative, New Care Models, takes the form of a challenge to the New York health, behavioral health and long term care communities to develop and promote models that achieve the Triple Aim. Funding will be used to provide seed capital for innovative ideas that are proposed by practitioners, health care agencies, and other external stakeholders. Only those proposals that create the right incentives to coordinate care, improve quality, outcomes, reduce disparities and contain costs will be funded.

This program will start by using planning grants to develop ideas, followed by operational dollars to launch promising models. Additionally, a quality pool will be developed as an incentive for providers that exceed quality benchmarks.

Once tested and proven, successful new models of care will be built into the fabric of the regular New York State Medicaid program. Those programs that demonstrate improved health care delivery, improved patient outcomes, reduced health disparities and cost savings will be mainstreamed as covered Medicaid benefits with traditional reimbursement.

To actuate this transition, as the demonstration matures during years four and five, the waiver funded program dollars for the new models will begin a planned transition from waiver funding to regular Medicaid services funding and the waiver funded quality pool will transition to a gain sharing model based on savings achieved against pre-set targets. To engage the community in the planning process, New York will issue a solicitation document seeking plans to implement innovative new care models that achieve the Triple Aim.

Solicitation requirements will include:

- A comprehensive description of the proposed new model of care;
- The problem the proposed new care model will address, including data to support the need for the intervention;
- Any evidence upon which the new model is based;
- The population(s) targeted by the care model and their characteristics and how the proposed model will reduce health care disparities;
- The health care partners that will participate in the model program;
- Demonstrated use of health information technology as appropriate to better inform care at the point of service and enable analysis of and action on metrics for patient centered outcomes and community health improvement and elimination/reduction of health care disparities;
- How the new model will impact the Triple Aim;
- How it will demonstrate return on investment and over what time frame, and
- The performance measures against which the model will be evaluated, both in real time and at the conclusion of the five-year waiver period.

Planning grants will be awarded using a competitive bid process. Table 1 outlines the timeline for planning, developing, implementing, and evaluating new care models selected for funding.

Table 1: Proposed Timeline: Planning Grants for New Models of Care

Planning Grant – Five Year Term	Core Activities
Competitive Bid Process/Year 1	○ Issue solicitation seeking proposals for new models of care ○ Complete the planning and development process ○ Initiate program implementation
Years 2 and 3	○ Program fully implemented ○ Proof of concept ○ Demonstrate return on investment ○ Ongoing, real time evaluation of new care models ○ Quality Pool payments made
Years 4, 5	○ Continue activities from Years 2 and 3. Formal program review – Proven models transition to ongoing Medicaid support – Models not meeting Medicaid program goals are phased out and enrollees are transitioned to effective care models/services – Quality pool transitions to gain sharing model based on savings achieved against case mix adjusted targets

While a competitive bid process will be employed to solicit and ultimately fund new, innovative models of care, the state did receive a number of ideas for new care models through the stakeholder outreach/engagement process, which may be illustrative of the types of models that will be funded. Some of these ideas are listed below:

Peer Services: This suggestion aims to break down traditional health care delivery silos by encouraging providers to work together in an integrated fashion with peer services. Peer services programming could include peer run wellness coaching, bridging and crisis services. The goal of these pilots is to launch and demonstrate the effectiveness of fidelity-level peer innovations for 'high needs' Medicaid beneficiaries in areas of the state where they currently don't exist.

Collaborative Care Transition Improvement – Model Facilitating Movement of Difficult-to-Place Patients between Hospitals and Nursing Homes: The creation of this model would test the potential to improve movement of difficult-to-place patients between hospital and nursing home settings. The model would use waiver resources to 1) assess the post-acute partner's capacity to effectively address the medical and nursing needs of the more complex cohort of hospitalized patients awaiting discharge; 2) identify the areas within the post-acute setting that would require a higher level of clinical support to ensure that appropriate care could be delivered on a sustained basis; and 3) implement targeted training and standardized protocols and interventions to enhance the skills and performance among key post-acute direct caregivers and

interdisciplinary team members to ensure that patient post-acute care needs can be met. The model would also provide enhanced communication plans and data exchange protocols to identify and prioritize patients for transfer and to identify what specific patient needs must be addressed in the post-acute setting. Waiver resources could also be used to test models of offsetting the extra costs of providing post-acute care to this difficult-to-place population.

Expand Availability of 'Environmental Modifications and Assistive Technology': Stakeholders are recommending that the Medicaid program implement coverage for certain environmental modifications and assistive technology provided to eligible homebound elderly and disabled members. An innovative home modification and assistive technology program is presently in place for some Medicaid members, however, far more could benefit if the program is expanded. Members for whom coverage is available include those enrolled in the Traumatic Brain Injury, Nursing Home Transition, and Care at Home waivers.

Patient Navigation and Transition Assistance: Stakeholder engagement sessions, including our Medicaid member focus groups, generated a significant number of comments about the need to help patients with managing the complexities associated with all the change and transition in Medicaid and health care in general. Specifically, some suggested that community health workers should be utilized to assist complex patients' transition to managed care and health homes.

Enhance Intensive Residential Services for Substance Use Disorder: The Office of Alcoholism and Substance Abuse Services (OASAS) currently certifies and funds Intensive Residential programs through state-only funds. This level of care is for patients who have significant functional deficits due to substance use disorders and frequently, co-occurring physical and mental health problems. These programs are currently not medically directed and are peer focused based on "community as method" behavioral modification. These programs can be improved with more Medical Direction and increased professional staffing, while retaining the peer based recovery principles of the therapeutic community model.

Support for New Organizational Structures: In a time of limit resources providers and community-based organizations are often financial stressed with the result being declines in the quality of care provided to Medicaid members. New York needs robust, financially stable organizations to partner with the state in the effort to reduce Medicaid costs and improve patient outcomes. Stakeholders have suggested that waiver funds could be used to facilitate mergers and new corporate governance structures with the end product being more stable providers of key Medicaid services. These one-time grants (modeled on HEAL-NY) could ensure that the state has a robust service provider network well into the future.

Medical Respite Care for Chronically Homeless Individuals: Stakeholders have suggested that the state use waiver funds to launch demonstration programs to test the efficacy of respite care. Medical Respite Care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.

Medical respite programs would allow homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. It is offered in various parts of the country in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing. The hope is that this new health care alternative would lower Medicaid costs by preventing readmissions and by allowing homeless individuals in hospitals to leave for a less costly, more appropriate setting.

IMPACT ON OVERALL MEDICAID SPENDING

While many of these programs may be built from existing evidence based practices some will be testing completely new ways to promote quality and reduce cost. Whether a proven strategy or a promising new one is employed, all programs will be tracked against the standard performance measures. Those programs meeting both quality and cost savings benchmarks are expected to have a return on investment even after consideration of new program spending and quality pool incentive payments.

Successful planning grants and the new care models that emerge from them will form the foundation for important transformation of the Medicaid program. Successful new care models that are evidence-based, foster collaboration, and achieve MRT and ACA goals will also result in proven cost savings to the program and the community as a whole. The average annual investment in new models of care and the quality pool combined is $75 million a year over the five year period. Operational funding phases down during years three through five as the state eliminates less successful programs and begins to mainstream more promising programs into regular Medicaid. The quality pool set aside begins in year three and grows to $87.5M by year five.

MRT Reinvestment Program
Expand Vital Access/Safety Net Program

BACKGROUND

Safety-net institutions, including hospitals, nursing homes and clinics, are a vital part of the healthcare system and are essential to ensuring the health of New York's most vulnerable populations. At present time, the state's safety-net institutions are operating under tremendous financial pressures and additional pressures will be placed on these providers with upcoming changes to the Affordable Care Act (ACA) and MRT reforms.

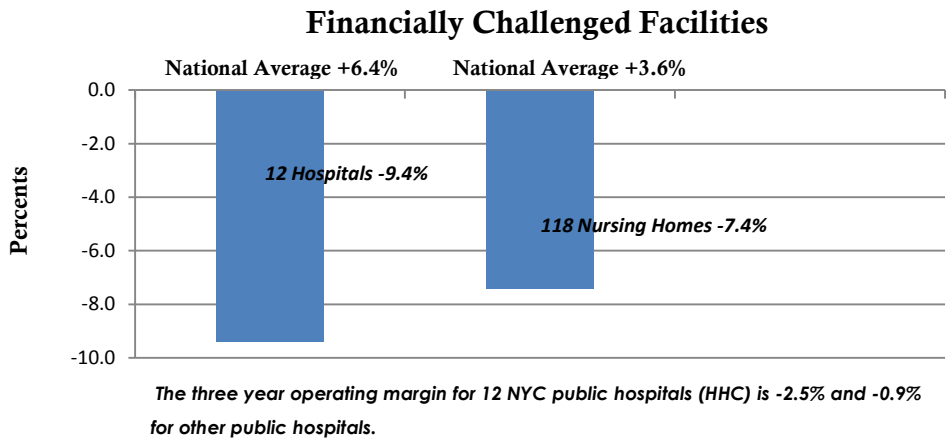
The MRT Payment Reform and Quality Measurement Workgroup, which was comprised of both industry leaders and consumer advocates, spent considerable time discussing the impact of the changing health care environment on these safety net providers. The concerns expressed by the Work Group were focused first and foremost on ensuring that access to patient services is maintained and enhanced, while transforming the service system to meet each community's unique needs. The Work Group unanimously voted that the state establish a special pool of funds, the Vital Access Program (VAP)/Safety Net Provider Pool, to target funding to a select group of providers aimed at achieving specific well-defined goals. The enacted 2012-13 state budget authorized up to $100 million for this purpose, and CMS conceptually approved the state's authorizing State Plan to advance this initiative. This funding was a positive first step for the state's safety net providers; however, additional resources are needed under the waiver to maintain a financially viable safety net health care community. Without additional resources, NYS and the stakeholder community have serious concerns that if some of these fragile providers that comprise the Medicaid and uninsured service delivery system fail or do not have adequate resources to reconfigure their operations in a planned way, there could be serious consequences to health care access.

The New York State Department of Health (NYSDOH) has conducted numerous financial analysis studies to examine the state's safety net community. For example, a recent financial analysis showed that of the 171 non-public hospitals in NYS, 12 reported a negative operating margin greater than 5 percent. It is important to note that these facilities tend to serve a disproportionate number of the state's Medicare, Medicaid, uninsured and other vulnerable populations.

[1] **Note:** There are facilities that are vital to NYS's provider network that are in serious financial condition. This proposal and one that follows later in this report (Capital Stabilization for Safety Net Hospitals) are aimed at relieving the immediate pressure these hospitals face and putting them on a course for stability. The distinction between the 2 programs is that VAP/Safety Net is targeted at providing operational resources (inclusive of other provider groups) while the Capital Stabilization will provide immediate relief to repair hospital balance sheets as well as provide technical assistance and traditional capital investments.

Similar trends are also apparent in the nursing home sector. For instance, nearly one quarter of nursing homes within the state have been deemed to be in serious financial condition. While the movement to a new Nursing Home Pricing System will provide critical resources and financial relief to many of these homes, there appears to be at least 40 homes that will not improve and may even worsen.

As evidenced by the following chart, the operating margins of some New York hospitals and nursing homes remains well below the national average. Please note this analysis is for illustrative purposes only and the VAP/Safety Net program will include both public and non-public facilities.



New York State also conducted an analysis of the nursing home bed needs/access across the various regions of the State. This analysis, which is based upon the 2016 bed needs methodology, shows an estimated shortage of 7,166 nursing home beds in New York. This is comprised of 10,639 under beds (mainly in New York City and Long Island) offset by 3,473 over beds (primarily in Rochester and Erie counties).

PROGRAM DESCRIPTION

In addition to the $100 million already conceptually approved by CMS, New York seeks to expand funding for the Vital Access Program/Safety Net Provider Program and dedicate an additional $1 billion over five years. In total, the state will have $1.5 billion to ensure a stable transition of the health care system. It is important to note that the MRT waiver funding would be limited to five years, while the state funding would continue after the five year waiver period.

As already mentioned, New York has two programs designed to assist uniquely situated and financially challenged health care providers strengthen their fiscal viability and improve their capacity to provide quality care to populations in need:

1) Safety Net Provider Program:

This program provides short-term funding, up to 3 years, to achieve defined operational goals related to facility closures, mergers, integration or reconfiguration of services.

2) Vital Access Provider Program (VAP):

This program provides longer-term support, up to 5 years, to ensure financial stability and advance ongoing operational changes to improve community care.

Eligible Providers

It is anticipated that funding will be available to qualifying providers, which includes hospitals, nursing homes, free standing clinics, and home health providers, in urban, suburban, and rural markets. To be eligible for assistance, the facility will likely be financially challenged and provide services to a high-volume of patients covered by government payers and/or the uninsured or be essential given their location and function as the sole source of care within a community (often in rural areas). Funding will be granted based on needs as well as the quality of the applications.

Requests for VAP /Safety Net funding will be evaluated based on the following four criteria:

1. **Facility Financial Viability** – The VAP/Safety Net plans must include specific actions for achieving long term financial stability, including benchmarks to measure performance in achieving the goals outlined in these plans.

2. **Community Service Needs** – All proposals will be evaluated in context of ensuring the facility is meeting community health needs. It is anticipated that many VAP/Safety Net plans will include a reconfiguration of services from intensive inpatient acute care to providing greater access to, and higher quality primary care services. Moreover, favorable consideration will be provided to hospitals and health systems in both rural and urban communities that have actively collaborated with regional stakeholders in conducting their community health needs assessments and in developing an actionable plan to meet those needs, or are pursuing integration with other providers. Active engagement in regional planning and the support of the regional planning organization (in regions where such organizations are operating) will be an important factor in evaluating applications. In addition, favorable consideration will also be extended to providers that need immediate or shorter term funding to achieve defined operational goals such as a merger, integration, closure, or service reconfiguration. It should be noted that New York State is currently working with stakeholders to align the state's community service plan requirements with the ACA's community health needs assessment requirements.

3. **Quality Care Improvements** – The initial analysis of Safety Net facilities indicates that some providers perform in the lower quartile on certain quality performance measures. VAP/Safety Net plans will target improvements in these areas.

4. **Health Equity –** A greater weight will be given to those VAP/Safety Net plans that address disparities in health services, or providing care to vulnerable populations who are at greater risk for experiencing poorer health outcomes than the general population.

New York State is currently working with the various stakeholders and industry associations to develop an analytical model that incorporates the measures above to determine and define VAP and Safety Net eligibility. These models will continue to be fine-tuned over the next few months. Providers will need to put forth solid VAP/Safety Net plans that provide for their long term financial viability, ability to meet community health needs, and to improve the overall quality of care for patients.

IMPACT ON OVERALL MEDICAID SPENDING

The objective of VAP and Safety Net initiatives is to improve access to needed services while reducing Medicaid program costs. The state and stakeholder communities have serious concerns that if some of these fragile providers that comprise the Medicaid and uninsured service delivery system fail or do not have adequate resources to reconfigure their operations in a planned way, there could be serious consequences to health care access. It is well documented with the literature, especially within high density urban areas and rural communities, that any delay in accessing needed health care services can result in poor health outcomes and overall higher costs. Moreover, implementation of the ACA will provide nearly one million New Yorkers with health care coverage and they too will be in need of services.

As mentioned in the Capital Stabilization for Safety Net Hospitals section of this document, outpatient and primary health care services are predominantly offered by hospital networks (particularly in New York City), and these Safety Net facilities will need to be strong and financially viable into the future.

Financially, a collapse of VAP and Safety Net providers could significantly impair the financial market, making it difficult for those facilities – many which have aged facilities – to access capital. It is important to note that if such a dire scenario were to unfold there could be a direct financial impact on the federal government as some of these providers currently have outstanding debt (i.e. FHA loans) which is backed by the government.

Lastly, at a granular level, measuring impact on the Medicaid program, the state will require each approved VAP and Safety Net plan to include analysis of how this additional funding will generate a return on investment within the five years of the waiver.

MRT Reinvestment Program
Public Hospital Innovation

BACKGROUND

New York State relies heavily on public hospitals to provide vital care to Medicaid patients and the uninsured. As Charts I and II in the Appendix to this section illustrate, public hospitals account for $1.7 billion in Medicaid spending (over a quarter of the total hospital Medicaid spending in NYS) and 51 percent of all hospital emergency Medicaid spending in NYS is in the public system. The success of various MRT initiatives relies heavily on these critical providers. While ACA will reduce the number of uninsured individuals, the challenges of uncompensated care and access to needed services for Medicaid patients will remain and public hospitals will continue to have to serve those who have nowhere else to go for care.

With regard to the uninsured, emergency Medicaid is clearly not the way to "get in front" of high health care costs. Statewide 31,000 emergency Medicaid patients are treated annually and 51 percent of these individuals are cared for in public hospitals at a cost of $267 million per year. Despite this high spending, uninsured patients lack access to basic primary care and preventative services. HHC data indicates that uninsured patients only have three encounters per year on average and only .5 of those visits are for primary care in any given year.

The MRT Waiver Amendment will enable New York State and CMS to test innovative payment and service delivery models to reduce Medicaid expenditures, enhance efficiency and improve care within the public hospital setting. These goals are especially critical to public hospital systems, such the New York City Health & Hospitals Corporation (HHC); the nation's largest municipal health care and hospital system (Chart II in the Appendix of this section indicates spending and utilization for each public hospital).

The Medicaid expansion under the Affordable Care Act necessitates efficient public safety net delivery systems so that newly eligible patients can access care. The continued viability of the public safety net systems is also critical because in New York State there will continue to be a significant number of Medicaid, uninsured and other vulnerable patient populations who have historically depended upon these systems for their health care.

At the same time we are asking more of public hospitals, the very funding streams these hospitals have historically relied upon are now at risk. These hospitals rely heavily on DSH funding which is scheduled to be reduced. For example, the DSH cuts enacted in the ACA, and extended in recent legislation, will result in nearly $2.3 billion in losses in DSH funding to HHC over eight years beginning in 2014. Such losses are also likely to occur for other public hospitals in New York State. Further, with New York State's transition of its

Medicaid population into managed care, the federal government will save a significant amount in federal UPL payments. These federal savings are not typically recognized in waiver savings calculations. The waiver funding proposed in this demonstration will help position public hospitals to more effectively prepare for a world with less DSH and UPL funding.

The waiver funding will build on existing successes in HHC and other public hospitals. Public hospitals in NYS have a mission to provide the highest quality health care for all New Yorkers regardless of their ability to pay. In order to maintain this important mission, HHC has adopted as one of its strategic goals – the Triple Aim. This strong imperative has driven HHC's efforts to build and develop an integrated delivery system that has demonstrated measurable improvements in quality and cost effectiveness. These achievements include:

- All of HHC's primary care sites have attained NCQA designation as Level 3 Patient Centered Medical Homes;
- HHC was an early adopter of an enterprise-wide electronic medical record. All patient data is in one electronic registry which has enabled coordination of care and has fostered outcome accountability;
- HHC has implemented a team-based approach to performance improvement using LEAN to redesign processes around patients and reduce waste. Over the last 5 years improvement work has resulted in $225 million in savings and new revenues;
- HHC publicly shares its performance measures on its website, and
- HHC's health plan, MetroPlus, which has more than 425,000 members (the third largest in the State), has been consistently rated number one for quality and patient satisfaction by New York State. That recognition is a reflection of the quality of care provided by HHC as most of MetroPlus' members receive their care within the HHC system. MetroPlus also has the lowest administrative costs among health plans in the state.

HHC is keenly aware that despite its many successes its current performance in certain areas is not at the level needed. Access to care when and where it is needed is a key domain of quality and is one where HHC is challenged. While HHC is working hard in this area to redesign its existing operations to create additional capacity, external support and resources are needed to assist this vital access provider to ensure that expanded coverage among those in communities served by HHC results in expanded access to primary care. HHC's successful attainment of NCQA designation is a reflection of its efforts in this area. But more must be done including partnerships with community health centers, behavioral health providers, housing agencies and other organizations to expand access to this most critical building block for improved health outcomes.

HHC also must do more in the area of readmission for chronic disease. Although the public hospitals' mortality rates for Acute Myocardial Infarction (AMI), Heart Failure and Pneumonia are at or above national averages; their readmissions rates for these conditions have lagged behind. HHC hospitals have achieved significant improvements for Heart Failure, but have been hampered in their efforts by the combined factors of homelessness or housing instability, inadequate access to primary care post discharge and language and literacy challenges associated with the diverse populations they serve.

Against this backdrop of a promising public hospital track record with significant remaining challenges, the state sought input from public hospitals and other providers (including behavioral health providers) during the MRT waiver amendment comment period about how to best position the public hospital system to advance MRT and ACA objectives. Based on this feedback which has been incorporated into this proposal, New York State is prepared to fundamentally reform they way care is provided to the Medicaid population and the remaining uninsured in public hospitals. Waiver funding will be specifically used to plug existing gaps in public hospital systems related to the continued need for additional care management and targeted primary care capacity for the Medicaid population and the uninsured. New York State hopes to design and implement an exciting new demonstration program that will provide "pre-emergency" Medicaid services to both uninsured and Medicaid members to provide these patients with access to: 1) culturally appropriate care management; 2) improved discharge planning for higher need patients and 3) Primary Care Expansion through integrated Patient Centered Medical Homes with co-located behavioral health. It is expected these targeted investments will improve patients' health and reduce overall Medicaid spending. As this new capacity will be made available to Medicaid beneficiaries and other patients being treated in the public hospital system the clinical benefits and savings will accrue in both emergency Medicaid and regular Medicaid.

PROGRAM DESCRIPTION

New York State plans to invest $1.5 billion over the next five years to test innovative payment and service delivery models to reduce Medicaid expenditures, enhance efficiency and improve care for Medicaid members within the public hospital setting. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

To improve care and lower costs, care management and primary care expansion programs will be built in HHC and other public hospitals. The first set of programs are specific HHC efforts that have been successfully piloted and would be brought to scale with specific sub-components all aimed at more and better primary care and care management. The last program is a broader statewide effort to support similar work to be done in the balance of the public hospitals in NYS. The goal of both the HHC and other public hospital programs is to bring state of the art primary care access and care management capacity to the high risk uninsured and Medicaid populations served by public hospitals. This new capacity will be developed in the higher risk communities of New York City including Central and Northern Brooklyn, the Bronx, North Shore of Staten Island, Southeast and Western Queens, and East and Central Harlem; and in other at-risk rural and urban communities in the State.

Waiver resources will fund these needed care management and primary care services, as well as be used to track results and savings in Emergency Medicaid and other Medicaid expenditures. These public hospital focused efforts may be blended with other waiver efforts in a coordinated fashion. Waiver dollars will be allocated in a single bundled payment to each public hospital system with a pay for performance program implemented during years 3-5 of the waiver period. Lower performing components of the program will be revised during the demonstration or eliminated. Higher performance against standard metrics will be rewarded with pay for performance dollars from a quality pool set aside for such purpose. All waiver dollars will be used to build capacity that is not available from other Medicaid funding sources (such as health homes) but will help to fund gaps in both the emergency Medicaid and the regular Medicaid programs. Regular Medicaid funding will be fully leveraged prior to using waiver dollars and both the waiver funded and the Medicaid funded efforts will be coordinated and synchronized to avoid any possible duplication or confusion.

The state will work with CMS during the demonstration period to build an ongoing financing model to support the highest performing projects after the waiver expires.

The table below summarizes the programs to be funded under the waiver and the HHC subcomponents.

Project Sponsor	Project #	Project Title/Description	Goals/Approach
HHC	1.	Intensive Care Coordination	Reducing avoidable admissions and readmissions through a three prong care management approach.
	1a.	Emergency Department Care/Case Management	Inpatient Diversion and Readmission reduction through resourcing the ER and psych ER to provide better assessment of admission need and discharge planning
	1b.	Inpatient Care/Case Management	Reduction in Inpatient Readmission and adverse events post discharge through multi-level care management
	1c.	Post-Acute Care Home Care/Care Management	Reducing avoidable admissions and readmissions
	2.	Hot-spotting Uninsured Patients	Focusing indexed care delivery and care management on higher risk communities through patient stratification and matching higher risk patients with tailored care teams.
	3.	Primary Care Expansion	Enhanced access to care will be available through expanding HHC's PCMH teams that will be responsible for ongoing care and coordination of care across all elements of the health care continuum. Effective team-based primary care will be facilitated by registries, information technology and other means to assure that patients get the indicated health and behavioral care when and where needed and wanted in a culturally and linguistically responsive manner.
Other Public Hospitals	4.	Care Coordination and Primary Care Expansion	Reducing avoidable admissions and readmissions through a variety of strategies building off of the HHC specific models.

Following are more detailed descriptions of the HHC proposals and the effort to build out similar capacity in the remainder of the public hospital system.

1) Intensive Care Coordination/Case Management Initiative for Uninsured Patients Who "Touch" HHC Hospitals

HHC has piloted intensive care coordination/case management at its acute hospitals during the hours of 9 AM to 5 PM, Monday through Friday. The pilot has been effective in reducing avoidable admissions and readmissions over the two year pilot at two of its hospitals. As a result of the pilot, more than 2,000 admissions were averted. The waiver amendment proposes to bring to scale this initiative focused on HHC patients who present to its ED and Inpatient Psychiatric Units (IPUs), including uninsured patients. The intensive services care/case management initiative has as its goal the transformation of care across HHC's system in order to provide the right level of quality care, when and where the patient needs it. The initiative is grounded in the CMS' Triple Aim of ensuring a healthy population, providing quality individualized care when needed and containing health care costs where appropriate. This initiative focuses on the transitions in care as opportunities to work with patients and families to improve the course of illness, strengthen wellness, and provide effective and efficient care.

This HHC care management initiative can be described in three parts: A) Care/ Case Management in the Medical Emergency and Psychiatric Emergency Departments; B) Care/Case Management in inpatient medical/surgical units and psychiatric units; and C) Home Care Acute Transitional Care.

1a) HHC Emergency Department Care /Case Management

The medical ED initiative works to: 1) ensure that patients are admitted who need an inpatient level of care and that documentation in the medical record for the admission is accurate and complete; 2) that readmissions are assessed and prevented if it is appropriate for the patient ; and 3) that patients who can be discharged from the ED and whose ongoing care can be provided safely in the community with appropriate services receive the necessary care coordination and assistance so that unnecessary admissions are avoided. The ED Care Coordinator will be responsible for follow up and connecting the high risk patient to the next level of care.

Through a standardized approach across the HHC system, a care and case manager assigned to the medical ED for 2 shifts a day, 7 days a week will be integrated into the emergency room team to accomplish the above goals. A physician champion/advisor will be a member of the ED staff and coordinate the team. Data will be gathered on readmissions, avoidable admissions, patients discharged who return to the ED within 7 days and discharged patients who keep their follow up appointments and are successfully connected to the next level of care.

In the psychiatric emergency department, or Comprehensive Psychiatric Emergency Program (CPEP), the team of a social worker and community liaison worker/ peer counselor will work to: 1) assess patients with the ED team to determine patients whose care can be safely provided in the community and for whom inappropriate hospitalizations can be avoided; 2) develop a plan of care after discharge from the ED/CPEP that provides the necessary intensive community services to avoid unnecessary readmissions and preventable admissions; and 3) provide patients, through the community liaison worker/peer counselor, the necessary real time follow up in the community, including conducting home visits, accompanying patients to appointments, arranging transportation and other community resource support, etc. until the patient is connected to the next level of care. Data will be gathered on readmissions, avoidable admissions, patients successfully connected to the next level of care and revisits to the ED.

1b) HHC Inpatient Care/Case Management Initiative

The Inpatient Care/Case Management initiative is focused on providing timely and effective care coordination for uninsured/emergency Medicaid patients at high risk for readmissions or adverse events after discharge on the medical /surgical and psychiatric inpatient services. In addition, case management will be focused on real time monitoring of length of stay.

The diagnoses being prioritized initially are congestive heart failure (CHF), followed by pneumonia and myocardial infarction (MI). Additional diagnoses will be added as staffing allows. It is estimated that 30 percent of inpatients on HHC medical /surgical units and 40 percent of HHC psychiatric inpatient units are high risk and in need of intensive care coordination during their stays and for their successful transition to the next level of care.

On the medical/surgical units Project Red, an evidenced-based best practice developed by Boston University is being implemented throughout HHC and could be piloted at other public hospitals as well. At HHC this project initially focused on patients with CHF who have a high readmission rate in all facilities. A care manager is assigned upon admission to readmissions and high risk patients who are in need of comprehensive discharge planning and care coordination. The inpatient care manager is responsible for developing the plan of care with the patient and family and the inpatient team, educating the patient and family, ensuring effective medication reconciliation, and providing a successful connection to the recommended next level of care. This involves intensive work during the admission, and follow up calls and interventions after admissions until the patient is safely connected to the next level of care. The inpatient care manager will work closely with community-based programs, home care agencies, the family, and other supports.

On the Inpatient Psychiatric Units a model similar to Project Red, but modified for psychiatric patients, will be implemented focused on the patient at high risk for readmission or adverse outcomes after discharge. The project will use social work care coordinators who will work with patients and families from the time of admission, develop with the entire psychiatric team a comprehensive care plan, and ensure that patients are connected successfully to aftercare in the community. The social worker, inpatient care manager, will work collaboratively with community-based programs, home care agency, family, and other supports.

If this were adopted as a standardized approach across HHC's public hospitals, it is expected that readmissions can be reduced to less than the national benchmark. It is also expected that adverse events post discharge would be decreased. Readmissions and ER visits within 30 days will be monitored for all patients in the initiative. Resources needed include a standardized staffing pattern based on volume across all acute care facilities.

1c) HHC Home Care/Acute Transitional Care Management

HHC Home Care has developed a care management approach to provide transitional services to high risk discharged patients with at least three of the CMS monitored diagnoses of Myocardial Infarction, CHF and pneumonia as well as high risk diabetics discharged from HHC's Emergency Department and inpatient services.

This proposal would provide services to all discharged high risk patients with the above diagnoses, and would stratify those services from a minimum of post-discharge calls to ensure that patients make their aftercare appointments to the more intensive use of telehealth and face-to-face contact for up to 90 days post discharge.

Effectiveness would be measured by a decrease in readmissions within 30 days, prevention of avoidable admissions for up to 90 days for enrolled patients, and patients' assessment of progress on their self-management goals.

2) Expanding the Concept of "Hot Spotting" to Uninsured Adult HHC Patients

Using state data, HHC will identify uninsured individuals who they "touch" and risk stratify them based on their risk of a non-OB hospital admission and on their risk of being a high cost patient ($10,000+). HHC would then map where these individuals live within each city borough and, working with community-based organizations, gather information about these individuals and their physical and behavioral health and community and social services resource challenges.

These individuals would be invited to participate in the "HHC Options Health Home Program (HOHHP)"; a program that would pair high performing patient-centered medical home teams based in the nearest HHC Diagnostic and Treatment Center or hospital, with these high-risk/high-cost uninsured patients to improve their health outcomes and prevent or reduce "downstream" costs. HOHHP would provide different intensity levels of care coordination based upon a shared care plan developed with each patient.

Each patient would be assigned a health coach (clinical or nonclinical based on their needs and self-management goals). This level of support would be layered on the foundation of patient-centered team-based primary care and the state's newest initiative, Health Homes. The care team, guided by the primary care provider will take responsibility for the ongoing care of participants across all of the elements of the health care continuum.

3) Primary Care Expansion

One of the most critical elements of HHC's proposed projects will be the system's capacity to ensure that all of its patients have access to a primary care provider within three to five days of demand and 24 hour access to a member of the care team when issues arise. This capability must be in place without displacing the public hospital system's capacity to serve existing Medicaid patients and newly insured patients from the state's Health Exchange and Medicaid expansion efforts. HHC proposes to ensure open access to all of its patients by creating additional primary care capacity through expanding hours of operations, partnering with other safety net primary care providers, creating additional sites of care (i.e., capital funds) and increasing mid-level providers (Physicians Assistants (PA), Nurse Practitioners (NP)) in behavioral health settings and behavioral health providers (Psychiatric NPs, Social Workers) in primary care settings.

OTHER PUBLIC HOSPITAL PROJECTS

4) Other Public Hospitals - Primary Care Expansion and Care Management Services

The challenges for public hospitals that serve uninsured and high risk individuals, often with uncompensated care, also exist in other communities in New York State. Accordingly, the state intends to use waiver resources to extend components of the HHC models presented above to other public hospitals, especially those serving vulnerable communities with higher numbers of uninsured patients. The state believes that the demonstrated success of HHC's innovative pilot for managing health care for the uninsured warrants further expansion, however, it should be tailored to the unique needs of each community.

To implement this proposal the state would issue a request for proposals from the other public hospitals to propose demonstrations that would:

- Develop or expand high competence (PCMH) primary care and behavioral health ambulatory capacity to the uninsured.
- Develop or expand care coordination and transitional support services to higher risk uninsured patients.

IMPACT ON OVERALL MEDICAID SPENDING

This program will reduce spending (i.e, emergency and regular Medicaid spending) by providing care and care coordination services that prevents unnecessary ED, inpatient and Dialysis visits. Previous efforts to focus care management and patient centered primary care have proven successful. For instance the health care teams used as part of a patient centered medical home project implemented by the Group Health Cooperative of Puget Sound generated a 29 percent reduction in ER visits and 11 percent reduction in ambulatory sensitive care admissions. In this same project investment in primary care of $16 per patient per year was associated with offsetting cost reductions as reportedly unpublished data from the 24 month evaluation show a statistically significant decrease in total costs.

Community Care of North Carolina using PCMH with care coordination and disease management tools produced a 40 percent decrease in hospitalizations for asthma and 16 percent lower ER visit rate and total savings to the Medicaid and SCHIP programs in NC are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population.

Care management focused on high cost/high need populations has also shown promise in New York. In the New York City Health and Hospitals Corporation's Chronic Illness Demonstration Project:

- 263 H2H patients were enrolled;
- $71, 146 per patient per year average cost to Medicaid pre-enrollment into H2H;
- $57,064 per patient per year average cost to Medicaid post H2H enrollment;
- Annual saving $14,082 (20%); more than $3.7 million for 263 patients including program costs;
- Of the 263 H2H patients, 53 were homeless;
    - ✓ Among those 53 H2H participants, there was a significant reduction in inpatient admissions from 0.68 per month to 0.36 per month with a 47% decrease in admissions (a 27% decrease in inpatient costs).
    - ✓ Among the 53 H2H participants, there was a significant reduction in ED visits from 1.13 per month to 0.53 per month with 53% decrease in visits (a 30% decrease in ED costs).

While the public hospital proposals are being presented in the context of the MRT Waiver and one of the aims is to show savings to the Medicaid program, it is important to consider that these savings may not be evidenced in the first years of the demonstration grant as there will be a need for upfront investments in operational infrastructure and increases in costs related to utilization of primary care and other preventative services.

The evidence clearly suggests that investments such as those laid out in this document will generate significant savings in the long term. It is expected that the total waiver reinvestment will equal $300 million with a quality pool of $50 million beginning in year three and increasing to $75 million by year five. In addition to ancillary benefit to Medicaid and Medicare as new primary care and care management capacity is built, the program is projected to save at least $158 million in savings over the demonstration period in Emergency Medicaid spending.

APPENDIX

Chart I

NYS Medicaid Expenditures and Utilization
by Major Categories of Service
For People Receiving Medicaid Services with Emergency Services Only Coverage
Service Dates: July 2010 - June 2011 (NYC Fiscal Year 2010-11)

	Provided by All NYS Hospitals		Provided by Public Hospitals		%s of Public Hospitals	
Category of Service	**Medicaid Expenditures**	**Medicaid Recipients****	**Medicaid Expenditures**	**Medicaid Recipients****	**Medicaid Expenditures**	**Medicaid Recipients**
All Medicaid Services	**$528,976,246**	**30,773**	**$267,295,049**	**15,738**	**51%**	**51%**
Inpatient	469,703,328	21,759	249,213,594	11,339	53%	52%
Hospital Based Dialysis	26,198,785	10,636	15,510,218	5,667	59%	53%
Emergency Room*	2,245,977	4,705	611,122	1,495	27%	32%
Freestanding Dialysis	9,383,467	770	0	0	0%	0%
Physicians	8,881,865	16,131	0	0	0%	0%
All Other Services	14,808,801	n.a.	2,571,237	n.a.	17%	n.a.

* ER is a subset of Hospital Clinic

**Recipient counts do not add up to totals because a recipient might have received more than one service during a time period.

Source: NYS DOH/OHIP Datamart (based on claims paid through 6/2012)

APPENDIX

Chart II

NYS Medicaid Expenditures and Utilization
by Public Hospitals
In Descending of Total Medicaid Paid Amounts
Service Dates: July 2010 - June 2011
Source: NYS DOH/OHIP Datamart (based on claims paid through 6/2012)

Hospital Name	Medicaid Paid Amount Spent on All Medicaid Recipients	Medicaid Paid Amount Spent on People with Emergency Services Only Coverage	%Dollars Spent on People with Emergency Services Only Coverage
TOTAL	**$1,683,964,288**	**$267,295,049**	**16%**
BELLEVUE HOSPITAL CTR*	234,031,382	50,973,262	22%
KINGS COUNTY HOSP CTR*	232,287,269	41,198,994	18%
JACOBI MEDICAL CENTER*	170,239,905	16,736,486	10%
ELMHURST HOSP CTR*	164,923,529	50,626,314	31%
LINCOLN MEDICAL*	146,553,818	18,627,427	13%
WOODHULL MEDICAL*	109,347,006	12,295,468	11%
HARLEM HOSPITAL CTR*	96,487,935	9,425,936	10%
METROPOLITAN HOSPITAL CTR*	93,247,941	13,192,944	14%
QUEENS HOSPITAL CTR*	93,061,522	18,160,534	20%
CONEY ISLAND HOSPITAL*	83,984,223	20,686,985	25%
GOLDWATER MEM HOSP*	58,079,054	5,170,434	9%
ERIE COUNTY MED CTR	49,470,283	91,069	0%
NORTH CENTRAL BRONX*	47,543,586	6,807,249	14%
SUNY DOWNSTATEMED CTR AT LICH	38,188,061	1,233,598	3%
WESTCHESTER MED CTR	18,862,169	527,285	3%
COLER MEMORIAL HOSP	14,513,536	1,466,590	10%
ROSWELL PARK MEMORIAL INSTITUTE	10,787,034	-	0%
UNIVERSITY HOSPITAL AT STONY BROOK	5,621,569	74,051	1%
UPSTATEUNIV HOSP AT COMM GEN	4,450,400	-	0%
HELEN HAYES HOSPITAL	4,091,685	422	0%
WYOMING CO COMMUNITY HOSP	2,522,677	-	0%
UNIV HOSP SUNY HLTH SCIENCE CTR	2,300,121	-	0%
SUMMIT PARK HOSPITAL	2,066,318	-	0%
SUNY HOSPITAL DOWNSTATEMEDICAL CENTER	1,085,090	-	0%
MONROE COMMUNITY HOSPITAL	115,858	-	0%
MASSENA MEMORIAL HOSP	93,212	-	0%
LEWIS COUNTY GENERAL	9,106	-	0%

* Health and Hospitals Corporation (HHC) Facility

MRT Reinvestment Program
Medicaid Supportive Housing Expansion

BACKGROUND

A critical component to improving the health of New Yorkers and containing health care costs is to ensure that an individual's housing needs are also met. "Supportive Housing", which is housing coupled with appropriate individual-based services, is an innovative and cost-effective model of care designed to provide an integrated solution for both housing and health care needs. There is compelling evidence, both in New York and nationally, that for people coping with chronic illness or disability and behavioral health challenges, the lack of stable housing often results in avoidable health care utilization and, in turn, avoidable Medicaid expenses. Moreover, the lack of affordable housing, in combination with accessible health care, continues to be an obstacle to serving individuals in the most integrated setting. This includes individuals in nursing homes and other long term care settings, who cannot be discharged because they lack a place to live, as well as homeless individuals and those in shelters whose chronic health and behavioral health conditions lead to overuse of emergency departments and hospital inpatient care.

Over a decade of independent research has shown that transitioning individuals into supportive housing dramatically reduces immediate and long-term spending for Medicaid reimbursable expenses, as well as spending on other public programs. This is a fundamental premise of the U.S. Department of Justice's vigorous enforcement activities to assure the availability of community living options for people with disabilities. In New York, supportive housing costs $47 per day while it costs $437 a day in a psychiatric hospital, $755 in an inpatient hospital, $68 in a homeless shelter, and $129 for jail.[2] By increasing the availability of supportive housing for high-need Medicaid beneficiaries, there is a significant opportunity to reduce Medicaid costs and improve the quality of care for these individuals.

A preliminary analysis of 28,724 recipients in need of supportive housing found a total of over $1 billion in annual Medicaid expenditures, including $212 million on inpatient hospital care, $5 million on emergency department services and $266 million on long term care services.[3] Supportive housing services have the potential to decrease these costs dramatically – producing millions in Medicaid savings. For example, multiple national studies have found reductions in emergency department (ED) and inpatient costs averaging 60 percent,[4] potentially saving New York's Medicaid program over $650 million over five years in ED and inpatient costs alone. Clearly, expanding the availability of supportive needs is an integral component to attaining Medicaid cost containment.

[2] Culhane, et al. "Public Service Reductions Associated with Supportive Housing." Housing Policy Debate.
[3] Medicaid utilization for people in need of housing; CY2011; NYSDOH/OHIP Data Mart.
[4] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Costs for People with Multiple Health and Social Needs,. IHI Innovation Series White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

Access to supportive housing services is of paramount importance to achieve the Triple Aim of better health, better care, and lower costs for traditionally underserved populations. The MRT Affordable Housing Work Group evaluated the expansion of supportive housing programs for the purpose of assuring that individuals who have compelling needs for health care are adequately served in a manner that makes the most efficient possible use of the Medicaid dollar. Over the course of the Work Group's deliberations, the Work Group members and the stakeholder community identified multiple populations in need of supportive housing services. The Work Group findings underscored the belief that supportive housing is an essential component of a service constellation necessary to assuring access to primary care and preventative services.

There is a growing national recognition that addressing the social determinants of health is critical for improving health while reducing health care costs.[5] This is most evident in the matter of housing. People who are homeless or lack stable housing face multiple health risks,[6] die younger,[7] have less access to primary care,[8] and are frequent users of expensive hospital services. Among those New York City Medicaid patients at highest risk for future costly hospital admissions, as predicted by a validated algorithm, a full 60 percent were homeless or precariously housed.[9]

Moreover, economic and demographic trends are reinforcing barriers to community-based care for low-income people with disabilities – particularly in New York City (NYC) where the Fair Market Rent is equivalent to 166 percent of the average monthly Supplemental Security Income ("SSI"). Housing costs in other downstate areas are similarly out of reach for disabled people on fixed incomes. Financial assistance for supportive housing services will provide the necessary wherewithal to allow low-income disabled individuals to live in the community.

New York has committed significant resources and made vigorous efforts to ensure compliance with the ADA and the Supreme Court decision in *Olmstead v. United States*. Nevertheless, thousands of New Yorkers with disabilities continue to live in institutions or other inappropriate settings because of the lack of affordable, accessible housing options in the community. For example, there are currently 22,248 New Yorkers living in nursing facilities who have indicated they wish to return to the community.[10]

If those nursing facility residents who are Medicaid eligible were transitioned to the community, the state would potentially save $129 million annually in the non-federal share of Medicaid.[11] Unfortunately, HUD financed housing continues to be primarily directed to meeting the needs of low income families and individuals, for the most part, and HUD financed housing is very difficult to access by individuals with disabilities and other special needs.

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[5] Bradley E.H., Taylor L. "To Fix Health, Help the Poor." *NY Times.* 8 Dec 2011.
[6] Baggett T.P., et al. The unmet health care needs of homeless adults: a national study. *Am J Public Health.* 2010.
[7] Barrow S.M., et al. Mortality among homeless shelter residents in New York City. *Am J Public Health.* 1999.
[8] Kushel M.B., et al. Factors associated with the health care utilization of homeless persons. *JAMA.* 2001.
[9] Raven M.C., et al. Medicaid patients at high risk for frequent hospital admission: real-time identification and remediable risks. *J Urban Health.* 2008.
[10] New York Association of Independent Living. Center for Medicare and Medicaid Services Minimum Data Set, 2010 3rd quarter QiA report.
[11] Proposals to Reduce New York State Spending and Promote the Independence and Integration of Seniors and People with Disabilities: Fiscal Analysis, New York Association on Independent Living and the Center for Disability Rights, January 7, 2011.

Additional supportive housing services will also reduce health disparities by focusing on a diverse population of low-income New Yorkers. Racial minorities, including African-Americans, Hispanics, and Native Americans are overrepresented among those who are homeless and marginally housed, and stand to benefit the most from supportive housing services.[12] In addition, focusing on the Health Home eligible population will have the ancillary benefit of contributing to reducing health disparities among the minority community. For example, of the Health Home eligible population, over 20 percent are African-American and over 26 percent are Hispanic. Increased funding for supportive housing services for the racial and ethnic minority population will contribute to the state's efforts at reducing health care disparities.

Finally, recognizing the importance of stakeholder feedback, recommendations for this initiative were gathered through multiple stakeholder engagement processes, including the MRT waiver website public feedback form, face to face meetings with stakeholders, multiple webinars, the MRT waiver amendment survey tool, public hearings and Medicaid recipient focus groups. Throughout the stakeholder engagement process, individuals throughout the state expressed the need to increase funding for supportive housing services.

PROGRAM DESCRIPTION

New York seeks to dedicate $150 million annually, totaling $750 million over five years, to expand access to supportive housing services. Under this proposal, two programs would be created – the Supportive Housing Capital Expansion Program, totaling $75 million annually, to fund capital projects, and the Supportive Housing Services Program, totaling $75 million annually, to provide supportive housing services. Funding would target high cost, high need Medicaid members who require supportive services to live independently.

Target Populations

Individuals would be eligible for supportive housing services insofar as they are at high risk of not being able to live independently if they are not provided with the supportive services available through this program. Funding would target "high users" of Medicaid services, with a primary focus on the Health Home eligible population. As such, the program would work in conjunction with New York's Health Homes and Managed Long Term Care Plans to provide needed housing services to New York's most complex Medicaid populations.

[12] National Coalition for the Homeless. "Minorities and Homelessness." July 2009.

The target populations intended to be recipients of the housing and services developed as a result of this program, include, but are not limited to:

- Chronically homeless adults who suffer from mental illness and/or substance abuse;
- Chronically homeless and physically disabled;
- Chronically homeless adults living with HIV/AIDS;
- Single adults who are presently living in New York State-operated psychiatric centers;
- Young adults with a serious mental illness and/or substance abuse disorder;
- Individuals with serious behavioral health or health conditions coming out of prison or jail;
- Individuals residing in long term care settings who prefer to return to the community (i.e. adult homes and nursing homes);
- Individuals residing in acute hospitals (i.e. hospital homeless) who cannot be discharged because they lack housing options;
- Low-income disabled individuals enrolled in or eligible for Managed Long Term Care plans or Consumer Directed Programs;
- Frail elderly individuals living in arrangements, which create a potential for harm or neglect.

1) Supportive Housing Capital Expansion Program

New York seeks to dedicate $75 million annually for capital funding to increase access to supportive housing. Funds must target high cost, high need Medicaid members who require supportive services to live independently. Funds would be distributed through a variety of state and local housing agencies via a competitive request for proposal approach. It is estimated that 600 new units will be created annually[13], totaling 3,000 units over the next five years.

Sustainable projects, with the greatest Medicaid return-on-investment (ROI), would be prioritized over other projects. These funds would be used to leverage other state, local, and federal capital resources and private tax credit investments prioritized for this purpose. Development would emphasize the creation of supportive housing units integrated into the community and with other affordable units for non-disabled populations.

[13] The estimate assumes $125,000 per unit, with developers of this housing would need to leverage other resources from OTDA, OMH, OASAS, or other partnering agencies.

Funds may be used for the following purposes:

- Development costs associated with the conversion of existing housing to supportive housing standards;
- Development and construction of new supportive housing units;
- Capital funding to support home modifications. Funding would provide financial assistance to property owners to make dwelling units accessible for low- and moderate income persons with disabilities. Providing assistance with the cost of adapting homes to meet the needs of those with disabilities will enable individuals to safely and comfortably continue to live in their residences and avoid institutional care;
- Co-location and integration of health care services with supportive housing. Project funds would create "free-standing" easily-accessible clinics for individuals in need of supportive housing services, as well as for individuals within the community. Funding would be used similar to the HEAL-NY program, a program which was also funded with 1115 waiver dollars.

2) Supportive Housing Services Program

New York seeks to dedicate $75 million annually for supportive housing services to increase access to supportive housing. Funds would be distributed through a competitive request for proposal process. Sustainable projects, with the greatest Medicaid ROI, would be prioritized over other projects. Funds must target high cost, high need Medicaid members who require supportive services to live independently. This Program would work in coordination with the Supportive Housing Capital Expansion Program as multiple projects would receive funds for both capital and supportive services. Funds may be used for various supportive housing services, including but not limited to:

- Crisis management;
- Case management;
- Patient navigation and care coordination services (including linkages with Health Homes);
- Counseling;
- Relapse management;
- Linkages to community resources;
- Education and employment assistance;
- Landlord-tenant mediation;
- Entitlement advocacy;
- Budgeting and help with legal issues.

Many of the supportive housing services targeted under this proposal are already covered services for existing Medicaid populations in other settings. To ensure that supportive housing projects funded under both programs receive all the components necessary to be fully operational and successful, state-only dollars or other non-Medicaid federal dollars would be used to fund rental subsidies. The MRT dedicated $75 million in state Medicaid funds on an annual basis to fund supportive housing programs and services. A portion of this funding would be targeted to fund the rental subsidy costs associated with these programs.

Eligible applicants

Eligible applicants may include, but are not limited to, for profit and non-profit housing developers, and private nonprofit organizations. New York State agency partners may include: the Office of Mental Health (OMH), the Office of Temporary and Disability Assistance (OTDA), the AIDS Institute within the Department of Health, the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and New York State Homes and Community Renewal (HCR).

Advocacy Community Input

All recommendations were reviewed for consideration and numerous recommendations from the advocates of this population were incorporated into this proposal. See the Appendix for a list of stakeholders who were consulted.

IMPACT ON OVERALL MEDICAID SPENDING

The lack of appropriate supportive housing, especially in New York's urban areas, is a major driver of unnecessary Medicaid spending. For every individual served under this program, it is estimated to save Medicaid costs by approximately $16,281 - $31,291 annually per person[14], with savings ranging by the types of populations and disabilities served and intensity of targeting. Preliminary estimates suggest that Medicaid savings would total between $142 million - $273 million annually, totaling between $711 million - $1.3 billion over a five-year period.[15]

[14] NYNY Housing SMI; and Harlem United, "2009 Program Evaluation," 2010.
[15] Fiscal estimates assume 8,743 individuals per year, with savings ranging from $16,281 - $31,291 per person per year.

APPENDIX

Advocacy Community Input

Recommendations and feedback for this initiative were gathered through multiple stakeholder engagement processes, including the MRT Waiver Public Feedback Form, face-to-face meetings with stakeholders, multiple Webinars, MRT waiver amendment survey tool, public hearings and Medicaid recipient focus groups. Throughout the stakeholder engagement process, individuals throughout the state expressed the need to increase funding for supportive housing services. All recommendations were reviewed for consideration and numerous recommendations from the advocates of this population were incorporated into this proposal.

Recommendations were submitted from the following stakeholders:

- The Supportive Housing Network of New York (SHNNY)
- The Healthcare Association of New York State (HANYS)
- New York City Department of Health and Mental Hygiene
- Corporation for Supportive Housing
- Harlem United
- Association for Community Living
- New York City Human Resources Administration
- New York City Department for the Aging
- Community Health Care Association of New York State (CHCANYS)
- Coalition for Children's Mental Health
- The Fortune Society
- ArchCare
- Empowerment by Design
- Nassau County Office for the Aging

MRT Reinvestment Program
Long Term Transformation and Integration to Managed Care

BACKGROUND

One of the most significant reforms recommended by the MRT is the plan to migrate long term care services to a managed care environment. Non-institutional, community-based long term care was one of the major cost drivers in New York Medicaid prior to the MRT. There was no comprehensive system of quality assurance, and empirical analysis demonstrated little relationship between hours of care provided and level of patient acuity. In order to transform New York's long term care system to one that ensures care management for all, supports choice for consumers, and emphasizes community integration, it is necessary to invest in key areas of the long term care community.

The MRT moved New York's long term care system in a new direction through a series of short term payment reforms as well as longer term changes in the delivery system. First, the MRT put in place a new payment system for home health care that linked payment rates to utilization thresholds that more accurately reflected patient need. Next the MRT created a new episodic payment system for home health care that will continue to assure that the benefit is related to the needs of the recipient. In addition, personal care utilization growth is being better managed by a city and state partnership. Each of these strategies saved taxpayers hundreds of millions of dollars while maintaining a robust community-based system.

In addition to these initial payment reforms, the MRT also moved forward with a systemic reform plan in long term care – the end of fee-for-service long term care and its replacement with a statewide system of managed long term care. This sweeping change is built off the state's highly successful voluntary Managed Long Term Care Program (MLTCP) and the sound base of New York's successful Mainstream Managed Care Program. Under the reform, over a several year period (beginning in August 2012) MLTCP will expand statewide and the majority of community-based long term care service recipients will be enrolled in plans. This new approach to care will save Medicaid and Medicare expenditures, increase care management to beneficiaries, provide opportunities for enhanced quality assurance and metrics to measure service provision, increase consumer direction opportunities and incentivize community-based options over institutionalization.

New York is not going to stop by simply moving long term care services into effective management. Rather, New York seeks to lead the nation in fully integrating all services (including Medicare services) for individuals in need of long term care. In New York, long term care recipients will eventually have the opportunity to enroll into plans that are fully integrated. The entire array of services to which a member is entitled will be under one care management entity reducing fragmentation, increasing coordination and resulting in cost savings.

To achieve full integration, New York will partner with Medicare through a duals demonstration project. Dually eligible members are among society's most vulnerable people. Historically, duals have been poorly served by the health care delivery system. Their needs often cross multiple silos including payer silos. The duals project in New York will build off the statewide MLTCP roll-out by "converting in place" duals enrolled in MLTCP plans in January 2014. New York is confident that by using its successful MLTCP plans as the basis for full integration, the Triple Aim of improving the patient experience of care, improving health of populations, and reducing per capita costs for some of the nation's most challenged patients can be realized.

The move to managed long term care and full integration for duals is a major structural change. This structural change will require waiver funding to assist in the transition for both patients and providers to minimize unintended consequences and support expected improvements. New York envisions using waiver funds in a number of ways to ensure successful implementation of these reforms. Below is a description of specific programs that would be funded:

PROGRAM DESCRIPTION

New York State plans to invest $839.1 million over the next five years to transform New York's long term care system so as to support consumer choice, emphasize community integration and ensure successful implementation of care management for all. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Nursing Home Transition – Assuring Access and Choice

New York nursing homes have been mostly exempt from managed care and many are financially fragile. The transition to managed care will put financial pressure on homes as they are asked to transform into effective care managers that are highly focused on reducing hospitalizations and improving patient quality of life. Historically, fee-for-service (FFS) payment systems have actually rewarded nursing homes for moving residents back and forth from hospitals. Running counter to the state's policy on community integration, the need to fill beds has been a driving force behind nursing home behavior to maintain occupancy with patients that could be better served in the community.

Nursing homes will play a key role in providing care to dually eligible patients in a fully integrated environment. Capital investments in the state's nursing home facilities will be required to ensure a smooth transition to manage care, and preserve access to high quality care and choice for the complex needs of this population. These investments will need to be multifaceted to allow for necessary upgrades in the aging capital stock (at least 20 percent of the state's nursing homes were originally constructed before 1971), support investments which were approved by the state's CON process (i.e., "legacy capital"), facilitate maintenance and upgrades and help financially challenged nursing homes access the credit markets.

One critical concern nursing homes have about the move to managed care is capital funding. FFS has historically reimbursed homes for capital investments made with state regulatory (Certificate of Need - CON) approval. Nursing homes fear that when managed care becomes mandatory, these past capital expenditures will put them at a competitive disadvantage by providing plans and incentive to drive utilization to lower price homes.

One approach to address these concerns would be to seek either a change in or a waiver from the federal regulation to 42 CFR § 438.60. This regulation effectively precludes payments to providers for services provided under a Medicaid managed care contract, unless: (1) there is an exception in the Medicaid statute; or (2) the state has adjusted its capitation rates to make separate payments for graduate medical education.

The revision or waiver to 42 CFR § 438.60 would be intended to carve nursing home Medicaid capital reimbursement out of Medicaid managed care plan benefits and capitation payments, and require that such amounts continue to be reimbursed directly to providers. For this purpose, the state would adjust the actuarially sound capitation rates to account for the capital cost payments to be made on behalf of Medicaid managed care enrollees residing in nursing homes, not to exceed the aggregate amount that would have been paid for capital costs under the approved State Plan.

A major advantage of this approach is that it would maintain capital cost reimbursement of legacy assets without any added cost, thus preserving available waiver resources for other MLTC preparation activities. If the state is unsuccessful in securing approval of the payment waiver, the Department could develop, in consultation with stakeholders, a regional price for capital. MRT waiver dollars would then be used to provide transitional assistance to homes that are above the price. This assistance would provide a "glide path" to managed care by maintaining legacy investments, providing an infusion of needed capital for homes with rates that are now below the price and assist financially challenged homes.

2) Capital funding for Assisted Living Programs – Increasing Capacity

New York has a Medicaid funded Assisted Living Program (ALP) that serves as a residential setting for persons who are nursing home eligible but can be served in a more home- like and less institutional setting. The current program lacks any dedicated capital funding stream. In order to provide a wider range of options for people in need of long term care residential care, the state has slated the program for a dramatic expansion in the next 3 years. In 2014 this service will also be included in the benefit package of both Mainstream Managed Care and Managed Long Term Care Plans. In order to support this effort to allow individuals in community-based residential setting, improve satisfaction and save money waiver funding would be used for one time investment in new assisted living program slots. The state has initiated a process to expand program slots, and only new slots will access the support for capital. The waiver funding will be front loaded over the first three years with $50 million for years one and two and $25 million in year three.

3) Expand New York Connects - Improving Satisfaction

Transforming long term care delivery and achieving true integration is going to require enhanced communication, community outreach and training for members, their families, providers and advocates. New York is going to need "boots on the ground" across the state to help facilitate these significant changes. New York has a severely under-funded system of Aging and Disability Resource Centers (ADRCs) – called New York Connects – which are ideally suited to support the need for information and assist in the transition to managed care. Additionally, the Affordable Care Act (ACA) and the MRT also provide unprecedented opportunities for the aging services networks. The increasing need for long-term care services, due to the impending dramatic shift of individuals over the age of 65, combined with the number of disabled adults and children with impairments, demands innovative policy and programs. NY Connects, a federally endorsed Aging and Disability Resource Center is positioned to provide locally accessible, consumer-centered access points that provide comprehensive information about long term care options and linkages to services. It is presently is operational in 54 counties. Additional funding will be needed to expand the program into the New York City metropolitan region as well as four upstate counties where the program is not currently available.

New York Connects sites will also help reduce Medicaid expenditures by providing counseling to individuals and families regarding their long term care needs so that they can stay in their homes and actually stay off Medicaid. In addition the use of a front end will enhance the state's ability to access satisfaction data directly from consumers, a much needed component of the long term care delivery system. ADRCs have been successful in other states and with a relatively modest investment through the waiver New York could see comparable benefits. The waiver funding needed to support the start up for expansion and enhancement of New York's ADRC capacity over the five year period is $10 million the first year and $18.4 million for the remaining four years. Allocation of this funding will be based on the population of aged and disabled individuals by region.

4) Quality Improvement Program – Assuring Positive Outcomes

The move to managed long term care and full integration for duals places a great deal of responsibility in the hands of health plans. While New York is confident its current plan partners as well as new partners that will emerge will be successful, there is a need to ensure that the plans are in fact fulfilling the Triple Aim. With an investment of waiver funding the state will contract with an outside vendor to assist in monitoring plan activities during the implementation of mandatory managed long term care and the duals demonstration. This vendor will act beyond the state's enrollment broker's relationship to plans and the state's External Quality Review Organization (EQRO). It will closely monitor both plan behavior and the actions of the plan's network to ensure that members are getting the most cost-effective services possible during this important period of transition. The waiver funding needed for this activity will be $3 million annually for the five years of the waiver – the time frame covering the statewide implementation of mandatory managed long term care and the proposed dual demonstration.

5) HIT - Supporting Delivery System Integration

New York has high expectation for plans and their networks to be responsible for managing the complete needs of dually eligible members. During implementation of mandatory managed long term care, plans will be required to report more information about their members, provide real time assessment data in a uniform assessment system, and assure that the information to and from its network providers in accurate and reportable. In addition, within the proposed duals demonstration, plans will be expected to expand this effort to encompass all Medicare data and services. Plans, especially community-based not-for profit partners, will find it difficult to fund the HIT systems necessary to achieve the state's full vision.

The need for investment in HIT for long term care has been identified at all levels of the health delivery system. An investment of waiver funds is needed to address the HIT challenges facing plans and network providers to fully integrate so that care management can be realized, clinical integration and collaboration across the continuum can occur, and payment aligns with desired outcomes. The investment for the level of improvement needed is over the waiver period allowing the state to prioritize investments.

Year one will be a ramp up with $25 million to focus on systems enhancements related to supporting Plans and providers to adopt the Uniform Assessment System – NY (UAS-NY) with funding for hardware, access to this architecture build by the State and assure connectivity for Plans and providers to share information across the already established Regional Health Information Organizations (RHIOs); year two will increase to $50 million to expand these efforts to network providers; and $37.5 million for each of the remaining three years to focus on components such as community-based network members and other integrations. Funds, hardware and systems will be synchronized with those requested under the health home program to leverage existing capabilities, the new Health Home capabilities and the State's vision for HIE.

6) Ombudsperson Program –Supporting Choice

Even with investments in ADRC's and significant plan oversight, there will be situations in which members need assistance to understand their benefits, advocate for themselves related to the quantity and/or quality of service they are receiving from plans, and access a resource for information. New York seeks to create a statewide Ombudsperson Program that will assist members who are concerned or unhappy with the quality of service they are receiving from their plans. The aim of this effort is anticipated to reduce grievances and appeals and ensure that members have an independent and knowledgeable voice that can help them. The state would seek to replicate a similar program currently in operation in Wisconsin, and would look for a single statewide contractor who would use subcontractors across the state to ensure sufficient coverage and personalized attention for members. This investment recognizes that savings from Medicaid should be reinvested in approaches that enhance the members' participation in their care and supports a higher degree of consumer satisfaction in significant and perhaps frightening change from the FFS delivery system. The ramp up of such a program would require a year one investment of $3 million and then to maintain the investment through the transition phase an additional $5 million for each successive year.

IMPACT ON OVERALL MEDICAID SPENDING

The move to mandatory managed long term care is one of the most transformative reforms in the MRT action plan. In recent years, FFS long term care services have been the number one cost driver in the program. Moving to managed care in this important area will save money and improve patient outcomes. Also, thanks to the Duals Demonstration New York will take a further step by moving to fully integrated managed care for dually eligible members by adding the Medicare benefit to the managed long term care plan contract. A recent analysis by a respected actuarial firm found that if New York were to implement fully integrated managed care for all duals Medicare and Medicaid could save a combined $1 billion per year. The initiatives funded through this program will help smooth the way to successful implementation of managed long term care and the further effort to fully integrate managed care for duals.

MRT Reinvestment Program
Capital Stabilization for Safety Net Hospitals

BACKGROUND

Hospitals in New York have developed as the hub of health care delivery in many communities. In underserved, inner-city communities and in areas that are geographically isolated, the hospital is the health care delivery system. In developing recommendations for transforming the Medicaid program the MRT recognized the importance of preserving and strengthening safety net providers that are essential to preserving access to care in their communities. Of particular focus were providers with high proportions of Medicaid and uninsured patients and providers that serve more remote populations and are the sole source of care in their communities. These are truly the "safety net". The importance of the safety net will increase as New York adds over one million uninsured New Yorkers to its insurance rolls through the new Health Insurance Exchange.

Many safety net institutions have limited financial resources to respond to the call for change and while access t o capital for not-for-profits is problematic across the country it is almost non-existent for the safety net in New York State. Moody's has characterized the non-profit health care environment in 2012 as challenging and identifies some of the following as reasons:

- Increased need for capital relating to plant modernizations and IT;
- Greater limitations on access to capital due to wider credit spreads for lower rate credits;
- Cost of compliance with changing regulatory environment along with new requirements from health care reform;
- Increased reimbursement pressures;
- Large unfunded pension liabilities;
- Diminished benefits for tax exemption[16]

Most of these factors are present in New York State and they present even greater challenges for safety net hospitals, particularly those that are weak financially or even insolvent. Many of these providers have to make choices every day as to whether to fund medical malpractice or meet payroll or pay vendors. Some have even experienced disruptions in day to day operations as vendors, even food vendors, abruptly ceased service due to delays in payments. This prohibits meaningful participation in development of clinically integrated delivery systems in communities that are in clear need of improved population health.

[16] Moody's Investment Service

New York State has a number of safety net hospitals in this situation and while there are well defined specific problems in the downstate areas, particularly in Brooklyn, there are other providers in rural and even some suburban areas of New York with comparable financial constraints.

Hospital margins in New York are well below national benchmarks. In 2010, the median margin for all hospitals in the state was roughly break even, while the margin for hospitals with Medicaid patient loads in the highest quartile was negative 1.3 percent, and the margin for New York's rural hospitals was negative 0.3 percent.[17] The median numbers of course do not tell the full story: more than a dozen hospitals have margins worse than negative 10 percent.

When the analysis is focused on hospitals that derive more than 30 percent of their net patient revenue from Medicaid, excluding disproportionate share hospital (DSH) payments, all measures of financial operating strength, liquidity (cash availability), and balance sheet viability are exponentially worse. In fact, the federal government's own hospital mortgage insurance program though the Federal Housing Administration (FHA) would classify these hospitals as risky based on underwriting benchmarks.

***	NY Medicaid-Dependent Hospitals*	Other Hospitals	All Hospitals	National Benchmark**
Financial Condition				
Operating Margins	-3.2%	1.9%	0.6%	3.0%
Total Margin	-2.9%	2.2%	0.9%	N/A
Current Ratio	1.34	1.57	1.48	1.75
Equity Financing Ratio	12%	27%	24%	30%
Quality				
% of Patients Reporting Best Experience of Care	53%	58%	57%	
Medicare Risk-Adjusted Readmission Rates	24.5%	22.8%	23.1%	

* Medicaid-dependent hospitals consistently derive more than 30% of their net patient revenue from Medicaid, not including Medicaid DSH payments. There are 36 general, acute care Medicaid-dependent hospitals in New York, 24 voluntary and 12 public. ** Benchmarks are thresholds used by the FHA in designating applicants for hospital mortgage insurance as low risk. *** Financial measures are 2008-2010 averages; quality measures were derived from the May 2012 release of Hospital Compare, the hospital performance web site maintained by the Centers for Medicare & Medicaid Services in the U.S. Department of Health & Human Services. Data provided by Greater New York Hospital Association (GNYHA).

While financial viability—or lack thereof—impairs a hospital's ability to sustain access in needy communities, it also can influence quality and outcomes. This is illustrated by the two composite quality measures in the chart above. The patient experience of care measures include several that are influenced by facility age and condition, including the general level of noise and cleanliness, and the patient's overall experience of care. New York's Medicaid-dependent hospitals score materially lower than other hospitals.

[17] Data provided by Healthcare Association of New York State (HANYS)

The risk-adjusted readmissions measures reflect not only how well the hospital handles transitions in care, but also whether the hospital can intervene to help patients with poor access to community-based care or social needs, such as unstable housing or limited English proficiency. Again, New York's Medicaid-dependent hospitals score worse than other hospitals.

In 2011, a MRT Brooklyn Work Group, convened by NYS Health Commissioner Nirav Shah, studied the borough of Brooklyn and determined that excess inpatient capacity, high levels of debt, lack of meaningful primary care alternatives, and weak governance had led to several failing hospitals and extremely poor health outcomes for many Brooklyn communities.
(http://www.health.ny.gov/health_care/medicaid/redesign/brooklyn.html)

The recommendations of the Brooklyn Work Group were to consolidate hospitals and develop meaningful outpatient capacity under strong leadership and governance. In order to accomplish this transformation, capital investment is required to restructure balance sheets and to invest in the creation of outpatient capacity in the target neighborhoods. The obstacle to such changes posed by deficient safety net hospital balance sheets is illustrated by data for the 10 hospitals assessed in Brooklyn which shows that four had balance sheets with negative net assets, meaning that they carried more liabilities than assets. This coupled with negative operating margins signified no ability to retire old liabilities and accrue a positive fund balance for capital investment. In fact, one hospital carried a negative net asset figure of $285 million in 2011.

As a part of the regional planning component of this waiver application, the type of assessment done for Brooklyn hospitals will be conducted in other targeted parts of the state and investment is proposed for selected safety net hospitals that both demonstrate meaningful integration with other providers and have developed plans to improve community health outcomes and reduce health disparities.

In developing the Capital Stabilization program, the state actively solicited feedback from a multitude of stakeholders and worked to ensure that hospital stakeholders in particular weighed in on the initiatives that should be included in the 1115 waiver. To outline the state's approach and solicit feedback, public hearings and webinars were conducted for all stakeholders, including the general public. The Healthcare Association of New York State (HANYS), Greater New York Hospital Association (GNYHA), and member advocacy organizations were among the stakeholders that provided input into how waiver funds should be invested, and their comments are reflected throughout this document.

PROGRAM DESCRIPTION

New York State plans to invest $1.7 billion over the next five years to transform, preserve and strengthen safety net hospitals which are essential to preserving access to care in communities all across New York. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

Capital investment is required for safety net hospitals to play a meaningful role in reshaping the delivery systems in their communities. The successful partnership between the state and federal government through the HEAL/FSHRP program demonstrated this with $3 billion dollars in shared capital investment for the State's health delivery system. Much of it served to downsize acute care capacity at the state's nursing homes and hospitals and to support unprecedented investments in health information technology over an 8 year period. When completed in 2014, altogether the partnership will have invested $1.6 billion in restructuring and closing of facilities, $400 million in long term care, and $400 million in information technology infrastructure. Additionally, it began investment in much needed development of primary care to sustain the changing delivery system.

Unlike the longer-term HEAL/FSHRP program, this program is a short term infusion of funding to meet the objective of facilitating long term structural sustainability. New York State safety net providers are, by definition, ill prepared to participate financially in transformations/network development and yet are well positioned to make meaningful progress in changing models of care for our most chronically ill and underserved populations and communities. Capital investment will be needed in a number of different forms and should serve as leverage for other investors, including traditional debt markets (tax exempt bond programs) and private equity interests. Indeed, "there is significant capital available and being deployed by for profit health care companies, both publically (sic) traded and privately owned, principally funded by private-equity firms" [18] New York State law continues to prevent publicly traded corporations from operating hospitals, but there are many innovative models that can explored within the current statutory framework and perhaps as part of a demonstration project.

The requested waiver funds will be made available in conjunction with a hospital's work with a regional planning body to discern where and how it can contribute to regional health care delivery and improved community health. Preference will be given to applications that are supported by regional planning organizations. The state proposes to use federal funds in three separate program categories.

[18] "The Capital Challenge", Frederick Hessler, Managing Director, Citigroup Global Markets Inc

It is expected that applicants may submit requests in any or all categories:

1) **Technical Assistance to Safety Net Hospital Boards ($10M average annual)** This program will provide technical assistance to hire experts, including independent strategic planners, to advise safety net hospital boards on alternatives and strategies for positioning their institutions in a sustainable, albeit, new role in the delivery system of the future. Funds will also be made available for the purpose of hiring restructuring management to assist hospital boards in implementation.

2) **Transitional Capital ($125.2M average annual)** Further investment for "bricks and mortar" and health information technology will allow safety net hospitals to participate in new delivery models once determined. This can include investment in critical infrastructure, such as HVAC systems, and will include capital to renovate/repurpose inpatient capacity to improve the patient's experience of care. This capital will also support development of outpatient capacity and physician alignment.

3) **Balance Sheet restructuring ($209M average annual)** This program will solicit and fund grant opportunities to support balance sheet relief. Relief will assist safety net hospitals in partnering with other providers to develop new models of delivery, including mergers and consolidations that will support further downsizing of acute care beds, development of alternate care models (FQHCs and clinics, urgi-centers, physician organizations). These funds could also assist closure and/or new integrated delivery models for a safety net hospital, in favor of alternate service delivery providers under the auspices of a regional acute care provider, such as an academic medical center.

   This funding is essential to give safety net hospitals the opportunity for thoughtful reconfiguration, to avoid precipitous hospital closures in high need communities, and to prevent significant disruptions in access for Medicaid patients. As discussed in the background, there are a number of hospitals on the brink of failure with significant balance sheet liabilities at this time. There is a compelling need for immediate funding beginning in early 2013.

IMPACT ON OVERALL MEDICAID SPENDING

The investment should lead to reduced Medicaid expenses in these regions due to reduced inpatient capacity and treatment in more appropriate, lower cost settings. Additionally, Medicaid will be saved the cost of abrupt hospital closures. There will also be a direct Medicaid fee-for-service reduction in capital reimbursement to the degree that capital debt liabilities are reduced.

MRT Reinvestment Program
Hospital Transition

BACKGROUND

New York State hospitals, along with other providers and payors, will be critical drivers of the delivery system changes required by the Affordable Care Act (ACA). These changes are intended to advance population health management with the goal of improving the overall health of the population and the patient experience of care (including quality and satisfaction) while at the same time reducing the per capita cost of health care. The work of the MRT focused on how to meet the Triple Aim objectives within the New York State Medicaid program and established the priorities for future program policy. The ACA and MRT reforms will require hospitals to develop new financial and business models that are drastically different from today's model where reimbursement systems largely incentivize providers to focus on the volume of services they provide rather than service efficacy.

Historically, hospitals in New York have developed as the hub of health care delivery in many communities and consequently, the resources and capacity for both inpatient and ambulatory care were developed as part of the hospital campus and incorporated into the business model of the hospital. In many areas, particularly those that serve rural geographies, and large numbers of uninsured and Medicaid members, the hospital is the health delivery system. In fact, for the Medicaid population, hospitals can be the sole provider of care in the community, even for primary care services. Based upon a review of utilization data, the vast majority of the clinic visits provided to New York's Medicaid members are provided by hospitals. More than three quarters of the outpatient visits (77 percent) occur at hospital outpatient departments (OPDs). Without the services provided by New York's hospitals, access to primary care for the Medicaid population would be severely compromised.

However, while hospitals are critical to the delivery of primary and specialty outpatient care for some populations, the institutional structure of New York's delivery system is not without consequence. The Brooklyn Workgroup of the Medicaid Redesign Team, convened by NYS Health Commissioner Nirav Shah, observed, "Decades ago, New York State built, funded and supported a big box health care system, dominated by hospitals, and fostered a regulatory and reimbursement environment to oversee and support it. The big box system's importance to the economy has strengthened its ability to resist desirable change and efforts to rein in costs."[19]

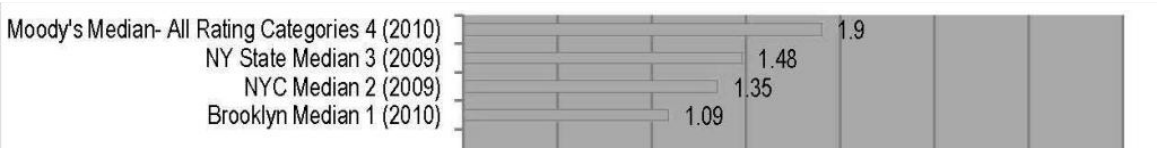
[19] At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn, Brooklyn Health systems Redesign Work Group, 2011

This construct has led to an expensive delivery system, which at times, encouraged inappropriate visits to hospitals and emergency rooms with less focus on promoting good preventive care and/or improved community health outcomes. In fact, the state ranks 18th (it was 24th in 2010) out of all states for overall health system quality and ranks 50th among all states for avoidable hospital use and costs. Hospital readmissions are a particularly costly problem for New York.

A report issued by the New York State Health Foundation found hospital readmissions cost New York $3.7 billion per year, with nearly 1 in 7 initial hospital stays resulting in a readmission. Many of these readmissions are the result of poor access in the community to follow up care, mental health and substance abuse co-morbidities that impede compliance with treatment regimens and lack of social support services.

At the same time, New York State hospitals have both financial and liquidity indicators well below the national averages, with some providers in economically challenged communities struggling for financial survival. In 2010 median operating margins for hospitals in New York State were break even at best and hospitals with Medicaid patient loads in the highest quartile ran an average operating margin of negative 1.3 percent. New York's rural hospitals had a total operating margin of negative 0.3 percent.[20] Liquidity, which is key to enabling investment for reform, remains challenging for New York hospitals lag significantly behind national median ratings and in certain regions of the state liquidity is particularly problematic.

Current Ratio—measuring liquidity[21]



Hospitals are necessary partners and/or leaders in developing new clinically integrated, health care network delivery systems and right sizing the number of inpatient hospital beds for their communities.

It is clear that in New York State transition funds will be necessary to support hospitals in developing new integrated delivery systems designed to promote clinical integration and improved quality and outcomes. An assessment of the future of hospitals in the new integrated delivery system states "the hospital will have to be more than a hospital alone." [22]

[20] Data provided by HANYS and GNYHA
[21] At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn, Brooklyn Health systems Redesign Work Group ,2011
[22] Integrated Delivery Networks: A Detour On The Road To Integrated Health Care?, Lawton R. Burns and Mark V. Pauly Health Affairs, VOL. 31| NO. 7, July 2012

Transition funding will provide for such areas as capital investment in expanded health information technology, primary care/outpatient services linked to acute care bed reductions, workforce retraining, and developing networks to provide the full continuum of care and to focus on services necessary to reduce potentially preventable admissions and readmissions.

The state actively solicited the feedback of a multitude of partners and worked to ensure that hospital stakeholders in particular provided feedback on the initiatives that should be included in the waiver amendment application. Public hearings were held and webinars were conducted and open to all stakeholders, including the general public, to outline the Department's approach and request feedback. The Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA) were among the stakeholders to provide their opinions on how waiver funds should be invested and their comments are reflected throughout this document.

PROGRAM DESCRIPTION

New York State plans to invest $520 million over the next five years to transform New York's hospitals into highly effective integrated delivery systems. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

This program will provide funding for transitional plans for development of future integrated delivery systems. Funding will be directed to enable hospitals to become active partners in shaping future healthcare network delivery systems. It will support development and execution of plans that are targeted at elements associated with the health system of the future:

- Organizations with sufficient size to take advantage of economies of scale
- Fully integrated provider network and responsible for community health outcomes;
- A primary focus on quality and service outcomes
- Significant support from well developed health information technology
- Operational flexibility and nimbleness in resource allocation;
- Progressive governance and management oversight [23]

An annual average of $104 million will be used for technical assistance for plan development and short term financial assistance (up to three years) for hospital plans that are focused on transitioning from a hospital delivery system based upon a "volume" driven business model to that of an "outcome based" integrated delivery system model. The plans will have established metrics to address population health outcomes and include participation of non-hospital providers, including physicians, nursing homes, clinics and home health agencies.

[23] "The Capital Challenge", Frederick Hessler, Managing Director, Citigroup Global Markets Inc.

Funding will be available for technical assistance to support hospital planning with the support of independent strategic planners as well as implementation of plans. Each hospital plan must address a future care delivery model that includes:

- expanded networks of services focused on population health management with emphasis on prevention and wellness;
- expanded access to primary care and social support services in the community;
- participation in the Medicaid Health Home program to assure improved care coordination;
- use of health information technology to better inform care at the point of service and enable analysis of and action on metrics for patient centered outcomes and community health improvement and elimination/reduction of health care disparities;
- demonstrated leadership; and
- initiatives to reduce avoidable hospital admissions or preventable readmissions and inappropriate emergency room utilization.

Preference will be given to applications that are supported by regional planning efforts and/or organizations. Significant additional consideration will be given to plans that demonstrate informed and involved governance and inclusion and support of financially distressed safety net and vital access providers in the development of future delivery system.

IMPACT ON OVERALL MEDICAID SPENDING

The investments in assisting New York State hospitals to either create or become a part of new integrated delivery systems are expected to decrease expenses for medical costs, including Medicaid, in a number of ways. The new business arrangements will allow for hospitals to participate more fully in proven models of expense reduction and improved patient outcomes.

Traditional models of integrated delivery systems have shown that mere structural integration does not in and of itself provide improved outcomes or improved financial performance. It is noted that financial and process alignment between network members are equally as important. There are also newer constructs (some of which are highlighted in other waiver request categories) that have promise and have demonstrated cost savings. These include:

- Customized integration and disease management**;**
- Co-location of care.
- IT-integrated health care
- Patient-integrated health care.[24]

[24] Integrated Delivery Networks: A Detour On The Road To Integrated Health Care? ,Lawton R. Burns and Mark V. Pauly Health Affairs, VOL. 31| NO. 7, July 2012

MRT Reinvestment Program
Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform

BACKGROUND

State and federal health reform efforts that place increasing emphasis on development of a sufficiently sized and adequately trained workforce is crucial to achieving the goals of transforming the health care delivery system to achieve the Triple Aim. While New York State spends more on health care than any other state, it has the highest rate of avoidable hospitalizations and is in the 'middle of the pack' in terms of overall quality of care, based on standardized national measures. This poor performance is, in part, attributed to the fact that many patients, particularly those who are the most complex and costly, are not well-connected to primary care, a medical home, or a coordinated care setting.

The ACA provides opportunities to transform the health care delivery system, addressing isolated care delivery structures and lack of systemic care coordination through implementation of new models of integrated care delivery. Healthcare organizations across New York State have begun creating access to high quality primary care and providing comprehensive care management through the National Quality Committee on Assurance (NCQA) Patient-Centered Medical Homes (PCMH) and intensive care management systems for complex populations that are essential components of a lasting solution.

Healthcare providers in New York State have determinedly pursued NCQA PCMH accreditation making New York State the nation's leader in the number of providers and practices recognized as a PCMH. Currently approximately 1.8 million Medicaid members receive their primary care in a PCMH (mostly NCQA Level 3), representing over 5,000 clinicians and 460 discrete practices. Similarly, the New York State Department of Health (NYS DOH) actively encouraged healthcare providers to apply for New York State Health Home designation consistent with the goals of the ACA. With approximately fifty-five Health Homes, there will be a health home serving every county in the State. Each Health Home "network" is required to include a broad range of mandatory provider capacities including medical, behavioral health, HIV, housing and wrap around services all integrated with HIT capabilities and reporting through a single point of accountability for the patient.

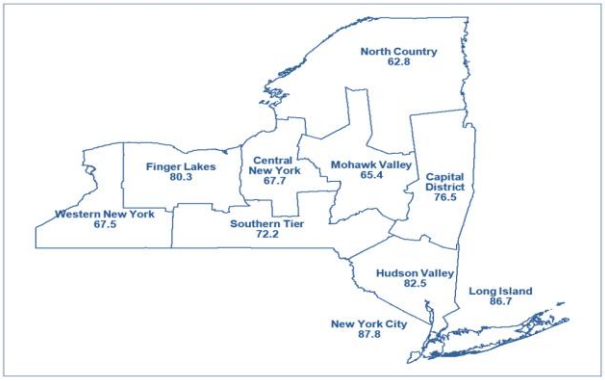
A fundamental challenge that these providers face is assuring an adequately sized and well trained health workforce for the transformed health care delivery system. New York faces a substantial mal-distribution of primary care physicians with most upstate regions having much lower numbers of primary care physicians per capita than downstate regions.

See Figure 1 for the number of physicians per 100,000 population by region. Approximately 450 full time equivalent primary care physicians are needed statewide to minimally address unmet need in Health Professional Shortage Areas. However, New York also has a substantial mal-distribution of primary care physicians. During 2010, health care providers across the state reported recruitment and retention difficulties for a wide array of professions and occupations; for example:

- Hospitals statewide reported difficulty recruiting and retaining clinical laboratory technologists. They also reported that recruitment was problematic for health information technology staff, including analysts and program managers, as well as medical coders. In half of the state's regions, hospitals also reported difficulty recruiting pharmacists, with the Hudson Valley and the North Country regions reporting the most difficulties.
- Hospitals, nursing homes, and home health agencies all reported difficulty recruiting experienced registered nurses (RNs). Nursing homes and home health agencies also indicated that the retention of both experienced RNs and newly-trained RNs was problematic.
- New York's nursing homes and home health agencies statewide reported difficulty recruiting occupational therapists, physical therapists, speech language pathologists, dietitians/nutritionists, and respiratory therapists.
- Community health centers reported difficulties recruiting dentists, geriatric nurse practitioners, and psychiatric nurse practitioners.

More recent evidence suggests growing need to train healthcare care workers in two additional areas including: training personnel care attendants to become home health aides with a focus on care coordination and training of assistive personnel in care coordination, health coaching, patient navigation and chronic disease management.

Figure 1: Number of Primary Care Physicians per 100,000 population in New York[25]



[25] Center for Health Workforce Studies. 2009.

Another major challenge that New York State's providers face is ensuring that their workforce is flexible enough to adapt to the changing roles that are required with the implementation of Health Homes, PCMH and Accountable Care Organizations including, but not limited to, the need to provide more patient-centered coordinated care in community settings. With the passage of the Affordable Care Act and establishment of Governor Cuomo's Health Exchange, an additional estimated one million uninsured New Yorkers will have access to health insurance for the first time and as a result, there will be a surge in demand for health workers in primary care.

Recognizing the need to further develop New York's health care workforce, the MRT established a Workforce Flexibility/Scope of Practice Workgroup to develop a multi-year strategy for developing an adequately prepared workforce to ensure that the future health care needs of the State's population are met. The MRT adopted a series of proposals aimed at:

- Removing statutory and regulatory barriers to implementing a full scope of practice for various occupations across the care continuum;
- Allowing assistive personnel with training and supervision to assume more responsibilities; and,
- Supporting the development of career ladders.

A number of proposals that are described herein incorporate many of the concepts included in the recommendations of the MRT Workforce Work Group recommendations. Federal funding is needed under this MRT waiver amendment to systematically grow and develop the health care workforce in two critical areas: (1) expansion of the workforce retraining initiatives; and, (2) creation of new recruitment and retention initiatives.

Funds will be used to train additional providers to allow New York State to better address the goals of the Triple Aim, to prepare for the increased demand for services resulting from the implementation of ACA, and to focus on re-training the existing workforce in emerging models of collaborative care, work in interdisciplinary teams and maximizing utilization of Health Information Technology (HIT). Funding will be directed to organizations capable of providing appropriate workforce training across the care continuum.

Funds will be used to train health workers to care for high need and vulnerable populations in order to improve health and healthcare and lower healthcare costs among Medicaid, Dual Eligibles, and CHIP beneficiaries that have complex medical, behavioral, and long-term care needs that inappropriately drive up utilization and the cost of care.

PROGRAM DESCRIPTION

New York State plans to invest $500 million over the next five years to develop and implement a multi-year strategy that ensures that New York has the health care workforce that allows the stateto achieve the Triple Aim. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Health Workforce Retraining Initiative (HWRI) – Over the past decade, New York Statehas provided hospitals, nursing homes, home care agencies, educational institutions and unions with funding to train health industry workers. This state-funded program was targeted to health care shortage occupations or workers that needed new skills in order to maintain current employment or avoid displacement. Much of the funding was invested in the training of: nurses; technologists; technicians; therapists; and front line workers in home care, long term care and mental health. Substantial investment was also made in the areas of computer skills, health information technology, foreign language interpretation, substance abuse, disaster readiness and customer service**.** However, with the passage of the Affordable Care Act, the development and promotion of PCMH and health homes, ACOs, and integrated delivery systems, there is an increased need for more coordinated, culturally sensitive, patient centered care. Healthcare workers should reflect the demographics of the population that they serve and understand the cultural sensitivities of their patients, to eliminate communication barriers between provider and patient. As a result, workforce training efforts must evolve to address these needs.

Redesigning and expanding HWRI in the following ways will help New York State better adapt to this changing landscape and better meet the evolving needs of both providers and patients. These initiatives address reductions in health disparities by focusing on the placement of health care workers in medically underserved communities. In addition, these initiatives address training of needed workers to care for currently uninsured populations who tend to either not seek care at all or minimally on an episodic basis, will seek care under ACA's expansion of insurance coverage. Last, several of the initiatives specifically address expanding diversity and enhancing cultural competence of the workforce.

1a) Workforce Development for Patient Centered Medical Homes and Health Homes: An essential component of assuring success in New York's transition to PCMH and Health Homes involves training existing and new workers in emerging models of collaborative, interdisciplinary and team-based care. Waiver funding is requested to expand upon state Health Workforce Retraining Initiative funds to retrain the workforce in hospitals, federally qualified health centers, and home care agencies, to gain the skills required to realize the goals of expanding PCMH and Health Homes in New York State.

For example, funding will be used to support training and re-training for: Transitional Care Managers (TCMs) to focus on the more comprehensive and multi-disciplinary nature of health home jobs; Nurse Assistants (NAs) and Certified Nurse Assistants (CNAs) as medical assistants; Registered Nurses (RNs) and nutritionists as certified diabetes educators; Medical Assistants (MAs) and Licensed Practical Nurses (LPNs) as health coaches; training social workers and RNs as System Navigators; MAs, LPNs, community health workers as care coordinators; and the Health Information Technology workforce. Waiver funds will be used to train and retrain workers across all health care settings in the effective use of electronic health record (EHR) and other health information systems technology as it is expanded statewide. Training would target end-users of EHRs, as well as help desk support staff and data analysts.

1b) Workforce Development for Long-Term Care: Expanding home care and respite care enables those in need of long term care to remain in their homes and communities while reducing New York's Medicaid costs associated with long term care. By training personal care attendants to become home health aides, and training home care workers to assume new roles in care coordination, the New York State Medicaid program would have increased workforce flexibility and lowered costs under managed care. Waiver funds would also be used to complement and reinforce existing State workforce development efforts under its Medicaid Redesign Team to develop stackable credential career pathways for advanced aide positions in both home care and long-term care.

1c) Training the Health Workforce in Culturally-Competent Patient Centered Care: Health care workers at all levels need specific training on what it means to work in a system where patients are increasingly diverse, and have a myriad of social and economic problems that contribute to poor health. A retooled Health Workforce Training Initiative will support training initiatives that focus on sensitizing the care management team to cultural differences among patients that may impact patient willingness to access services and accept and follow treatment regimens. In addition, training will educate providers on the benefits of a culturally diverse workforce reflective of their patient population.

1d) Interdisciplinary Education and Training: There is evidence that interdisciplinary team based care can have positive impacts on quality, cost and access to care. It is critical to support the development of interdisciplinary education and training in order to prepare the health workforce to function effectively in new and emerging models of care that are team focused. Waiver funding would be used to support the development of interdisciplinary education and training that include both professionals and the local public health workforce, as well as assistive personnel.

1e) Promoting Labor-Management Partnerships: Research has shown that unit-based teams where workers and their managers problem solve day-to-day care delivery challenges together have been used in New York and around the country to achieve better care and reduce costs.[26] Funds are requested for retraining of health personnel, as part of multi-disciplinary teams, to determine priorities and direct change initiatives in the areas of data analysis, understanding health care operations, performance improvement methodologies and problem solving, all essential to implement effective change at the institutional level.

1f) Building Health Care Career Ladders: Given the persistent problems recruiting and retaining a wide array of health professions and occupations increased support is proposed for building career ladders in shortage occupations in order to attract qualified candidates and provide support for career advancement. Existing workers can be retrained, or new workers can be trained to become health care workers in critical shortage areas (i.e. lab technicians to laboratory technologists and associate degree RNs to Bachelor of Science nurses).

2) Recruitment and Retention Incentives for the Underserved Initiatives

There are approximately 2.3 million New Yorkers who are identified as "underserved" for primary care services in New York's 99 primary care HPSAs[27]. According to the federal Office of Shortage Designation, 450 full-time equivalent (FTE) primary care physicians would be needed to remove all primary care shortage designations in New York, but over 1,100 primary care physicians are needed to achieve the desired 2,000:1 population to primary care provider ratio in all shortage areas.

Maximizing workforce funding opportunities through the sub-initiatives listed below will encourage a larger number of qualified applicants to serve in these underserved primary care areas and would ensure better access to primary care services statewide.

[26] See http://www.ilr.cornell.edu/news/upload/How-Labor-Management-Partnerships-Improve-Patient-Care-Cost-Control-and-Labor-Relations.pdf
[27] As of June 28, 2012

2a) Expand Doctors Across New York: The Doctors Across New York (DANY) program is a set of state-funded initiatives enacted in 2008 to help train and place physicians in a variety of settings and specialties to care for New York's diverse population.

- The Physician Practice Support Program provides up to $100,000 in state funding over a two-year period to applicants who can identify a licensed physician who has completed training and who will commit to a two-year service obligation in an underserved region within New York State. During its first four years of implementation, the Program has placed 101 physicians in underserved areas.

- The Physician Loan Repayment Program provides up to $150,000 in state funding over a five-year period for physicians who commit to a five-year service obligation in an underserved region. During its first four years of implementation, the program has placed 57 physicians in underserved areas in exchange for debt repayment.

As a result of these initiatives, it is anticipated that approximately 200 physicians will be under contract in 2012-13 for the Physician Loan Repayment and Physician Practice Support programs. In addition, funding eligibility would be extended to physicians who are willing to obligate service in a health care facility such as the psychiatric centers operated by the New York State Office of Mental Health, or the Veterans Homes or Rehabilitation Hospital run by the New York State Department of Health.

Expanding funding for the DANY Physician Loan Repayment and Practice Support programs through the MRT Waiver Amendment will allow the state to increase awards to physicians who have agreed to work in medically underserved regions in exchange for a DANY award in the following ways:

- The Ambulatory Care Training Program provides funding to sponsoring institutions to train residents and medical students in ambulatory care sites in order to enhance clinical training experiences in culturally diverse settings, an experience that would benefit physicians throughout their careers. It is anticipated that additional funding to sponsoring institutions will provide clinical training in freestanding ambulatory care sites to approximately 10,000 residents and medical students.

- Create an Incentive Program for Medical Residents to Work in Underserved Areas. This program would provide teaching hospitals with waiver funding to pay enhanced salaries or loan repayment to medical residents who agree to work in a medically underserved community within New York upon completion of their residency training. Medicaid waiver funding would be set-aside for each annual cohort of approximately 100 -200 awardees. There would be a maximum of four cohorts over the duration of this program.

The Diversity in Medicine/Post-Baccalaureate Program is a comprehensive support and enrichment program that provides minority and economically disadvantaged (Under-Represented in Medicine – URM) students with unique opportunities to engage in health care professions beginning in high school and extending through medical school. As a consequence of these experiences, there will be an increase in the number of qualified URM physicians in New York State.

2 b) Expand Primary Care Service Corps (PCSC) Funding: Similar to the Doctors Across New York Loan Repayment program, PCSC is a service-obligated, state-funded[28] loan repayment program developed to increase the supply of dentists, dental hygienists, nurse practitioners, physician assistants, midwives, clinical psychologists, licensed clinical social workers, psychiatric nurse practitioners, licensed marriage and family therapists and, licensed mental health counselors who practice in the State's Health Professional Shortage Areas (HPSAs). Additional annual waiver funding will be used to expand the Corps to enhance the recruitment and retention of these non-physician clinicians in medically underserved areas. In addition, funding eligibility would be extended to additional clinicians such as RNs and to state-run facilities such as the psychiatric centers operated by the New York State Office of Mental Health.

2c) Health Workforce Data Repository: Funds are also requested to establish a Health Workforce Data Repository to support ongoing collection, analysis and dissemination of data on health workforce supply, the educational pipeline, and demand for health workers. In addition, the funding will support a statewide system for monitoring health workforce demand across all health sectors – hospitals, nursing homes, home care, ambulatory care sites (clinics, federally qualified health centers and private practices) as well as local health departments.

Information drawn from the repository and associated research will be used in regional health workforce planning efforts that build collaborations across sectors (health care providers, educators, regulators, etc.) to more fully understand the most pressing workforce needs in a region and to develop regional strategies to address those needs. Data from the repository will be used in analyses of primary care capacity and will be used to identify areas and populations that qualify for federal designation as Health Professional Shortage Areas or Medically Underserved Areas or Populations. Information drawn from the data repository will also be used to support the more effective use of resources for worker training or retraining as well as incentives to attract health professionals to underserved communities. At a time when healthcare systems, and especially Medicaid, are undergoing dramatic change, data and information on the healthcare workforce can contribute greatly to informed decision-making.

[28] It is anticipated that federal StateLoan Repayment Program (SLRP) funds will be awarded in Sept. 2012 as a match for $500,000 in statePCSC funds.

2d) Health Workforce Research: Waiver funding will also support a statewide study to identify and describe the roles, responsibilities, qualifications and training needed for new and emerging job titles across all healthcare sectors as a result of healthcare reform/primary care service growth. Examples of emerging titles include patient care coordinators, patient navigators, and health coaches, among others. A committee of healthcare industry, labor union representatives, and academia, from various regions of the state will be convened to provide direction for the study, review the study findings, and to obtain consensus on the alignment of job titles with credentials for each title studied.

Waiver funding will also be used to support comparative effectiveness health workforce research, which entails a detailed analysis of the content of health care services provided by clinicians to support a better understanding of the comparative effectiveness of different health workforce staffing models. Clearly, data available through electronic health records will be an important resource for these studies. This research will be designed to evaluate the impact of the workforce on new models of care delivery and on healthcare cost, quality, and access.

Waiver funds are requested to convene a commission to study access barriers to oral health services in order to identify the most appropriate strategies (alternatives/feasibility/models/incentives) for expanding the number of oral health providers and productivity in areas of the state and to high need populations that are underserved for oral health. Access to oral health services in the state is uneven, and often results in oral health disparities. Groups at greatest risk for limited access to oral health services include the poor, children, racial/ethnic minorities, the elderly, and residents of rural communities. A small number of the state's dentists treat most of the Medicaid patients who receive oral health services. Over half of New York dentists report no Medicaid patients on their caseloads, while 10 percent indicate that 60 percent or more of their caseloads are Medicaid patients. New York State needs to research and implement a demonstration workforce models to meet the increased oral health demand driven by the ACA.

2e) Regional Health Workforce Information Centers: MRT Waiver Amendment funding would support the development of regional Health Workforce Information Centers that would:

- Provide regional information about health careers and training opportunities. Marketing information and increasing awareness about primary care and allied health careers at primary and secondary education levels is necessary to encourage early health career aspirations among students. Advocating and promoting interest in health occupations as early as possible has proven to be a successful 'Grow Your Own' health workforce strategy in other states. Further, many incumbent workers are interested in learning about opportunities that build on their current training and skills to afford them opportunities for upgrading.

- Provide up-to-date and timely information on current funding streams, healthcare opportunities, and provide real-time data on areas in the region with health personnel shortages;

- Facilitate clinical placements for health professionals in training within the region with emphasis on safety net providers serving high need populations that use interdisciplinary team based approaches to care;

- Assist qualified applicants from the state and federal scholarship and loan repayment programs to secure employment at sites in the region that meet service obligation requirements by maintaining and updating information on current vacancies reported by potential employers in underserved communities across the state.

It is proposed that waiver funding be allocated to fund the Department of Health's efforts to market opportunities related to primary care and allied health careers, as well as incentives to serve in underserved areas under the regional Health Workforce Information Centers. The Department will work closely with its partners in the Department of Labor to ensure that it builds on and complements the functions of DOL's one-stop career centers. It is expected that the Department will use the existing Area Health Education Centers to carry out and coordinate many of the functions described above since several of the state's AHECs are currently invested in some of these activities, particularly the promotion of health careers.

IMPACT ON OVERALL MEDICAID SPENDING

Expanding and refocusing the health care workforce through training/retraining and expanding recruitment and retention incentives for underserved areas may result in increased Medicaid expenditures in the short term (i.e., first 2 years of the waiver), given the surge in newly insured patients under ACA, but will save the Medicaid program in the long term (i.e., over the 5-year waiver period) by:

- Expanding and building upon the healthcare workforce, particularly in those areas of greatest need, to ensure that it is patient-centered, cost-efficient and cost-effective, makes the best use of technology, and is focused on prevention as well as helping those with chronic conditions better manage their health.
- Enhancing provider level cooperation and meaningful improvement in service provision at the point of care through patient-centered medical homes and health homes;
- Reducing provider fragmentation that will reduce service utilization and improve health outcomes; and
- Reducing morbidity and mortality related to preventable conditions, thus reducing preventable hospitalizations and health care costs associated with these morbidities for patients in medically underserved areas.

Specific examples of documented savings directly related to recommendations in this section include:

[Recommendation 1B]: Reducing Medicaid costs associated with home care by training additional home care aides: the California CMMI grant proposal for its California Long-Term Care Education Center (http://innovations.cms.gov/initiatives/Innovation-Awards/california.html) estimated that investing $12 million in CMS grant funds to train 6,900 In-Home Supportive Service (IHSS) as personal and home care attendants (PHCAs) to serve as monitors, coaches, communicators, navigators and care aides, and Integrate the PHCAs into the patient-care team for their clients would achieve 3-year savings of $25 million (Medicaid: $10.2 million; Medicare $14.7 million) by reducing emergency room (ER) visits by 23%; hospital admission from the ER by 23%; and average nursing home length of stay (LOS) by 10%.

[Recommendation 1E]: An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following:

- $51,000 reduction in overtime wages (Operator Services, San Rafael Medical Center).
- Reduced staff turnover rate from 14 percent in 2008 to 3.9 percent in 2010 (Contact Center, CMO, the Care Management Company).
- Reduced cost per communication contact from $7.62 in 2004 to $4.06 in 2010; (Contact Center, CMO, the Care Management Company).
- Reduced nursing staff turnover and traveling nurse hires (Fletcher Allen Health Care).[29]

[29] http://www.ilr.cornell.edu/news/upload/How-Labor-Management-Partnerships-Improve-Patient-Care-Cost-Control-and-Labor-Relations.pdf, p. iv.

MRT Reinvestment Program
Public Health Innovation

BACKGROUND

Chronic diseases – such as heart disease, cancer, stroke, and diabetes – are responsible for 7 of 10 deaths among Americans each year and account for 75 percent of the nation's health spending. Often due to economic, social, and physical factors, too many New Yorkers engage in behaviors such as tobacco use, poor diet, physical inactivity, and alcohol abuse that lead to poor health.

Actions to prevent chronic disease (such as pre-diabetes interventions) and prevent exacerbations of disease (such as home-based interventions for asthma) will be implemented to promote health and reduce costs. It has been estimated that $100 to $110 billion of New York's $160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term care for patients with one or more chronic diseases, a group of patients that is expanding rapidly[i]. The growing financial impact of chronic disease on the health care system is pervasive and far-reaching. Examples of the annual cost of chronic disease in New York, attributable to both direct medical costs and lost productivity include:

- **Diabetes — $12 billion**
- **Asthma — $1.3 billion**

To address these challenges, particularly among racial and ethnic minorities, New York State will integrate community-based public health prevention programs into the Medicaid program. These evidence-based strategies will advance New York's efforts to achieve the Triple Aim of improved quality, better health and reduced health care costs. Effective integration of community-based public health as part of the broader health care system inclusive of local health departments and clinical providers will promote population health and reduce systemic costs including Medicaid costs of care and treatment. By concentrating on the underlying drivers of chronic disease, New York will move from today's sick-care system to a true "health care" system that encourages health and well-being.

The proposed initiatives are consistent with the goals of the recently created National Prevention, Health Promotion, and Public Health Council and with New York's State Health Improvement Plan (Prevention Agenda 2013) which prioritizes prevention of chronic diseases; advancing a healthy and safe environment and promoting healthy women, babies and children. Through these complementary initiatives New York seeks to promote health by addressing rising rates of chronic illness, persistent health disparities, and escalating health care costs.[1ii]

Waiver recommendations that will fulfill these goals are: **(1)** evidence-based preventive nurse home visiting services for first time mothers and their children to prevent pre-term births and promote other positive health outcomes; **(2)** home-based self-management education and environmental assessments to improve asthma control, promote health and prevent avoidable emergency room visits and hospital admissions for Medicaid recipients with asthma; **(3)** home visits to promote childhood lead poisoning prevention and treatment for Medicaid recipients; **(4)** pre-diabetes screening and interventions to prevent progression to diabetes and to improve quality of diabetes care among Medicaid recipients; **(5)** water fluoridation to promote dental health for children on Medicaid; and **(6)** quality improvement efforts to address healthcare acquired infections and prevent sepsis.

The proposed efforts will be implemented as demonstration programs and will be closely evaluated for effectiveness. Once tested and proven to improve health care delivery, improve patient outcomes, and achieve cost savings these new models of care will be built into the fabric of the New York State Medicaid program. Several of the initiatives listed below (lead, asthma, diabetes and nurse home visiting) will start by using planning grants to develop ideas, followed by operational dollars made available for only the most promising models as venture capital to facilitate development and evaluation of the selected programs. In addition, a quality pool will be developed as an incentive for providers that exceed quality benchmarks. New York State will use funds from this program to launch new partnerships and test new models of care that could be expanded across the state and country. The savings potential for each of the proposed initiatives is significant.

PROGRAM DESCRIPTION

New York State plans to invest $395.3 million over the next five years to integrate evidence-based public health prevention programs into the Medicaid program. Effective integration of evidence-based public health strategies as part of broader health care system redesign will promote population health and reduce systemic costs including Medicaid costs of care and treatment. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this document.

1) Evidence-based preventive nurse home visiting services such as Nurse Family Partnership (NFP)

Programs delivering nurse home visiting services such as the NFP have demonstrated consistent, rigorous evidence of positive impacts on a wide range of short- and long-term maternal and child health behaviors and outcomes, including but not limited to preterm births, maternal smoking, pregnancy-related hypertension, breastfeeding, child injuries, child abuse and neglect, immunization rates, child development across multiple domains, birth spacing and long term economic self-sufficiency. NFP is a nationally recognized means of achieving improved health outcomes, self-sufficiency and parenting skills and results in reduced health and social service costs[iii].

Evidence Base: Nationally, Nurse Family Partnership (NFP) has achieved the following outcomes:

- Improvements in pregnancy outcomes (including a 79% reduction in preterm births among women who smoke and 35% fewer hypertensive disorders during pregnancy); [2-4]
- Reductions in early childhood injuries (including 39% fewer injuries among children, and a 56% reduction in emergency room visits for accidents); [5-7]
- Reductions in child abuse and neglect by 48%; [8]
- Reductions in childhood emotional, behavioral and cognitive problems (including 50% reduction in language delays of child age 21 months, and a 67% reduction in behavioral and intellectual problems at child age 6); [9-11]
- Increased spacing between pregnancies for Medicaid-eligible women (including a 28-month greater interval between the first and second child, 31% fewer closely spaced subsequent pregnancies, and a 32% reduction in subsequent pregnancies); [12-16]

The data from national studies of NFP and from New York City's First-time Mothers/Newborns (F/TMN) program all demonstrate similar improvements in health outcomes for mothers and their children. Public comments submitted regarding this waiver application support expansion of this evidence-based intervention. Expansion of F/TMN to all of New York State will give all Medicaid-eligible first-time mothers the opportunity for improved pregnancy outcomes.

Implementation: Funding will support evidence based preventive nurse home visiting services for first time mothers and their children up to age two years. Current Medicaid coverage for these programs is limited to Targeted Case Management and is in place in just two localities in New York State (New York City and Monroe County). Waiver funding will be made available for preventive services consistent with the NFP model to enhance access to, and coordination of, health and supportive services necessary to improve birth and health outcomes for high risk women and their infants in six high need areas of New York State. For existing NFP programs, funding will be provided to support the full set of preventive services consistent with the NFP model. In addition, funding will be provided during years one and two for planning and development of six new programs with full program operations envisioned to begin during year three. New York State will work with managed care plans to identify eligible members, coordinate services and document outcomes. During years four and five the programs will be evaluated to determine effectiveness in improving birth outcomes and reducing health care costs. If found to be effective these programs will be continued beyond the waiver period and expanded as appropriate given need, evidenced return on investment and funding availability.

2) Asthma Home Based Services

New Yorkers with asthma often live in environments that can exacerbate their symptoms[2,3], leading to preventable hospitalizations and ED visits. Compared to the nation, New York has higher asthma ED and hospital discharge rates for all age groups[4]. New York State's rates are roughly two times higher than the levels targeted in Healthy People 2010 [4]. The financial impact of New York's higher burden of asthma is significant. In 2007, the total annual cost of asthma hospitalizations in NYS was estimated to be $535 million[4].
For 2005-2007, Medicaid accounted for 43% of the total asthma hospitalizations and incurred 37% of the total asthma hospitalization costs in NYS (Medicare accounted for 23% of the total asthma hospitalizations and 34% of the costs)[4]. The total cost of asthma hospitalizations in NYS in 2007 was approximately $535 million.[iv]

Evidence Base: The National Asthma Education and Prevention Program (NAEPP) Asthma Clinical Guidelines[5], recommends environmental interventions to reduce ED visit and hospitalization rates. Evidence indicates that home environmental asthma programs will result in a range of health and financial benefits, including a reduction in asthma hospitalizations and ED visits of up to 60 percent and a return on investment of up to 14:1[5-13]. This proposal will reduce asthma hospitalizations and ED visits for people with poorly controlled asthma by increasing access to home environmental assessments and interventions aimed at reducing exposure to common asthma triggers that contribute to preventable exacerbations.

Implementation: Over the waiver period, the Department will work with managed care plans to identify persons and families who might best benefit from asthma home visits and will contract with community-based providers to deliver home-based asthma assessment and education to promote asthma self management and control of environmental triggers in the home. It is anticipated that registered nurses employed by Certified Home Health Agencies and/or Licensed Home Care Services Agencies will render the asthma home-based services and that these services will be reimbursed on a per visit basis as a model for a future reimbursement program. Medicaid-enrolled individuals who had one or more inpatient hospital stays and/or two or more ED visits in the prior 12 months with a primary diagnosis of asthma OR who have asthma that is classified as "not well controlled" or "poorly controlled", as defined by the National Asthma Education and Prevention Program (NAEPP) Asthma Clinical Guideline, will be eligible to receive the service through a series of home visits conducted over a 12-month period (an initial visit with one to two follow-up visits). This service will be phased in statewide over a period of five years, beginning with a solicitation to select contractors who demonstrate readiness to implement the service. Following initial implementation, if metrics indicate success in reducing asthma related hospitalizations, a waiver will be submitted to continue this initiative as a Medicaid reimbursable service to be provided by managed care plans through the capitated rate utilizing savings achieved through this and other population health interventions.

3) Diabetes Prevention and Quality Improvement

Between 1999 and 2009, the prevalence of diabetes in adults in NYS increased from 5.7% to 8.9%.(NYS Behavioral Risk Factor Surveillance System, 2010) In addition, there are an estimated 3.7-4.2 million (25-30%) adult New Yorkers with pre-diabetes*. During the same years, the prevalence of obesity in adults, a leading risk factor for diabetes, increased from 17.4% to 24.6% (NYS Behavioral Risk Factor Surveillance System, 2010). Without lifestyle changes to improve their health, 15 to 30 percent of people with pre diabetes will develop type 2 diabetes within five years.

In New York State diabetes disproportionately impacts people of color and low-income individuals African Americans are twice as likely as whites to develop diabetes and are more likely to experience complications such as lower extremity amputations (NYSDOH health indicators by race/ethnicity 2007-2009). The total cost of diabetes in NYS was estimated at $12.9 billion in 2007, including $8.7 billion in diabetes-related medical expenditures and $4.2 billion attributed to lost productivity costs (American Diabetes Association: Diabetes Cost Calculator. NYS Medicaid spent approximately $4.6 billion for the nearly 307,000 fee-for-service members with diabetes in 2008.

Evidence Base: The Diabetes Prevention Program, led by the National Institutes of Health, was the largest clinical trial of lifestyle intervention for diabetes prevention ever conducted. This research demonstrated that intensive, individualized lifestyle modifications that achieve and maintain modest weight loss (5-7% body weight) and an increase in physical activity (primarily brisk walking) to 150 minutes/week in adults with prediabetes, could reduce the 3-year risk of developing diabetes by 58% overall, and 71% for adults 60 years of age and older. Based on the success of the Diabetes Prevention Program (DPP), the Centers for Disease Control and Prevention (CDC) launched the National Diabetes Prevention Program (NDPP) to reach people with prediabetes through a community-based lifestyle intervention. The DPP demonstrated that lifestyle modifications yielding modest weight loss can reduce the risk of developing diabetes by 58%, and 71% for adults over the age of 60. Indiana University School of Medicine Diabetes Translational Research Center researchers successfully translated the initial DPP protocol into a 16-week group-based lifestyle intervention program delivered through YMCAs. In an effort to reach high-risk populations, New York State is building program capacity among community-based organizations (including YMCAs, community health centers, aging organizations, county health departments and coalitions, and independent living centers) and engaged a quality and technical assistance center to oversee program delivery for quality and fidelity.

* (Based on national estimates from Cowie CC, Rust KF, Fored ES, Eberhardt MS, Dyrd-Holt DD, Li C, Williams DE, Gregg EW, Bainbridge KE, Saydah SH, Geiss LS. Full accounting of diabetes and prediabetes in the U.S. population in 1988-1994 and 2005-2006. *Diabetes Care*. February 2009;32(2):287-294) including about 25% of Medicaid enrollees (761,026).

Implementation: Two initiatives will be implemented: an initiative to work with community-based providers to prevent diabetes and an initiative to promote quality improvement to reduce complications for those New Yorkers already diagnosed with diabetes. In each initiative managed care plans will be asked to provide guidance regarding members and providers who might best benefit from diabetes prevention and control efforts. At the conclusion of the five year period, upon demonstration of program effectiveness, these initiatives will be proposed for inclusion as an integral component of the managed care capitated rate and service structure.

3a) Diabetes Prevention

Over the waiver period, funding opportunities will be provided to diverse community-based providers, such as YMCAs, Federally Qualified Health Centers, faith-based organizations, worksites, aging networks, hospital systems, health plans and independent living centers, to deliver CDC recognized diabetes prevention programs to New York's most vulnerable populations. To be eligible to participate, agencies must be pending National Diabetes Prevention Program recognition status and provide services under a memorandum of understanding with a health system that participates with, and can bill Medicaid and/or Medicaid managed care plans. This initiative will be phased-in over a period of five years beginning with an initial assessment of readiness to implement on a county-by-county basis followed by a solicitation to select contractors.

3b) Diabetes Quality Improvement to Reduce Complications

Building on the successes of New York's Healthcare Efficiency and Affordability Law (HEAL) projects, evidence-based quality improvement initiatives will be implemented across a variety of providers in order to improve health information systems, redesign work flow to support prevention and control in population based diabetes care, and support diabetes self-management so that patients take a greater role in their own care. Activities that will be implemented include:

- An evidence-based diabetes screening, messaging and detection campaign to improve timely diagnosis;
- A Quality Improvement initiative to improve prevention and control of pre diabetes and diabetes. This initiative will use HEDIS diabetes quality of care measures and create "dashboards" of quality diabetes metrics;
- Enhanced use of Certified Diabetes Educators for Medicaid members through use of financial incentives to providers, practices, and members to improve diabetes self-management; and
- Development of a quality reward program for practices that achieve NCQA Patient Centered Medical Home level 2 or 3 status that includes rewards for practices who achieve improved diabetes care for their patients as measured by the Department.

Following implementation, if metrics indicate success in reducing diabetes related hospitalizations, New York will look to continue this initiative as a Medicaid reimbursable service utilizing savings achieved through this and other population health interventions.

4) Lead Poisoning Prevention

Lead is among the most common environmental toxins for young children in New York State. Children are most commonly exposed to lead by the ingestion of paint chips or soil that is contaminated with lead. In 2009 in New York State, 2,717 children were diagnosed with lead poisoning. Lead poisoning is an important cause of learning disabilities, anemia, and growth problems. Children exposed to lead may have problems with paying attention and being aggressive. Elimination of childhood lead poisoning is essential to improving the lives of children in NYS, especially socio-economically disadvantaged children who are disproportionately affected by lead poisoning. NYS has made significant progress towards reducing both the incidence and severity of childhood lead poisoning, but it remains a serious public health problem. In addition, recent changes used by CDC to identify children exposed to lead, will result increased caseloads and thus increased needs for investigations and follow up.

Evidence Base: Medicaid coverage for costs associated with environmental investigations and care coordination for children on Medicaid with lead poisoning is estimated to result in $30.5 million in state and local savings. Savings would be achieved through a reduction in the number of children exposed to lead and for those exposed, by assuring prompt access to appropriate care and treatment. Analysis indicates that approximately 77 percent of lead poisoning cases identified in New York State were MA-eligible children, i.e. it is estimated that in 2012 there are approximately 749 Medicaid-eligible children with incident blood lead levels of 15 mcg/dL or higher, increasing to 2,092 children in subsequent years with a change to in definition to include blood lead levels of 10ug/dL. Provision of follow-up services by local health department costs on average $ 6,750 per child.

Implementation: Managed care plans will be asked to provide guidance regarding members and geographies that might best benefit from lead poisoning prevention efforts. At the conclusion of the 5-year period, upon demonstration of program effectiveness, this initiative will be proposed for inclusion as an integral component of the managed care capitated rate and service structure. Based on the information provided by plans, over the waiver period, grants will be provided to community-based providers for home investigations and care coordination for Medicaid eligible children. This initiative will be phased-in over a period of five years beginning with an initial assessment of readiness to implement on a county-by-county basis followed by a solicitation to select contractors. Services will be reimbursed on a per visit basis as a model for a potential future reimbursement program.

5) Water Fluoridation

Tooth decay is the most common chronic childhood disease, with almost 80 percent of all children experiencing tooth decay by the time of high school graduation. Water fluoridation is the most cost-effective approach of reducing tooth decay [1-4]. Furthermore, it is also a successful cost-saving strategy for the Medicaid program. Analysis of dental procedures in predominantly fluoridated community water versus non-fluoridated drinking water communities in New York State suggests savings of $24 per child[5] . Out of the approximately 2 million children on Medicaid in New York State, about 500,000 live in less fluoridated counties and another 1.5 million live in mostly fluoridated counties.

Evidence Base: Assuring fluoride in community drinking water is especially important today because many people cannot afford dental care. Although tooth decay is preventable, the use of preventive dental services is low, with only 31 percent of children enrolled in Medicaid receiving any preventive dental service. Fluoridation of community drinking water helps people of all ages and income groups. Systematic reviews of the scientific evidence have concluded that community water fluoridation is effective in decreasing dental caries prevalence and severity (McDonagh MS, et al, 200030, Truman BI, et al, 200231, Griffin SO, et al, 200732). Effects included significant increases in the proportion of children who were caries-free and significant reductions in the number of teeth or tooth surfaces with caries in both children and adults (McDonagh MS, et al, 2000b, Griffin SO, et al, 2007). When analyses were limited to studies conducted after the introduction of other sources of fluoride, especially fluoride toothpaste, beneficial effects across the lifespan from community water fluoridation were still apparent (McDonagh MS, et al, 2000b; Griffin SO, et al, 2007).

Implementation: Over the waiver period New York State will implement this program through grants to water systems that in turn will implement or enhance fluoridation systems. The goal is that by the end of the waiver period all New York children would benefit from fluoridated water.

6) Healthcare Acquired Infections and Prevention of Sepsis

Population health promotion through quality care in hospitals will be addressed through an aggressive set of hospital quality improvement initiatives that both build on and incorporate programs that evidence early promise for success in addressing and reducing Healthcare Associated Infections (HAIs) and preventing sepsis.

Evidence Base: It is estimated that about 1 in 20 patients develop an infection while receiving treatment in U.S. hospitals, and HAIs in hospitals alone result in up to $33 billion in excess medical costs every year. For example, a single central-line associated bloodstream infection (CLABSI) could result in an estimated $16,550 in excess medical costs.

New York State initiatives suggest the potential for significant savings as evidenced by the following:

- Patients who had surgical site infections (SSIs) following coronary artery bypass grafts (CABGs) had hospital charges that were 1.6 times higher and a length of stay that was 2.2 times longer than patients who did not have SSIs. SSIs following CABGs were responsible for $29 million in hospital charges and over 4,800 hospital days per year statewide. Medicare and Medicaid together were charged over $21 million attributable to CABG SSIs.
- Since NYS public reporting of HAIs began in 2007, the reductions in colon, CABG, and hip replacement infection rates, as well as ICU related CLABSIs, have also resulted in cost savings. A recent CDC report provided a range of estimates for the direct hospital cost of treating of HAIs (Scott 2009)*. Ranges were provided because HAIs vary in severity and cost estimates vary widely. In 2011 it is estimated that reductions in CLABSIs in intensive care units in New York State resulted in between 11.8 and 47.3 million dollars saved. Similarly, reductions in surgical site infections resulted in between 2.7 and 8.0 million dollars saved.
- Previous prevention projects funded by New York State have resulted in decreases in CLABSIs in neonatal intensive care units, reductions in Clostridium difficile infections in a hospital collaborative group, reductions in CLABSIs on medical or surgical wards following changes in insertion and maintenance practices, and reductions in bloodstream infections after instituting chlorhexidine bathing in intensive and respiratory care units. One CLABSI prevention project documented an annual cost savings of $0.8-$3.2 million. A project to decrease infection rates in peripherally inserted central catheters (PICCs) found that decreased infection rates resulted in a cost savings of approximately $375,000, and readmissions because of PICC infections decreased from 8.5% to 3.8%.

Hospital quality initiatives, that build on and expand upon those included in the original Partnership Plan are anticipated to both improve patient outcomes through enhance quality of care and reduce overall Medicaid costs by avoiding costly infections secondary to medical procedures.

Implementation: New York proposes to partner with academic medical centers and other hospital and outpatient care settings to provide short-term prevention project awards to implement evidence-based HAI and sepsis prevention projects. The Department will select and work with an external evaluator to implement and monitor the program. This new initiative will complement the Patient Centered Medical Home initiative (limited to 60 hospitals at most) and New York State's Partnership for Patients.

Program components would include specific types of healthcare associated infections; surgical site infections; central line associated bloodstream infections; the reduction of specific microorganisms that cause HAIs (e.g. *Clostridium difficile*, extended spectrum beta lactamase (ESBL)- producing Gram negative bacteria, carbapenem resistant Enterobacteriaceae, and methicillin resistant *Staphylococcus aureus*); the reduction of specific infections in select population groups (e.g. oncology patients, patients on mechanical ventilation, surgical patients, dialysis patients); and evidence- based sepsis prevention measures including antimicrobial stewardship initiatives. The approaches used will follow the collaborative quality improvement model.

IMPACT ON HEALTH DISPARITIES

The initiatives proposed were selected as all represent critical health care and preventive services that are necessary to address documented health disparities in New York State. The recommendations were developed by and through the Medicaid Redesign process and were advanced by a committee whose sole goal was to develop recommendations to address health disparities. Examples of health disparities that will be addressed through these initiatives include the following:

- In New York State during 2006-2008, the teen pregnancy rate for black non-Hispanics was 69.0 per 1,000 females' ages 15-17 years, which was more than 5 times the rate for white non-Hispanics. The rate was also well above New York State's prevention agenda objective of 28.0 per 1,000 females.
- Recent statistics indicate that in 2010 the asthma hospitalization rate per 10,000 was five times higher for black non-Hispanic New Yorkers than White New Yorkers (45.5 as compared with 9.3).
- Short term complications of diabetes were five times greater among Black non-Hispanic New Yorkers than among white New Yorkers (13.5 as compared with 3.5).
- Childhood lead poisoning is largely concentrated in poor, minority communities (Landrigan, P. Rauh, V.A., and Galvez, M. Environmental Justice and the Health of Children. Mount Sinai Journal of Medicine 77(2010):78-187).
- Similarly, tooth decay is the single most common chronic childhood disease. Yet, among children enrolled in the New York State Medicaid program only one-third of all eligible children received any type of dental care in 2009. (The State of Children's Dental Health: Making Coverage Matter. The Pew Center on the States. Washington, DC. 2011).

IMPACT ON OVERALL MEDICAID SPENDING

The six public health interventions are anticipated to cost $395.3 million and could result in $2.8B in savings over five years as detailed by program below.

- Nurse home visiting: $82M cost; $466M savings
- Asthma: $32.5M cost; $97.5M savings
- Diabetes: $200M cost; $1B savings
- Lead: $61M cost; $1.1B savings
- Water Fluoridation: $10M cost; $140M savings
- Healthcare Acquired Infections and Sepsis Prevention: $10M cost; TBD savings

Evidence-based preventive nurse home visiting services: Based on experience of the NFP program costs and savings are estimated as follows: Expansion of the Medicaid case load of the 3 current NFP programs to serve 2,518 first time mothers annually for five years is estimated to cost $13,801,838 annually for a total five-year cost of $69,009,188. The establishment of 6 new NFP programs to cover an additional 950 first time mothers will be served annually, for a three-year period at a total annual cost of $4,275,000, and a total three-year cost of $12,825,000.

NFP has proven nationally to save $5.70 for every $1.00 invested. Based on that ratio, the annual savings with the expansion of the 3 current NFP programs in year one of the initiative will be approximately $78,670,474. The addition of 6 new NFP programs in year three of the initiative will save an additional $24,367,500 annually. By year three of the initiative, the total annual savings will be $103,037,974. The total savings over the five-year initiative is estimated to be $466,454,869.

Asthma Prevention and Treatment: A $6.5 million cost is based on an estimated 10,000 individuals receiving the services at a cost of $650.00 per individual. The savings are based on evidence from the literature which indicates that home environmental asthma programs will result in a range of health and financial benefits, including a reduction in asthma hospitalizations and ED visits of up to 60 percent and a return on investment of up to 14:1[5-13]The estimated $19.5 million savings is based on the lowest, conservative end of the demonstrated range.

Cost: $650/recipient x 10,000 visits/year = total program cost $6.5 million/year
Savings: $3.00 savings for every $1.00 invested = $3.00 x $6.5 million = $19.5 million in savings/year

Diabetes Prevention and Treatment: Since a disproportionately high burden of diabetes occurs among persons of low socioeconomic status who depend on Medicaid, reimbursement for diabetes prevention programs can play a vital role in controlling future health care costs and reducing the burden of diabetes in New York State. Effectively reducing the number of New Yorkers who progress to full diabetes will require a $25M investment that will result in 34,800 fewer Medicaid covered individuals being diagnosed with diabetes annually (assuming a 58% success rate) and will in turn save the Medicaid program $207 million annually, assuming savings of $6,649 per case averted. In addition, a comprehensive diabetes Quality Improvement Campaign to reduce complications is estimated to require a $15 million Medicaid investment and result in $238 million in Medicaid savings (ROI $15.88: $1). Both of these initiatives, representing a $40 million investment (prevention and care) is anticipated to result in savings of $445 million.

Lead Poising Prevention: Research published in 2009 found that for every dollar invested in lead paint hazard control results in a return of $17-$221 or a net savings of $181-269 billion. The benefits are attributed to higher lifetime earnings, increased tax revenue, lower health care costs and the direct costs for crime, and reduced need for special education. Surveillance figures suggest that the total cost of providing follow-up services to Medicaid eligible children with BLL group of 15 mcg/dl or higher would be approximately $5 million in 2013, increasing to $14 million per year in 2014 in response to lowered federal reference values for childhood lead poisoning. At least 50 percent of this cost, or $30.5 million, could be saved for the state overall (combined state and local shares) through federal financial participation. Children poisoned by lead are seven times more likely to drop out of school, earn less money, cost more in taxpayer dollars and provide less in tax revenue. The addition of Medicaid reimbursement would represent a significant step in the Department's comprehensive agenda to eliminate childhood lead poisoning in New York State, and could return between $85 million and $3 billion in benefits to New York.

Water Fluoridation: An investment of $10 million phased over a period of ten years is needed. With $1 million investment, we estimate that the number of children on fluoridated drinking water will increase by 200,000 to 1.7 million children. At a savings of $24 per child, and a utilization of 35 percent, we estimate the annual savings to be $14 million. Thus an investment of $10 million is likely to yield savings of $140 million to the Medicaid program.

Health-Care Acquired Infections and Sepsis Prevention: Four initiatives in distinct regions of the state funded at $500,000 each for five years will cost approximately $10 million. CDC estimates that effective infection control programs could prevent up to 70 percent of infections. This can translate into potential savings nationwide of up to $31.5 billion of the $45 billion expenditures attributed to HAIs. (Scott RD. The direct medical costs of healthcare-associated infections in U.S. hospitals and the benefits of prevention [report online]. 2009 Mar [cited 2010 Apr 21]. Available at: http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.)

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MRT Reinvestment Program
Regional Health Planning

BACKGROUND

In the context of dramatic changes in the delivery system driven by New York's MRT and the Affordable Care Act (ACA), collaborative, regional health planning will be an essential element of New York's effort to achieve the Triple Aim. A variety of factors demand a robust regional planning infrastructure in New York State. With one million New Yorkers soon to be newly-insured under the ACA, regional strategies to ensure access to high quality primary care will be needed. The impact of new payment mechanisms and new models of care can be optimized (and pitfalls avoided) through the work of regional collaboratives, supported by reliable data, to address population health and disparities concerns, to facilitate collaborations among providers along the continuum of care, and to align payment incentives to promote desired aims. Community health needs assessments and community benefits required of hospitals under the ACA and state law and of local health departments similarly demand strong data analysis and input from a variety of stakeholders. Underlying all of these initiatives is the imperative to reduce the per capita cost of health care, while improving health outcomes and status. New York's global cap on Medicaid provides a brake on spending. Keeping costs under the cap and bending the cost curve for other payers demands collaboration among multiple stakeholders based on upon reliable data.

New York State has a solid foundation on which to build a strong planning infrastructure to facilitate and manage the changes brought about by the ACA, the MRT and the effects of ongoing innovation in health care delivery and organization. In several regions, particularly upstate, broad-based regional planning is under way. For example, the Finger Lakes Health Systems Agency (FLHSA) – one of two remaining health systems agencies in New York State– is engaged in a broad range of planning activities to manage health care capacity, improve quality, reduce unnecessary utilization and improve population health. Its activities include convening consumer coalitions that work to eliminate disparities, convening commissions of regional leaders to evaluate health care capacity issues, conducting a hypertension collaborative among providers and the business community, sponsoring a care transitions program, and embedding care managers in primary care practices. Notably, the Rochester hospital referral region, where the FLHSA is headquartered, is the only referral region in New York State to score in the top ten percent nationwide on health system performance as measured by the Commonwealth Fund's local report card.[1]

[1]See The Commonwealth Fund Commission on a High Performance Health System, Rising to the Challenge: Results from a Scorecard on Local Health Performance, 2012, The Commonwealth Fund, March 2012.

At a more local level, local health departments are working with community partners to meet the goals of the State Health Improvement Plan (Prevention Agenda), and hospitals submit community service plans every three years to address their communities' health care needs. Rural health networks are involved in fostering collaboration among rural providers, and area health education centers seek to strengthen the health care workforce. These regional and local organizations provide invaluable contributions to the health of their communities and their local delivery systems. In many regions, however, health planning activities are limited in scope, fragmented, and not connected to an overall regional vision addressing each element of the Triple Aim. The funds requested under this waiver will help expand and strengthen broad-based regional planning throughout the state.

New York is unquestionably a diverse state, where health system performance and population health issues vary by region and even by community.[2] As the Health Care Association of New York State (HANYS) noted, health system improvement strategies that work in one region may not work in another. Regional planning provides a forum for assessing health care delivery system performance and population health and developing consensus-based strategies to drive improvements in performance on each element of the Triple Aim. Under this proposal, planning will be conducted by multi-stakeholder collaboratives that bring together consumers, providers, health insurers, public health officials, businesses, unions, and academic institutions and engage in rigorous data collection and analysis to support their work.

PROGRAM DESCRIPTION

New York State seeks to dedicate $25 million on average annually over five years to support regional planning activities. The Department of Health is working with its Public Health and Health Planning Council (PHHPC) to define the precise structure and functions of regional planning, the boundaries of the regions, the process for selecting regional planning organizations, and the metrics for measuring their performance.[3] The PHHPC will be holding public meetings over the course of the next several months and expects to issue a report on regional planning and redesigning certificate of need in early December. Stakeholder input has been solicited as part of this project, and public comment is welcome at every PHHPC Planning Committee meeting. The model or models adopted will be informed by extensive public discussion and feedback submitted by stakeholders.

One model under consideration is the designation of one regional health planning organization in each region that is considered a trusted and neutral convener, representative of, at a minimum, consumers, the local public health departments, providers, purchasers of health care, and health insurers or plans.

[2]See The Commonwealth Fund Commission on a High Performance Health System, Rising to the Challenge: Results from a Scorecard on Local Health Performance, 2012, The Commonwealth Fund, March 2012.

[3]The PHHPC is a panel of health care experts, representing providers, payers, consumers, and public health officials, that is responsible for making decisions on the establishment of new health care providers, adopting state sanitary code regulations, advising the Department on public health issues, making recommendations on health care construction projects subject to certificate of need (CON), making health planning recommendations, and adopting operating regulations for licensed health care facilities and home health agencies.

Potential functions that might be served through the convening of stakeholders by regional planning organizations include:

- Supporting local health department community health assessments, and hospitals' community health needs assessments, developing strategies to respond to identified needs and advancing State Health Improvement Plan (Prevention Agenda 2013) priorities;
- Measurement of health system performance, developing health system dashboards or scorecards, and addressing weaknesses;
- Addressing health and health care disparities;
- Facilitating effective strategies among providers, consumers and payers to coordinate care, reduce unnecessary utilization, and promote population health;
- Alignment of health care resources with community health needs, including through prospective capacity planning to inform such activities as capacity development and submission of recommendations on state grants and certificates of need;
- Identifying and implementing best practices to optimize health care quality and the patient's experience of care;
- Ensuring that consumers have a voice in the delivery system;
- Publishing data and implementing strategies to assure that consumers have the knowledge and resources to use the delivery system appropriately and effectively;
- Aligning payment incentives to promote high-quality, accessible, and cost-effective care; and
- Leveraging health information technology to engage in community-level analysis of health status, health care utilization, outcomes and spending.

This 21st century planning model addresses not only the supply and distribution of health care resources, but also the demand for health care (i.e., strategies to improve population health and reduce preventable utilization) and the quality of care. While the nature of the planning undertaken may vary by region, every region will be expected to engage in planning activities that address each element of the Triple Aim. They will also be required to identify and develop strategies to address disparities in health and/or health care. In addition, active engagement in regional planning and the support of the regional planning organization will be a significant factor in evaluating applications for waiver funding, including funding for primary care expansion, hospital transition, safety net and vital access providers, capital access, and new medical care models.

All planning activities must be supported by robust data analysis. As suggested by the Community Health Care Association of NYS (CHCANYS), regional planning organizations will leverage existing health planning tools and data and have access to a wealth of data collected by the state, including the Statewide Planning and Research Cooperative System (SPARCS), Behavioral Risk Factor Surveillance System, Disease and condition specific data from program registries and vital statistics data, as well as the data residing in the new, all-payer database which will be available at the end of 2013. In addition, regional planning organizations will likely engage in their own data collection activities with a regional or local focus.

The state's Regional Health Information Organizations (RHIOs) may play a key role in generating data for this purpose. Focus groups, surveys, and mapping of health care resources are also commonly used to identify community health needs and develop strategies.

Regional boundaries will be defined based on a number of considerations, including the existing health planning infrastructure, health care market considerations, and regional identity. One option is the use of the economic development regions implemented by Governor Cuomo (see attached map). The close linkages between a region's health care delivery system and its economic development activities argue in favor of a consistent regional approach for both purposes.

IMPACT ON OVERALL MEDICAID SPENDING

Regional health planning will reduce Medicaid spending by bringing together consumers, providers, purchasers of health care, and public health officials, among others, to:

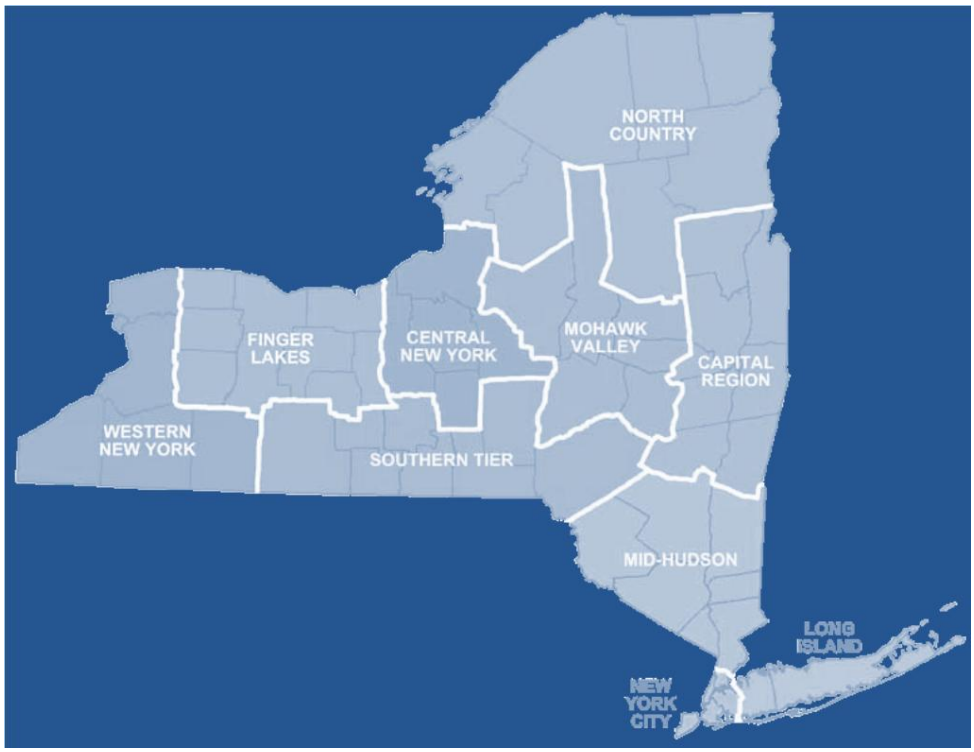
- Align payment incentives to promote better outcomes and reduce unnecessary or preventable utilization;
- Facilitate transitions in care and care coordination;
- Close important health and health care disparities that can lead to preventable utilization and poor outcomes; and
- Develop collaborative strategies to engage consumers not only in their own care and health promotion, but in the future of their delivery system and the health status of their communities.

The work of the FLHSA in reducing health care spending through care coordination, capacity management, and public health interventions illustrates the potential of regional planning. According to the Dartmouth Atlas of Health Care, the total Medicare cost per beneficiary in the Rochester hospital referral region is 21 percent below the national average and is the lowest of the comparable upstate hospital referral regions (Albany, Syracuse and Buffalo). [4]

Similarly, commercial health care costs in the Rochester hospital referral region are 60 percent of the national average for inpatient care, 77 percent for outpatient services, and 85 percent for physician care.[5] The FLHSA 2020 Commission evaluation of inpatient capacity resulted in a savings of $13 million in capital costs and approximately $20 million in annual operating costs. In addition, FLHSA's community-wide, multi-stakeholder implementation of a care transition intervention is showing an aggregated reduction of hospital readmissions among patients receiving transition coaching of 25 percent. [6]

[4] The Dartmouth Atlas of Health Care, Medicare Reimbursement per Enrollee, By Race and Program Component, available at www.dartmouthatlas.org, accessed on Aug. 1, 2012.
[5] Pyenson, Commercial Cost Variation by Hospital Referral Region: Actuarial Analysis of Commercial Claims Databases, prepared for the Institute for Healthcare Improvement, August 2010
[6] Interview with Art Streeter, FLHSA, Aug. 2, 2012; FLHSA, Progress Report to the Community: Year 2, 2020 Commission on Health System Performance, Dec. 2011.

Potential Regions



Western New York: Allegany, Cattaraugus, Chautauqua, Erie, Niagara
Finger Lakes: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates
Southern Tier: Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins
Central New York: Cayuga, Cortland, Madison, Onondaga, Oswego
Mohawk Valley: Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie
North Country: Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence
Capital Region: Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer, Warren, Washington
Mid-Hudson: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
New York City: Bronx, Kings, New York, Richmond, Queens
Long Island: Nassau, Suffolk

MRT Reinvestment Program
MRT Waiver Evaluation and Program Implementation

BACKGROUND

Improving the U.S. health care system requires pursuit of the Triple Aim: improving the experience of care for patients, improving the health of populations, and reducing per capita costs of health care. Higher-value care can only be realized through careful measurement of care and outcomes, use of those measures to promote and improve quality and support of payment methodologies that reflect high quality and efficient provision of services.

New York's Medicaid program is in the process of a fundamental restructuring intended to improve patient outcomes and lower program costs. To achieve these goals the Medicaid Redesign Team (MRT) developed a comprehensive multi-year action plan that if fully implemented will improve care and control spending. To complement and expand on these initiatives, this waiver amendment proposes unique and innovative models that will further New York's ability to achieve the Triple Aim.

This waiver amendment seeks to demonstrate a comprehensive approach to innovation and includes a number of reporting and evaluation requirements designed to inform the federal government and the state of the progress achieved, challenges encountered and lessons learned as the demonstration is implemented. Effective implementation and identification of lessons learned requires that a portion of the MRT savings generated as a result of the action plan be dedicated to a rigorous and thorough evaluation of ongoing as well as new MRT initiatives.

In addition to evaluation and process improvement, successful implementation will also require that each of the new programs funded by the waiver amendment are adequately staffed and that additional efforts are taken to effectively communicate with Medicaid members. Comprehensive reform will not be successful without sufficient implementation resources and an effective member communication strategy.

PROGRAM DESCRIPTION

New York State plans to invest $500 million over the next five years to evaluate as well as implement the MRT action plan and the MRT waiver amendment. Provided below is a description of how these funds will be used. A more detailed breakdown is provided in the MRT Expenditure Plan section of this report.

To ensure a robust system of monitoring and evaluation as well as government transparency and accountability, the New York State Department of Health (NYSDOH) will create comprehensive systems to measure, evaluate, track and report on metrics for each of the MRT initiatives including those already in some

stage of implementation as well as those requested through this waiver amendment. All initiatives will undergo rigorous evaluation to assure that unique goals and objectives are achieved and well as overarching or cross-cutting goals such as access for disenfranchised populations, reduction of health disparities, reduction of preventable events, promotion of a culture of quality and operation of an efficient and effective health care system.

Evaluation activities will follow two simultaneous tracks – evaluations of individual initiatives (both current MRT recommendations and those proposed as part of this waiver) and evaluation of the broader health care system to assure achievement of the three goals as enumerated by the Triple Aim. The evaluation funds will support comprehensive program monitoring, policy development and analysis, data analytics and creation of systems to track, monitor and post evaluation results to inform government officials, providers, consumers and external researchers. Through this process an evidence base will be developed that can be used by states throughout the nation as the health care system transforms over the coming years.

Funding of external evaluation partners will be done through a competitive Request for Proposal (RFP) process. It is expected that the NYSDOH will partner with the most advanced academic and health evaluation institutions, foundations, and associations from across the nation, as the waiver evaluation process will be objective, comprehensive, and will inform health systems change across the country.

The need for and import of evaluation was noted by several entities commenting on the draft waiver including the Hospital Association of New York State (HANYS) and the Conference of Local Mental Hygiene Directors, Inc. HANYS recommended that the standards used to evaluate waiver programs be: transparent; developed with stakeholder input; agreed upon in advance; grounded in evidence-based science, reliable; clearly defined; reproducible; standardized and useful.

In addition to evaluation, the state will also require waiver funding to both support waiver program implementation and member communication. Medicaid redesign in New York is a huge task and creates challenges for the state, stakeholders and members when it comes to successful implementation. Staffing shortages make it difficult for implementation to be monitored as effectively as possible and the raw amount of change occurring at the same time has led to member confusion. Modest amounts of waiver resources could address these challenges during this important implementation phase.

Overall, the state envisions four specific programs in order to effectively evaluate implement and communicate the MRT waiver amendment. Those sub-programs are described below:

1) Evaluation of Ongoing MRT Initiatives

MRT Phase 1 led to the development of 78 distinct initiatives which are now being implemented. These initiatives were a mix of traditional cost containment ideas (rate reductions, utilization controls), systemic reforms and traditional public health interventions. MRT Phase 2 generated additional proposals that both transcended the earlier work by addressing complex topics set aside in Phase 1, and helped provide clarity to certain key Phase 1 reforms. The overall MRT action plan ensures a comprehensive approach to redesign that will collectively achieve the Triple Aim. Evaluation of key initiatives being implemented as part of the MRT process is described below.

1a) Expanding Current Patient Centered Medical Homes

Background: In 2010, the NYSDOH initiated two incentive programs to increase the number of providers who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Home (PCMHs). Medicaid primary care providers (including clinics and Federally Qualified Health Centers (FQHCs)) who are certified as Level 1, 2 or 3 are currently reimbursed an additional $2, $4 and $6, respectively, per member per month for Medicaid managed care enrollees. Providers are reimbursed on a per visit basis for Medicaid fee-for-service (FFS) enrollees, with amounts ranging between $5.50 to $21.25 depending on the provider's recognition level and place of service. A unique program in the rural northeastern area of the state, the Adirondacks, is a multi-payer demonstration whereby nine payers, including Medicaid as well as Medicare FFS, are supporting practice transformation, including conversion to Level 3 PCMH. The demonstration includes multi-payer measurement using electronic health records and a data warehouse which will be used for pay-for-performance (P4P).

Metrics: The NYSDOH will evaluate the effectiveness of PCMH for the Medicaid managed care population on a statewide basis using HEDIS®, CAHPS®, encounter (utilization) and Prevention Quality Indicator (PQI) data comparing demographically similar cohorts of enrollees who are, and are not, assigned to a PCMH primary care provider. Additional resources will be necessary to assist in the evaluation of the FFS population and to evaluate provider-based P4P programs.

1b) Managed Long-Term Care

Background: The primary objective of this initiative is to enroll individuals with 120 days or more of community-based long-term care services into managed long-term care (MLTC) plans. Medicaid recipients currently receiving personal care, services from certified home care agencies, the long-term home health care program and individuals who have just begun receiving long-term care services will be included. Individuals in other programs, such as the Assisted Living Program, will subsequently transition to MLTC.

In addition, MLTC plans will expand enrollment to include those in need of long-term care services, but are not nursing home eligible. Another initiative is the inclusion of the Consumer-Directed Personal Assistance Program (CDPAP) to the MLTC benefit package.

Metrics: The NYSDOH has been collecting member-level functional assessment data through its Semi-Annual Assessment of Members (SAAM) instrument since 2006. Staff has also conducted two consumer satisfaction surveys. Performance measures based on the SAAM data have been developed and the first publicly reported performance data will be made available in 2012. In 2013, a select group of plans will be required to submit Medicare HEDIS® results. Assistance with evaluation is necessary to 1) determine whether the care provided to the enrollees has improved, 2) assess improvement in the overall health and functionality of the recipients and 3) determine if the transition into MLTC from other community-based programs has been cost effective. Research is also needed to evaluate the use of CDPAP and compare quality, performance and costs of enrollees who chose CDPAP and those who do not.

1c) Inclusion of Pharmacy in Medicaid Managed Care Benefit Package

Background: The pharmacy benefit is now included in the Medicaid managed care benefit package, effective October 1, 2011. Previously managed care enrollees received their prescription and over-the-counter medications through Medicaid FFS. This change was implemented in response to Affordable Care Act (ACA) provisions which enabled plans to receive the same rebates as FFS and take advantage of the plans' abilities to manage the pharmacy benefit.

Metrics: The NYSDOH has many years of FFS pharmacy claims and is now receiving pharmacy encounters from the plans. An evaluation will be needed to determine whether the targeted savings have been achieved as a result of this change, the impact, if any, on the care provided to enrollees and the health of this population. Evaluation assistance is needed to develop an objective study design including measure development related to pharmacy processes, outcomes and cost effectiveness.

1d) Establish Interim Behavioral Health Organizations (BHOs) to Manage Carved-Out Behavioral Health Services

Background: For both Supplemental Security Income (SSI) and non-SSI enrollees, mental health and chemical dependency services are not fully covered through managed care plans. The NYS DOH established Behavioral Health Organizations (BHOs) to manage these carved out services. For mental health services, the BHOs manage all SSI mental health care (excluding "detox") and "carved out" behavioral health services for all non-SSI populations and for individuals simultaneously enrolled in Medicare and Medicaid ("dual enrollees"), who are not eligible for MMC. Carved out services for non-SSI enrollees include: chemical dependency and specialty mental health services.

Metrics: Using standardized measures of performance from HEDIS®, the NYSDOH has measured the provision of mental health and chemical dependency services within managed care plans for over ten years. Staff is also working with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to develop additional measures related to the services and desired outcomes for both managed care and FFS enrollees using mental health and chemical dependency services. Using these measures of performance, assistance is needed to evaluate the processes and outcomes of care for both SSI and non-SSI populations in these two models of care: "mainstream" managed care and BHOs. An evaluator will also be called upon to evaluate the per member per month utilization and costs for mental health and chemical dependency services received in managed care and BHOs. Together, these evaluations will establish whether the goals of the Triple Aim have been achieved.

1e) Implement Health Homes for High-Cost, High-Need Enrollees

Background: Historically a small percentage of Medicaid enrollees with complicated combinations of physical and behavioral health issues have accounted for a large proportion of NYS Medicaid expenditures. In an effort to enhance these enrollees' engagement and better coordinate their care, the NYSDOH collaborated with the OMH, OASAS and Office for People with Developmental Disabilities (OPWDD) in the development of a set of operating and reporting requirements for Health Homes. The NYSDOH has an approved State Plan Amendment (SPA) and enrollment began in early 2012.

Metrics: A robust list of quality and utilization measures was included in the Health Homes SPA which will serve as the framework for ongoing evaluation and monitoring. Included in this list are standardized HEDIS® measures as well as NYSDOH-specific measures generated from two additional reporting sets: 1) As a result of the above-noted collaboration with OASAS and OMH on measure development for behavioral health, the NYSDOH is developing several measures appropriate to this population; and 2) In 2011, the NYSDOH developed the Case Management Annual Reporting Tool (CMART) for managed care plans to submit annual case management data. This tool and its related measurement set will also be used in health home evaluation.

Assistance with the evaluation of the program with respect to patient experience of care particularly access to and satisfaction with case management services will be needed. A possible approach would be a pre-post evaluation of changing utilization patterns and expenditures that would include total Medicaid costs for this population with a potential focus on inpatient and emergency department use.

1f) Care Management Population and Benefit Expansion, Access to Services and Consumer Rights

Background: This proposal has three major components: 1) Begin to enroll non-dual Medicaid recipients who are currently excluded or exempt from mandatory managed care, 2) Ensure populations have access to information to assist them in this transition and 3) Streamline managed care enrollment and eligibility processes. The first component involves transitioning formerly exempt and excluded populations into managed care over a three year period resulting in an additional 230,000 enrollees in plans. The last component is the establishment of guidelines requiring new managed care enrollees to select a plan at the time they apply, and are approved for, Medicaid.

Metrics: Monitoring of enrollment trends and oversight of enrollment procedures (components 2 and 3) will be accomplished by reviewing enrollment data as these populations transition to managed care. The quality these populations receive in managed care will be monitored as part of the annual Quality Assurance Reporting Requirements (QARR) submission of quality and utilization data and the biennial administration of CAHPS®. Assistance will be needed with surveys of the new populations to evaluate their perception of managed care versus FFS. Pre-post analysis of utilization and expenditures for these new mandatory populations will be essential to inform future policy.

2) Evaluation of Waiver Amendment Initiatives

The twelve reinvestment projects proposed under the waiver amendment will be carefully monitored and evaluated to determine the efficacy of each reinvestment program. The evaluation will be structured to focus on the contribution of each program area to the achievement of the Triple Aim, both individual and as a cohesive multi-faceted initiative.

As considerable variation in activities, participants, and short- and long-term goals exists among the 12 waiver reinvestment initiatives, the evaluations of these initiatives will also be diverse. However, the following core elements will be incorporated into all 12 of the evaluations:

- An articulation of the major questions to be addressed regarding the implementation and effectiveness of the reinvestment initiative that pertain to the Triple Aims of improvement in the patient experience of care, health outcomes, and reduction in per capita costs.
- Research designs and statistical analyses that enable the questions around each initiative to be meaningfully addressed.
- Use of available data and quality measures, as appropriate for each initiative.
- A schedule of reports to be produced and disseminated to all stakeholders to allow the monitoring of program implementation and outcomes.

The evaluations will be based largely upon a pre- and post-waiver program implementation design where Medicaid program participants will serve as their own control group. Where possible and given appropriate levels of resources for a more rigorous study, quasi-experimental designs with non-randomized control groups will be conducted. Other techniques such as the use of propensity scoring, matching, and the use of statistical modeling will also be employed whenever appropriate to control for the effects of confounding and other factors to best assess the impact of the initiatives on achieving the waiver and program goals. Additional consideration to the study design and analysis of each initiative would be given with respect to assessment of goals that may be achieved in the short- versus those achieved over the long term.

The Medicaid Supportive Housing Expansion initiative will serve as an example of the form a waiver evaluation initiative may take. On the premise that lack of stable housing results in avoidable health care utilization and increased Medicaid costs among those with chronic conditions, an investment of $750 million over five years is proposed to improve health outcomes and reduce health system expenditures by increasing the number of supportive housing units and through the provision of support services such as case management, counseling, and education and employment assistance.

For this unique initiative, some of the major questions to be answered include:

- Is there an increase in Medicaid recipients placed in stable housing situations?
- Has there been an increase in the use of primary care services and services received through patient-centered medical homes?
- Do recipients with mental illness and substance abuse disorders who receive supportive housing services show increased utilization, initiation and engagement in treatment compared to those with substance abuse not receiving supportive housing?
- Are chronic conditions such as HIV/AIDS, asthma, hypertension and diabetes better managed among those receiving supportive housing services than among those not receiving these services?
- Are Medicaid costs per member per year lower among those receiving supportive housing services than among a comparable group of Medicaid recipients who did not receive supportive housing?

To address these questions, the primary approach would be a pre-and post-study design of Medicaid enrollees living in supportive housing to assess the impact of this program. As such, key measures available through administrative data sources or new data collection activities among those using supportive housing would be assessed on a periodic basis to measure progress toward achieving the initiative's stated goals, objectives, and study questions.

In addition to long-term outcomes, patient and provider surveys may be used in the early stages of program implementation to assess patient experiences in obtaining housing and support services, barriers to not receiving these services, provider barriers to providing these services, etc. Such surveys will be conducted and the results distributed frequently during the first two years of the program to identify problem areas and make necessary modifications.

Detailed information on metrics proposed for each of the twelve initiatives may be found in Appendix V of this document. Please note that these metrics are preliminary in nature and are anticipated to evolve to reflect program design and formalization of policies associated with each initiative. For several initiatives, including regional health planning and new care models, additional metrics will be developed and refined in concert with program development and implementation.

3) Waiver Implementation Assistance

New York is seeking short-term assistance through the waiver so as to ensure that all the programs envisioned in this comprehensive amendment are effectively implemented. This funding would support additional contracted resources that would assist state staff in establishing and administering the various programs envisioned in this document. The funding request is modest and the contracted resources will be temporary but are essential given the existing state budget challenges. It is important to note that funds will not be used to hire permanent state staff.

4) Consumer Education to Promote Effective Health Service Utilization

Health literacy in its broadest definition is critical to the success of both federal health care reform and New York's proposed innovations to implement the ACA and achieve the Triple Aim. The innovative care models proposed as part of this waiver will result in new care options that will be unfamiliar to most. To assure optimal utilization of these models, outreach and education will be provided to consumers, providers and insurers. An evaluation of utilization of these new care options will inform both future program development as well as educational strategies. This information will complement requirements placed on health insurers under the ACA to provide key information about their policies in an easier to understand way.

In addition, research and evaluation on how best to convey information on the cost and quality of health care services in a way that empowers consumers and informs behavior will be conducted as a critical component of overall health systems reform. Factors that influence patient selection and utilization of new care options must be identified and evaluated in light of the importance of engaging consumers to promote greater quality and efficiency in the health care system. Strategies for engaging consumers and influencing their behavior will be evaluated through a review of the literature and key informant interviews as well as focusing on selected campaigns that have demonstrated an effect on consumer behavior. Strategies associated with success and challenges common to public health consumer education programs, will be explored.

METRICS

New York State is building a comprehensive system of performance measurement that will apply not only to the Medicaid program or health plans, but will measure performance across the state's health care system; the All Payer Database. In addition, two sets of performance measures have been developed and will be key indicators for these MRT evaluations. The first set are the Medicaid core measures which will build upon existing health care measures (HEDIS®, CAHPS®, hospital and provider level metrics and more), fill in the gaps in the measurement of long term care and behavioral health, and align efficiency measures such as preventable hospitalizations. Efficiency measures such as potentially preventable hospitalizations and preventable emergency room visits are key indicators of success for many MRT initiatives, including Health Homes, Patient-Centered Medical Homes and care management for all. The second set are population core measures, which will align with New York's public health goals, as well as monitor quality across all payers not just public programs. These measures are included in the MRT Final Report and Action Plan http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtfinalreport.pdf. With these two measurement sets, New York State will, for the first time, have a robust system of measurement that clearly captures the Triple Aim.

While the MRT measurement set includes a standard set of metrics, new metrics will need to be developed for the various MRT waiver initiatives outlined in this document. It is the NYSDOH's goal to use established metrics whenever possible, including measures already collected in New York State and/or measures from national measure sets (for example the National Quality Forum).

NYSDOH will use evaluation funds for data collection, such as member satisfaction surveys targeted at a specific intervention, and use both quantitative and qualitative methods to best evaluate the efficacy of each MRT waiver initiative. The NYSDOH will require both external partners and internal analysts to stratify analyses to further define quality metrics and target improvement.

IMPACT ON OVERALL MEDICAID SPENDING

The objective of this program is to assess whether the Medicaid reform action plan accomplishes its stated objectives of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. In addition, this program will provide vital resources to assist the state in implementing the waiver and ensuring that consumers are aware of new opportunities to improve their health and health care that result from the MRT. Each of these waiver initiatives will be evaluated independently and the results will help state and federal decision makers assess each initiative individually and as a whole to assess the impact on achieving the goals of the Triple Aim. New York is also interested in using MRT Waiver Amendment resources to forge new relationships and partnerships between providers and stakeholders to improve health care delivery and overall population health. Through this process the state will support efforts to ensure that providers work together across traditional "silos" and develop comprehensive proposals that address core challenges that exist within specific communities.

MRT Expenditure Plan

BACKGROUND

The MRT actions that have been or are currently being implemented will reduce federal support for New York's Medicaid program by approximately $17.1 billion over the waiver period and over $21 billion since 2011 when they were initially implemented. The state is requesting that a portion of these savings ($2 billion annually and $10 billion over the life of the waiver) be reinvested via this waiver amendment in order to allow New York to reform its health care infrastructure as well as the resources to innovate. The federal funding being requested is based on reimbursement for expenditures made by state and local government for health care related services for which there currently is no federal funding. These services have been identified as Designated State Health Programs (DSHPs).

The state is also submitting the required waiver budget neutrality demonstration information. These calculations demonstrate that the projected Medicaid expenditures with the 1115 waiver, as amended, do not exceed the projected Medicaid expenditures without the 1115 waiver for any year over the term of the waiver amendment (2013 – 2017). In fact, the calculations will show that the cumulative impact on total Medicaid expenditures of the 1115 Partnership Plan waiver since its inception including the proposed amendment is a reduction in spending by approximately $46.5 billion.

FINANCING STRATEGY

There are several critical elements of this waiver amendment request that form the basic tenets of the state's financing strategy. The first is the listing of DSHP funds that will generate the federal match of $2.0 billion on average annually. During previous discussions surrounding a possible 1115 waiver for the New York Office of People with Developmental Disabilities (OPWDD), the state and CMS identified sources of existing state/local funds eligible for a federal funding match. As it has been determined that OPWDD will no longer require the use of those funds, the state will utilize those items at least as a starting point for negotiations.

The second critical element is the actual methodology for generating the Federal match. The state is requesting that a 100% of match DSHP expenditures up to $2 billion on average annually be used for the MRT reinvestment projects. This request is consistent with decisions made in the most recent approval of New York's amendment to the 1115 Partnership Plan waiver.

The third critical element is the state's intention to use DSHPs previously approved in the Federal State Health Reform Partnership (FSHRP) 1115 waiver in this MRT waiver amendment. Since these DSHPs have already been approved by CMS, they should automatically be included in the MRT waiver approval amendment.

It is important to point out that the state will not be claiming 100% of the expenditures for the approved DSHPs in the FSHRP waiver and the state should be able to claim this funding immediately. The remaining program expenditures being matched would be included in the waiver amendment upon the expiration of the FSHRP waiver on March 31, 2014. The state will ensure that the same DSHP expenditure is not claimed in both the FSHRP and MRT waivers.

Finally, the most recently approved amendment to the 1115 Partnership Plan waiver (effective August 1, 2011) includes approved DSHPs that the federal matching funds are used for two Quality Demonstration Projects and Clinic Uncompensated Care funding. The state will include these DSHPs in the MRT waiver once the funding is no longer needed for the above noted projects (i.e. Quality Demonstrations expire December 31, 2014 and Clinic Uncompensated Care on December 31, 2013).

In total, the state has identified over $2.7 billion (average annually) in potential DSHP funds that would be used to generate a Federal match. The components of the state's DSHP proposal include the following:

1) Previously approved FSHRP funds not utilized to date - $900 million;

2) Previously approved FSHRP funds currently being expended but available April 1, 2014 - $575 million;

3) Previously approved Partnership Plan DSHPs - $336 million; and

4) New proposed DSHPs, which includes:

    a. New York City and state-supported public health programs – $461 million.

    b. State-supported physician medical malpractice insurance which offsets the cost of high premiums for doctors that handle the bulk of Medicaid deliveries throughout the state– $127 million.

    c. State-supported medical indemnity fund payments which pay the future health care costs of plaintiffs in medical malpractice actions related to birth-related neurological impairments and reduces what would otherwise be costly Medicaid reimbursement – $50 million.

    d. State-supported Elderly Pharmaceutical Insurance Coverage (EPIC) Program which is New York's senior prescription plan. EPIC provides prescription drug coverage to more than 275,000 low and moderate income seniors - $250 million.

Appendix I & Ia - **Summary of DSHP Resources** and Appendix II – **Sources of DSHP Resources by Waiver Year** provide additional details to the state's request. It is important to note that the state's financing strategy for this waiver takes into consideration the intent to extend the Partnership Waiver through December 31, 2017.

The funds being requested under this financing strategy will support investments critical to the successful implementation of the MRT program initiatives and Federal Health Reform as well as effectively bend the cost curve for the state's overall health care system. Additionally, this request complies with federal regulations and primarily relies on reallocation of previously approved FSHRP funds. Finally, this funding will allow New York to continue its significant efforts to fundamentally re-shape its health care delivery system so as to improve patient outcomes and lower costs.

BUDGET NEUTRALITY

The budget neutrality calculations are based on a per capita cost method, and the budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. For purposes of this demonstration, it is assumed that the current 1115 Partnership Plan waiver will be extended thru December 31, 2017.

The general methodology and assumptions used for calculating the budget neutrality expenditure cap is described below:

- An annual expenditure cap is calculated for each Medicaid Eligibility Group (MEG) utilizing the number of eligible member months and the applicable Per Member Per Month (PMPM) costs. This is done for each year of the term of the waiver amendment.
- The base PMPM costs have been inflated by the Presidential trends.
- The annual budget neutrality expenditure cap is the sum of the projected annual expenditure caps for each MEG.
- The overall budget neutrality expenditure cap for the waiver amendment is the sum of the annual budget neutrality expenditure caps for each year for the term (2013 – 2017) of the amendment.
- Applying the assumptions above, the state estimates that the budget neutrality room will increase from $41 billion for 2012 to $46.5 billion by the end of the waiver period.
- The enrollment projections do not include the impact changes that will result from the implementation of the ACA. The Urban Institute projects that approximately 500,000 new individuals will be eligible in the state for Medicaid coverage as a result of the ACA.[1] However, the state needs direction from CMS as to how this population should be incorporated in the waiver budget neutrality calculations.

The attached Exhibit 3 details the budget neutrality expenditure cap calculations and Exhibit 3 (a) illustrates the expenditure detail.

[1] Urban Institute Report available at: http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/2012-03_urban_institute_report.pdf

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The following Appendices provide additional details regarding the State's **MRT Waiver 5 Year Financing and Expenditure Plan**. The $10 billion ($2 billion annual average) in funding being requested will support various investments critical to the successful implementation of the MRT program initiatives and Federal Health Reform. This funding will allow New York to continue its significant efforts to fundamentally re-shape its health care delivery system.

- Appendix I – Summary of DSHP Resources
- Appendix I(a) – NYC and State Supported DSHPs
- Appendix II – NYS Partnership Plan Waiver
- Appendix III – MRT Waiver Amendment 5 Year Expenditure Plan
- Appendix III(a) – MRT Reinvestment Program: Primary Care Expansion
- Appendix III(b) – MRT Reinvestment Program: Health Home Development Fund
- Appendix III(c) – MRT Reinvestment Program: New Care Models
- Appendix III(d) – MRT Reinvestment Program: Expand the Vital Access Provider Program and Safety Net Provider Program
- Appendix III(e)– MRT Reinvestment Program: Public Hospital Innovation
- Appendix III(f) – MRT Reinvestment Program: Medicaid Supportive Housing Expansion
- Appendix III(g) – MRT Reinvestment Program: LTC Transformation and Integration to Managed Care
- Appendix III(h) – MRT Reinvestment Program: Capital Stabilization for Safety Net Hospitals
- Appendix III(i) – MRT Reinvestment Program: Hospital Transition
- Appendix III(j) – MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform
- Appendix III(k) – MRT Reinvestment Program: Public Health Innovation
- Appendix III(l) – MRT Reinvestment Program: Regional Health Planning
- Appendix III(m) – MRT Reinvestment Program: MRT & Waiver Evaluation Program
- Appendix IV – Budget Neutrality Impact Through December 31, 2017
- Appendix IV(a) – Expenditure and Enrollment Details

APPENDIX I

NYS Partnership Plan Waiver
Summary of DSHP Resources
MRT 1115 Waiver Amendment
($ Millions)

Federal-State Health Reform Partnership (F-SHRP) DSHPs	Total
New F-SHRP (Approved but Not Utilized)	**$900.0**
OMH (Adult and Children's Non-Residential and Emergency Services)	$333.0
OPWDD (Rental Subsidies, Crisis, Respite, Sheltered Workshops, Pre-Vocational, Employment, & Trans.)	$312.0
OASAS (Prevention, Residential Treatment, Crisis and Outpatient Services)	$255.0
Existing F-SHRP (Currently Utilized -- Until March 31, 2014)	**$574.7**
Early Intervention Services	$180.0
Healthy New York	$150.0
Services to Special Education Children (OCFS)	$80.0
Expanded In-Home Services to the Elderly Program (SOFA)	$49.9
AIDS Drug Assistance Program	$43.2
Tobacco Control Program	$40.0
Community Services for the Elderly (SOFA)	$16.6
Health Workforce Retraining	$15.0
Subtotal F-SHRP	**$1,474.7**

Medical Home and Readmission DSHPs (Currently Utilized - Until Dec. 31, 2014)	Total
General Public Health Work	$224.8
Clinic Indigent Care	$55.0
Cancer Services Programs	$20.4
Newborn Screening Program	$11.3
Childhood Lead Poisoning Primary Prevention	$10.2
Obesity and Diabetes programs	$6.5
Tuberculosis Treatment, Detection and Prevention	$4.7
Healthy Neighborhoods Program	$1.6
Homeless Health Services (OTDA)	$0.8
Tuberculosis Directly Observed Therapy	$0.6
Subtotal Medical Home and Readmission DSHPs	**$335.9**

New DSHPs	Total
New York City Supported Public Health Programs	$411.3
Elderly Pharmaceutical Insurance Program	$250.0
Excess Medical Malpractice Program	$127.0
State-Supported Public Health Programs	$50.0
Medical Indemnity Fund Program	$50.0
Subtotal New DSHPs	**$888.3**

Total F-SHRP, Medical Home, Readmission & New DSHPs	**$2,698.9**

APPENDIX I(a)

NYC and State-Supported DSHPs

MRT 1115 Waiver Amendment

($ Millions)

New York City DSHPs	Total
Early Intervention	$98.2
Department of Health and Mental Hygiene - Admin.	$78.7
School Health	$44.4
Other Environmental Health	$43.6
NY/NY III Supportive Housing Program	$20.8
Mental Health	$14.4
HIV/AIDS Contracts	$12.0
Chemical Dependency	$11.7
Chronic Disease Prevention	$10.9
Epidemiology	$10.8
Mental Retardation & Developmental Disabilities	$7.7
Other Mental Hygiene	$7.5
Other Health Care Access and Improvement Programs	$6.9
Tobacco Control	$6.6
Other Disease Control	$6.1
Child Health Clinics	$5.3
Other Maternal, Infant, Reproductive Health	$4.1
STD/HIV Clinics	$3.5
Primary Care Information Project	$3.0
District Public Health Offices	$2.8
Tuberculosis Evaluation and Treatment	$2.7
Mental Health-Criminal Justice Panel/Care Monitoring	$2.6
Nurse Family Partnership	$2.1
Lead Poisoning Prevention	$2.0
Newborn Home Visiting Program	$1.0
Day Care	$0.8
Immunization	$0.6
Health Promotion and Disease Prevention Programs - Admin.	$0.4
Health Care Access	$0.3
Total NYC DSHPs	**$411.3**

State-Supported Public Health DSHPs	Total
State Support for Local Government Costs (AIM Program)	$46.0
Legislative Member Items	$4.0
Total State-Supported Public Health DSHPs	**$50.0**

APPENDIX II

NYS Partnership Plan Waiver
5 Year Resource Plan
($ in Millions)

	2013	2014	2015	2016	2017	5 Year Total
DSHP Sources	**$1,788.3**	**$2,219.4**	**$2,698.9**	**$2,698.9**	**$2,698.9**	**$12,104.6**
New F-SHRP	$900.0	$900.0	$900.0	$900.0	$900.0	$4,500.0
Existing F-SHRP	$0.0	$431.0	$574.7	$574.7	$574.7	$2,155.1
Medical Home/Readmissions	$0.0	$0.0	$335.9	$335.9	$335.9	$1,007.7
Other	$888.3	$888.3	$888.3	$888.3	$888.3	$4,441.7

Notes:
1) Existing F-SHRP DSHP funding becomes available after March 31, 2014.
2) Med. Home/Readmission DSHPs become available after December 31, 2014.

APPENDIX III

MRT Waiver Amendment
5 Year Expenditure Plan
($ in Millions)

	2013	2014	2015	2016	2017	5 Year Total
Uses	**$1,663.3**	**$2,056.7**	**$2,195.0**	**$2,147.9**	**$1,937.0**	**$10,000.0**
Primary Care Expansion	$330.0	$295.0	$235.0	$215.0	$175.0	$1,250.0
Health Home Development Fund	$150.0	$150.0	$112.5	$75.0	$37.5	$525.0
New Care Models	$22.5	$75.0	$92.5	$75.0	$110.0	$375.0
Expand the Vital Access Provider Program and Safety Net Provider Program	$100.0	$150.0	$200.0	$300.0	$250.0	$1,000.0
Public Hospital Innovation	$240.0	$200.0	$300.0	$360.0	$400.0	$1,500.0
Medicaid Supportive Housing Expansion	$150.0	$150.0	$150.0	$150.0	$150.0	$750.0
LTC Transformation & Integration to Managed Care	$191.0	$226.4	$158.9	$133.9	$128.9	$839.1
Capital Stabilization for Safety Net Hospitals	$296.0	$350.0	$390.0	$355.0	$330.0	$1,721.0
Hospital Transition	$65.0	$120.0	$170.0	$110.0	$55.0	$520.0
Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform	$0.0	$125.0	$125.0	$125.0	$125.0	$500.0
Public Health Innovation	$63.4	$74.9	$86.7	$84.6	$85.6	$395.3
Regional Health Planning	$11.4	$22.4	$30.4	$30.4	$30.0	$124.6
MRT and Waiver Evaluation Program	$44.0	$118.0	$144.0	$134.0	$60.0	$500.0

APPENDIX III(a)

MRT Reinvestment Program: Primary Care Expansion

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Technical Assistance	$45.0	$30.0	$30.0	$20.0	$0.0	**$125.0**
Expand Capacity and Accessibility:						
2a) Capital Investment	$165.0	$100.0	$100.0	$110.0	$110.0	**$585.0**
2b) Operational Assistance	$20.0	$40.0	$40.0	$40.0	$40.0	**$180.0**
2c) Health IT Assistance	$100.0	$125.0	$65.0	$45.0	$25.0	**$360.0**
Subtotal Capacity & Accessibility	**$285.0**	**$265.0**	**$205.0**	**$195.0**	**$175.0**	**$1,125.0**
Total Funding Requirement	**$330.0**	**$295.0**	**$235.0**	**$215.0**	**$175.0**	**$1,250.0**

APPENDIX III(b)

MRT Reinvestment Program: Health Home Development Fund

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Member Engagement and Public Education	$4.5	$4.5	$3.4	$2.3	$1.1	**$15.8**
2) Staff Training & Retraining	$15.0	$15.0	$11.3	$7.5	$3.8	**$52.5**
3) Health Information Technology Implementation	$105.5	$115.5	$86.6	$57.8	$28.9	**$394.3**
4) Joint Governance Technical Assistance and Start Up	$25.0	$15.0	$11.3	$7.5	$3.8	**$62.5**
Total Funding Requirement	**$150.0**	**$150.0**	**$112.5**	**$75.0**	**$37.5**	**$525.0**

APPENDIX III(c)

MRT Reinvestment Program: New Care Models

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) New Care Models - Funding Opportunities	$22.5	$75.0	$67.5	$37.5	$22.5	**$225.0**
2) Quality Pool	$0.0	$0.0	$25.0	$37.5	$87.5	**$150.0**
Total Funding Requirement	**$22.5**	**$75.0**	**$92.5**	**$75.0**	**$110.0**	**$375.0**

APPENDIX III(d)

MRT Reinvestment Program: Expand the Vital Access Provider Program and Safety Net Provider Program

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
VAP and Safety Net Provider Program	$100.0	$150.0	$200.0	$300.0	$250.0	**$1,000.0**
Total Funding Requirement	**$100.0**	**$150.0**	**$200.0**	**$300.0**	**$250.0**	**$1,000.0**

APPENDIX III(e)

MRT Reinvestment Program: Public Hospital Innovation

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
NYC HHC Projects:						
1) Intensive Care Coordination / Case Management Initiative	$95.0	$84.0	$100.0	$113.0	$125.0	**$517.0**
2) Expanding the Concept of "Hot Spotting" to Uninsured	$80.0	$64.0	$85.0	$100.0	$110.0	**$439.0**
3) Primary Care Expansion	$38.0	$32.0	$40.0	$40.0	$50.0	**$200.0**
Subtotal	**$213.0**	**$180.0**	**$225.0**	**$253.0**	**$285.0**	**$1,156.0**
4) Primary Care and Care Management Expansion for Other Public Hospitals	$27.0	$20.0	$25.0	$32.0	$40.0	**$144.0**
5) Quality Pool			$50.0	$75.0	$75.0	**$200.0**
Total Funding Requirement	**$240.0**	**$200.0**	**$300.0**	**$360.0**	**$400.0**	**$1,500.0**

APPENDIX III(f)

MRT Reinvestment Program: Medicaid Supportive Housing Expansion

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Supportive Housing Capital Expansion Program	$75.0	$75.0	$75.0	$75.0	$75.0	**$375.0**
2) Supportive Housing Services Program	$75.0	$75.0	$75.0	$75.0	$75.0	**$375.0**
Total Funding Requirement	**$150.0**	**$150.0**	**$150.0**	**$150.0**	**$150.0**	**$750.0**

APPENDIX III(g)

MRT Reinvestment Program: LTC Tranformation and Integration to Managed Care

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Nursing Home Transition	$100.0	$100.0	$70.0	$70.0	$65.0	**$405.0**
2) ALP Investment	$50.0	$50.0	$25.0	$0.0	$0.0	**$125.0**
3) NY Connects	$10.0	$18.4	$18.4	$18.4	$18.4	**$83.6**
4) Quality Improvement - MLTC	$3.0	$3.0	$3.0	$3.0	$3.0	**$15.0**
5) HIT Investments	$25.0	$50.0	$37.5	$37.5	$37.5	**$187.5**
6) Ombudsperson	$3.0	$5.0	$5.0	$5.0	$5.0	**$23.0**
Total Funding Requirement	**$191.0**	**$226.4**	**$158.9**	**$133.9**	**$128.9**	**$839.1**

APPENDIX III(h)

MRT Reinvestment Program: Capital Stabilization for Safety Net Hospitals

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Revinvestment
1) Technical Assistance to Safety Hospital Boards	$15.0	$15.0	$10.0	$5.0	$5.0	**$50.0**
2) Transitional Capital for Hard Assets	$56.0	$110.0	$175.0	$150.0	$135.0	**$626.0**
3) Balance Sheet Restructuring	$225.0	$225.0	$205.0	$200.0	$190.0	**$1,045.0**
Total Funding Requirement	**$296.0**	**$350.0**	**$390.0**	**$355.0**	**$330.0**	**$1,721.0**

APPENDIX III(i)

MRT Reinvestment Program: Hospital Transition

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Technical Assistance	$20.0	$20.0	$20.0	$10.0	$0.0	**$70.0**
2) Plan Support	$45.0	$100.0	$150.0	$100.0	$55.0	**$450.0**
Total Funding Requirement	**$65.0**	**$120.0**	**$170.0**	**$110.0**	**$55.0**	**$520.0**

APPENDIX III(j)

MRT Reinvestment Program: Ensuring the Health Workforce Meets the Needs in the New Era of Health Care

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Health Workforce Retraining Initiative	$0.0	$62.5	$62.5	$62.5	$62.5	**$250.0**
2) Recruitment and Retention Incentives for the Underserved Initiatives	$0.0	$62.5	$62.5	$62.5	$62.5	**$250.0**
Total Funding Requirement	**$0.0**	**$125.0**	**$125.0**	**$125.0**	**$125.0**	**$500.0**

APPENDIX III(k)

MRT Reinvestment Program: Public Health Innovation

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) Evidence-Based Preventive Nurse Home Visiting Services	$13.8	$13.8	$18.1	$18.1	$18.1	**$81.8**
2) Asthma Home-Based Self-Management Education and Environmental Assessments	$3.6	$5.1	$9.6	$7.1	$7.1	**$32.5**
3) Diabetes Prevention and Treatment	$40.0	$40.0	$40.0	$40.0	$40.0	**$200.0**
4) Home Visits to Promote Childhood Lead Poisoning Prevention and Treatment	$5.0	$14.0	$14.0	$14.0	$14.0	**$61.0**
5) Water Fluoridation to Promote Dental Health for Children on Medicaid and 6) Quality Improvement Efforts to Address Health Care Acquired Infections and Prevent Sepsis	$1.0	$2.0	$5.0	$5.5	$6.5	**$20.0**
Total Funding Requirement	**$63.4**	**$74.9**	**$86.7**	**$84.6**	**$85.6**	**$395.3**

APPENDIX III(l)

MRT Reinvestment Program: Regional Health Planning

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
Regional Health Planning Grants	$11.4	$22.4	$30.4	$30.4	$30.0	**$124.6**
Total Funding Requirement	**$11.4**	**$22.4**	**$30.4**	**$30.4**	**$30.0**	**$124.6**

APPENDIX III(m)

MRT Reinvestment Program: MRT & Waiver Evaluation Program

MRT 1115 Waiver Amendment

($ Millions)

Initiative	2013	2014	2015	2016	2017	Five Year Reinvestment Total
1) MRT Evaluation (Projects Initiated in MRT)	$35.0	$55.0	$55.0	$45.0	$0.0	**$190.0**
2) MRT New Waiver Project Evaluation	$0.0	$50.0	$75.0	$75.0	$45.0	**$245.0**
3) MRT Waiver Project Management	$4.0	$8.0	$9.0	$9.0	$10.0	**$40.0**
4) MRT Consumer Education	$5.0	$5.0	$5.0	$5.0	$5.0	**$25.0**
Total Funding Requirement	**$44.0**	**$118.0**	**$144.0**	**$134.0**	**$60.0**	**$500.0**

APPENDIX IV
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2017

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$11,197,206,500	$6,105,699,488	$6,123,530,693	$13,426,169,462	$14,838,728,535	$7,942,549,075	$59,633,883,752
Demonstration Group 2 - TANF Adults 21-64		$4,511,421,595	$2,467,348,368	$2,454,367,076	$5,370,065,165	$5,929,497,585	$3,168,028,125	$23,900,727,913
Demonstration Group 6 - FHP Adults w/Children		$1,878,516,641	$1,043,047,420	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$9,674,942,501
Demonstration Group 8 - Family Planning Expansion				$5,140,241	$10,702,271	$11,139,306	$5,795,793	$32,777,610
Demonstration Group 9 - Duals 18-64					$256,709,619	$1,106,156,119	$290,806,439	$1,653,672,177
Demonstration Group 10 - Duals 65+					$2,598,007,202	$11,194,807,506	$2,943,089,849	$16,735,904,557
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$24,002,721,173**	**$35,712,566,663**	**$15,074,927,323**	**$111,631,908,510**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Projected	DY 13B (4/1/11-9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	DY 15 (10/1/12-9/30/13) Projected	DY 16 (10/1/13-12/31/13) Projected	BIPA Extension (10/1/09 - 12/31/13) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$5,006,727,158	$2,714,708,527	$2,722,636,616	$5,935,822,630	$6,523,312,850	$3,471,965,618	$26,375,173,399
Demonstration Group 2 - TANF Adults 21-64		$2,891,489,419	$1,575,447,496	$1,567,158,701	$3,416,017,313	$3,757,736,011	$2,000,129,300	$15,207,978,241
Demonstration Group 5 - Safety Net Adults		$5,947,064,577	$3,499,710,446	$3,596,498,109	$8,302,164,325	$9,567,591,719	$2,581,892,316	$33,494,921,492
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$910,895,137	$503,870,306	$509,844,937	$1,126,650,488	$1,262,025,032	$346,136,227	$4,659,422,127
Demonstration Group 7 - FHP Adults without Children up to 100%		$327,279,755	$168,015,728	$171,374,962	$383,180,812	$435,967,331	$120,734,643	$1,606,553,232
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$9,839,735	$4,164,485	$5,460,394	$11,576,340	$12,272,547	$6,504,704	$49,818,205
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	$3,699,108	$3,699,108	$3,699,108	$924,777	$12,022,101
Demonstration Group 9 - Duals 18-64					$249,276,515	$999,765,437	$249,927,129	$1,498,969,081
Demonstration Group 10 - Duals 65+					$2,561,508,288	$10,403,512,554	$2,629,869,736	$15,594,890,578
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)				$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)				$2,600,000	$14,650,000	$13,700,000	$3,400,000	$34,350,000
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)				$0	$133,400,000	$133,300,000	$33,300,000	$300,000,000
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)				$0	$5,000,000	$6,700,000	$1,600,000	$13,300,000
Demonstration Population 5: Designated State Health Programs (Various)						$1,292,500,000	$430,830,000	$1,723,330,000
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**	**$34,425,782,590**	**$11,880,614,449**	**$100,605,078,455**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,845,125,352**	**$1,286,784,073**	**$3,194,312,873**	**$11,026,830,055**

APPENDIX IV
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2017

Budget Neutrality Cap (Without Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$7,942,549,075	$16,933,174,020	$18,050,499,494	$19,232,176,099	$5,125,211,985	$67,283,610,673	
Demonstration Group 2 - TANF Adults 21-64	$3,168,028,125	$6,741,421,613	$7,172,746,363	$7,627,222,122	$2,028,764,816	$26,738,183,038	
Demonstration Group 6 - FHP Adults w/Children	$2,234,949,343	$3,314,166,058	$3,635,350,488	$3,976,371,601	$1,076,110,681	$14,236,948,171	
Demonstration Group 8 - Family Planning Expansion	$0	$0	$0	$0	$0	$0	
Demonstration Group 9 - Duals 18-64	$873,547,664	$1,225,692,908	$1,290,477,967	$1,357,731,985	$356,689,049	$5,104,139,573	
Demonstration Group 10 - Duals 65+	$8,840,665,721	$12,404,456,970	$13,060,120,982	$13,740,786,870	$3,609,836,937	$51,655,867,480	
W/O Waiver Total	**$23,059,739,928**	**$40,618,911,569**	**$43,209,195,293**	**$45,934,288,676**	**$12,196,613,468**	**$165,018,748,935**	**$464,041,232,585**

Budget Neutrality Cap (With Waiver)	DY 17 (1/1/14-9/30/14) Projected	DY 18 (10/1/14-9/30/15) Projected	DY 19 (10/1/15-9/30/16) Projected	DY 20 (10/1/16-9/30/17) Projected	DY 21 (10/1/17-12/31/17) Projected	DY 17-21 (1/1/14-12/31/17) Projected	DY 1 - 21 (10/1/97 - 12/31/17) Projected
Demostration Group 1 - TANF Children under age 1 through 20	$3,471,965,618	$7,360,506,306	$7,802,052,783	$8,266,040,188	$2,190,435,026	$29,090,999,921	
Demonstration Group 2 - TANF Adults 21-64	$2,000,129,300	$4,240,216,438	$4,494,541,044	$4,761,341,745	$1,261,708,922	$16,757,937,450	
Demonstration Group 5 - Safety Net Adults	$7,745,676,947	$11,050,525,928	$11,824,090,420	$12,651,822,218	$3,384,369,363	$46,656,484,875	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$1,067,533,772	$1,577,088,330	$1,723,450,041	$1,878,042,135	$506,338,494	$6,752,452,771	
Demonstration Group 7 - FHP Adults without Children up to 100%	$375,291,167	$561,405,772	$618,804,409	$679,603,143	$184,121,396	$2,419,225,887	
Demonstration Group 7A - FHP Adults without Children @ 160%	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion						$0	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)						$0	
Demonstration Group 9 - Duals 18-64	$747,134,811	$1,036,369,614	$1,059,388,516	$1,091,815,996	$286,255,977	$4,220,964,914	
Demonstration Group 10 - Duals 65+	$7,870,012,341	$10,965,561,955	$11,326,099,635	$11,793,622,604	$3,112,238,924	$45,067,535,458	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						$0	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						$0	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						$0	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						$0	
Demonstration Population 5: Designated State Health Programs (Various)	$1,617,530,000	$2,185,420,000	$2,114,700,000	$1,899,750,000	$459,260,000	$8,276,660,000	
With Waiver Total	**$24,895,273,956**	**$38,977,094,342**	**$40,963,126,849**	**$43,022,038,029**	**$11,384,728,101**	**$159,242,261,276**	**$417,477,289,377**
Expenditures (Over)/Under Cap	**($1,835,534,027)**	**$1,641,817,227**	**$2,246,068,445**	**$2,912,250,648**	**$811,885,367**	**$5,776,487,659**	**$46,563,943,208**

APPENDIX IV(a)
New York State Partnership Plan
PMPM's and Member Months

WITHOUT WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	$585.99	$624.67	$624.67	$665.90	$709.85	$756.70	$756.70	$806.64	$859.88	$916.63	$977.13
TANF Adults	$801.34	$852.63	$852.63	$907.20	$965.26	$1,027.04	$1,027.04	$1,092.77	$1,162.71	$1,237.12	$1,316.30
FHPlus Adults with Children	$625.55	$665.59	$665.59	$708.19	$753.51	$801.73	$801.73	$853.04	$907.63	$965.72	$1,027.53
Family Planning Expansion			$20.23	$21.06	$21.92	$22.81					
Duals 18-64				$4,160.34	$4,368.36	$4,586.78	$4,586.78	$4,816.12	$5,056.93	$5,309.78	$5,575.27
Duals 65+				$4,823.46	$5,064.63	$5,317.86	$5,317.86	$5,583.75	$5,862.94	$6,156.09	$6,463.89

WITH WAIVER PMPMS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	$262.02	$277.74	$277.74	$294.40	$312.06	$330.78	$330.78	$350.63	$371.67	$393.97	$417.61
TANF Adults	$513.60	$544.42	$544.42	$577.09	$611.72	$648.42	$648.42	$687.33	$728.57	$772.28	$818.62
SN - Adults	$797.09	$852.89	$852.89	$912.59	$976.47	$1,044.82	$1,044.82	$1,117.96	$1,196.22	$1,279.96	$1,369.56
FHPlus Adults with Children	$303.33	$321.53	$321.53	$340.82	$361.27	$382.95	$382.95	$405.93	$430.29	$456.11	$483.48
FHPlus Adults without Children	$367.84	$389.91	$389.91	$413.30	$438.10	$464.39	$464.39	$492.25	$521.79	$553.10	$586.29
Family Planning Expansion	$20.27	$16.39	$21.49	$22.78	$24.15	$25.60					
Duals 18-64				$4,039.88	$3,948.21	$3,942.01	$3,923.02	$4,072.21	$4,151.37	$4,269.84	$4,474.36
Duals 65+				$4,755.70	$4,706.64	$4,751.90	$4,733.99	$4,936.04	$5,084.50	$5,283.73	$5,572.88

MEMBER MONTHS

	DY12 2009-2010	DY13 2010-2011 (2 Qtrs	DY13 2010-2011 (2 Qtrs	DY14 2011-2012	DY15 2012-2013	DY16 2013-2014 (1 Qtr/2 Qtr)	DY17 2013-2014 (3 Qtr/2 Qtr)	DY18 2014-2015	DY19 2015-2016	DY20 2016-2017	DY21 2017 (1 Qtr)
TANF Kids	19,108,187	9,774,280	9,802,825	20,162,441	20,904,034	10,496,299	10,496,299	20,992,232	20,991,882	20,981,395	5,245,169
TANF Adults	5,629,847	2,893,809	2,878,584	5,919,384	6,142,902	3,084,620	3,084,620	6,169,113	6,168,990	6,165,305	1,541,263
SN Adults	7,460,970	4,103,355	4,216,837	9,097,365	9,798,142	2,471,136	7,413,408	9,884,545	9,884,545	9,884,545	2,471,136
FHPlus Adults with Children	3,002,984	1,567,102	1,585,684	3,305,705	3,493,301	903,868	2,787,658	3,885,124	4,005,322	4,117,520	1,047,279
FHPlus Adults without Children	889,734	430,909	439,524	927,125	995,132	259,985	808,138	1,140,489	1,185,926	1,228,717	314,045
Family Planning Expansion	485,446	254,090	254,090	508,180	508,180	254,090					
Duals 18-64				61,704	253,220	63,401	190,449	254,498	255,190	255,704	63,977
Duals 65+				538,619	2,210,390	553,435	1,662,448	2,221,528	2,227,572	2,232,064	558,462

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Access to Care/Utilization	Percent of Medicaid enrollees and/or uninsured with access to primary care	✓				✓	✓			✓			✓
	Primary care & behavioral health ambulatory capacity	✓				✓	✓						
	Percent of persons assigned to a PCMH	✓				✓	✓						
	Percent of persons with a visit to a PCMH	✓				✓	✓						
	Percent of persons in health homes	✓	✓			✓							
	Number of acute care inpatient beds in each region									✓			
	Nursing home admission rate per 1000 member months							✓					
	Number of nursing homes in plan network							✓					
	Number of newly contracted ALP slots/region							✓					
	Number of ALP beds per region							✓					
	Number of ALPs per plan network							✓					
	ALP utilization vs. nursing home utilization within plan (recipient count, LOS, case mix)							✓					
	Referral rate by type of service (information and referral, assistance)							✓					
	Utilization by category of service plan (pre and post enrollment)							✓					

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Quality of Care	MRT chronic measures (diabetes,hypertension, asthma, HIV)	✓	✓			✓	✓					✓	
	MRT measures of follow-up after mental and substance abuse hospitalization	✓	✓			✓							
	Initiation of substance abuse treatment & engagement	✓	✓		✓	✓	✓						
	Mental health and substance abuse outpatient follow-up	✓	✓		✓	✓							
	Average hospital length of stay overall and/or for select DRGs		✓		✓	✓				✓			
	Comprehensive assessment & care plan upon enrollment		✓										
	Number of interventions conducted by care manager/care management team		✓										
	MRT preventive measures (women/children, prenatal, oral)	✓	✓							✓		✓	✓
	MRT counseling measures (tobacco, alcohol, weight)	✓	✓										
	MRT measures (flu shots, fall prevention pain, injury prevention)							✓					
	Utilization within MLTC plans by category of service pre and post enrollment							✓					
	Number of persons selecting consumer directed services versus plan care manager							✓					
	Number and type of complaints by plan							✓					

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Potentially Preventable Events	Potentially avoidable ER visits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Potentially preventable hospitalizations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Potentially preventable hospital readmissions		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
	ER visits & inpatient stays by age	✓	✓	✓		✓	✓		✓				
Patient Perspective	Patient safety indicators		✓	✓	✓	✓	✓					✓	
	Patient satisfaction	✓	✓	✓		✓	✓	✓		✓			
	Getting care quickly	✓	✓	✓		✓	✓						
	Getting necessary care	✓	✓	✓		✓	✓						
	Care coordination	✓	✓	✓						✓			✓
Cost/Financial Stability	Per member per year health care costs	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓
	Operating margins				✓				✓				
	Days of cash on hand				✓				✓				
	Age of physical plant				✓				✓				
	Debt to capitalization								✓				
	Net assets								✓				
	SN hospitals affiliated with academic medical centers								✓				
	Current assets/current liabilities								✓				
	Level of debt of nursing home (debt/asset, debt/equity)							✓					
	Hospital liquidity ratio									✓			

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Operational	Implementation timelines/budgets				✓								
	Regional/community alignments				✓	✓	✓						✓
Disparities	Rates of measures by racial/ethnic group and other sociodemographic factors	✓	✓	✓		✓	✓				✓		✓
Healthcare Workforce - Underserved Communities	Health care workers completing training							✓			✓		
	Training and retraining programs for healthcare workers by facility							✓			✓		
	Graduating under represented in medicine students entering a health profession school or health related career										✓		
	Medically underserved communities & respective populations										✓		
	Physicians/dentists/mental health clinicians (FTEs) providing services in underserved communities										✓		
	Health care facilities in underserved communities										✓		
	Providers specializing in underserved communities										✓		
	Newly trained physicians practicing in underserved communities										✓		

Appendix V
Performance Measure Metrics

Evaluation Domain	Measure	(1) Primary Care Expansion	(2) Health Home Development	(3) New Care Models	(4) Expand Vital Access Program/ Safety Net Provider Program	(5) Public Hospital Innovation: New Models of Care for the Uninsured	(6) Medicaid Supportive Housing Expansion	(7) Managed Long Term Care Preparation Program	(8) Capital Stabilization for Safety Net Hospitals	(9) Hospital Transition	(10) Workforce Training	(11) Public Health Innovation	(12) Regional Health Planning
Public Health	Birth and prenatal outcome measures (percent of women diagnosed with pregnancy induced hypertension, reduction in preterm delivery for women who smoke, longer mean birth interval between first and second births, initiation and adherence rates for contraceptives)											✓	
	Lead measures (children exposed/tested/re-tested, identified with blood levels above 10 or 15 mcg/dL, referrals for care/treatment, housing units inspected for Medicaid eligible children with an elevated blood lead level)											✓	
	Diabetes prevention program measures (session attendance, physical activity, weight loss, health status)											✓	
	Water fluoridation measures (communities upgrading/installing equipment, fluoride levels, persons served, Medicaid claims reduction for dental caries)											✓	

Appendix VI

PUBLIC NOTICE: Published in June 20, 2012 New York State Register

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Department of Health

Pursuant to 31 CFR Section 431.408 the Department of Health hereby gives notice of the following:

New York State will request a waiver amendment from the federal government that will allow the state to invest up to $10 billion in savings generated by the Medicaid Redesign Team (MRT) reforms to implement an action plan to transform the state's health care system. The Medicaid 1115 waiver will enable New York to fully implement the MRT action plan, reinvest in the state's health care infrastructure, and lower costs over the long term. New York State will request that the federal government allow the state to reinvest over a five-year period up to $10 billion of the $17.1 billion in federal savings generated by MRT reforms.

Significant federal savings have already been realized through New York's MRT process and substantial savings will also accrue as part of this action plan. The waiver will also allow the state to prepare for implementation of national health care reform as well as effectively bend the cost curve for the state's overall health care system. The MRT action plan and the ACA if implemented in tandem could lead to sweeping changes in health care delivery that will benefit the state's 19 million residents.

New York will pursue an amendment to the state's existing 1115 waiver, the New York Partnership Plan, which has been the primary vehicle used by the state to expand access to managed care. Amending this waiver to facilitate MRT implementation makes sense since the move to ''care management for all'' is a vital part of the multi-year action plan. The Partnership Plan waiver also has substantial remaining budget neutrality capacity which will be further augmented by the MRT action plan.

The MRT waiver will be restricted to the portion of the Medicaid program controlled by the Department of Health. Specifically excluded from this 1115 waiver are those Medicaid services provided through waivers administered by the Office for People with Developmental Disabilities (OPWDD). The state is currently pursuing a different waiver agreement that will encompass services/waivers that relate to people with developmental disabilities. Both this waiver and the OPWDD waiver are consistent in their approaches to cost containment and in their commitment to improving outcomes. In particular, both waivers will rely on care management as the primary method for driving change and innovation. Due to the complexity of the OPWDD system in New York, the state believes that these two issues should be addressed separately.

The primary way to improve patient outcomes and lower costs is effective care management. The MRT recommended the state phase-out the uncoordinated FFS program and replace it with a new system of care management for all. This will eventually provide fully-integrated managed care for all Medicaid members. It will take New York State between three to five years to fully implement the state's care management vision.

The state's vision for a new MRT waiver is to utilize reinvested federal dollars that will both prepare the state for the Affordable Care Act (ACA) as well as maximize the value of key ACA provisions. In particular, New York's fragile health care safety net must be modernized and primary care access must be expanded in order to prepare for new enrollees. New York's vision for both Medicaid reform and ACA implementation is well summarized by the CMS Triple Aim. Health care reform must be about improving quality, improving health and reducing per capita costs. The MRT waiver will allow New York State to address all three goals in a coordinated fashion while also fulfilling the promise laid out in the ACA.

Areas of focus in the waiver amendment application would include: Primary Care Expansion, Health Home Development, New Care Models, Expand Vital Access Program/Safety Net Provider Program, Public Hospital Innovation: New Models of Care for the Uninsured, Medicaid Supportive Housing Expansion, Managed Long Term Care Preparation Program, Capital Stabilization for Safety Net Hospitals, Hospital Transition, Workforce Training, Public Health Innovation, Regional Health Planning, and MRT and Waiver Implementation Program.

New York is committed to slowing the rate of growth in Medicaid spending and that commitment will ensure that cost neutrality is maintained. The state's budget neutrality argument will be linked to the state's new Medicaid Global Spending Cap which is already working to control cost growth despite sharp enrollment growth.

The public is invited to review and comment on the state's proposed waiver amendment application. Public hearings were scheduled for:

Tuesday, June 12, Syracuse, NY, 1:00 PM – 4:00 PM.

Wednesday, June 13, Buffalo, NY, 1:30 – 4:30 PM.

Monday, June 18, Bronx, NY, 12:30 – 3:30 PM.

Wednesday, June 20, Rennselaer, NY, 1:00 – 4:00 PM.

Details on the waiver amendment proposal, full public notice, and more information on the state's public engagement process including hearings, topic-specific webinars, and other ways to provide comment, are available at the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm.

Comments (including comments sought through the public engagement process) concerning the state's plan to submit a waiver amendment will be through the above website and at the postal and email ad-

dresses below for a period of thirty (30) days from the date of this notice.

Additionally, the public is invited to sign up for an email list serve which will provide updates throughout the waiver public engagement and application process at http://www.health.ny.gov/health__care/medicaid/redesign/listserv.htm.

For further information, contact: Department of Health, MRT Waiver Team, Office of Health Insurance Programs, OCP-1211, Corning Tower, Albany, NY 12237, e-mail: mrtwaiver@health.state.ny.us

PUBLIC NOTICE

Office of Mental Health

As a result of the 2012-13 Enacted State Budget, the New York State Office of Mental Health hereby gives notice that it is proposing to amend its Medicaid State Plan to reflect the continuation of the 2011 rates for the 2013 rate year for private psychiatric hospitals, effective January 1, 2013.

PUBLIC NOTICE

Department of State
F-2012-0042
Date of Issuance – June 20, 2012

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2012-0042, The Castaways Yacht Club, New Rochelle, NY, is proposing to perform maintenance dredging of the existing marina facility within New Rochelle Creek, with subsequent un-confined and/or confined disposal of approximately 12,400 cubic yards of dredged material at the Western Long Island Sound Disposal Site (WLIS) and/or Central Long Island Sound Disposal Site (CLIS). The WLIS is located within Long Island Sound, approximately 2.8 nautical miles south of Long Neck Point, Noroton, CT and the CLIS is located within Long Island Sound, approximately 5.6 nautical miles south of East Haven, CT.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, by Thursday, July 5, 2012.

Comments should be addressed to the New York State Department of State, Division of Coastal Resources, ATTN: Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Avenue, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464. Comments can also be submitted electronically via e-mail at: LINK"mailto:CR@dos.ny.gov"CR@dos.ny.gov.

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE

Department of State

A meeting of the NYS Hearing Aid Dispensing Advisory Board will be held on Tuesday, June 26, 2012 at 10:30 a.m. at the New York State Department of State, 99 Washington Avenue, 5th Floor Conference Room, Albany, NY.

Should you require further information, please contact Carol Fansler at Carol.Fanslera@dos.ny.gov or 518-486-3857.

PUBLIC NOTICE

Susquehanna River Basin Commission
Projects Approved for Consumptive Uses of Water

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in ''DATES.''

DATE: April 1, 2012, through April 30, 2012.

ADDRESS: Susquehanna River Basin Commission, 1721 North Front Street, Harrisburg, PA 17102-2391.

FOR FURTHER INFORMATION CONTACT: Richard A. Cairo, General Counsel, telephone: (717) 238-0423, ext. 306; fax: (717) 238-2436; e-mail: rcairo@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR § 806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR § 806.22(f):

1. SWEPI, LP, Pad ID: Shedd 514, ABR-201204001, Rutland Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 11, 2012.

2. Chief Oil & Gas LLC, Pad ID: Leh Drilling Pad #1, ABR-201204002, Burlington Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

3. Chief Oil & Gas LLC, Pad ID: Yanavitch Drilling Pad #1, ABR-201204003, Stevens Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

4. Chief Oil & Gas LLC, Pad ID: D & J Farms Drilling Pad #1, ABR-201204004, Sheshequin Township, Bradford County, Pa.; Consumptive Use of Up to 2.000 mgd; Approval Date: April 11, 2012.

5. EXCO Resources (PA), Inc., Pad ID: Murray Unit Pad, ABR-201204005, Penn Township, Lycoming County, Pa.; Consumptive Use of Up to 8.000 mgd; Approval Date: April 11, 2012.

6. Chesapeake Appalachia, LLC, Pad ID: Maurice, ABR-201204006, Herrick Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 18, 2012.

7. SWEPI, LP, Pad ID: Owlett 843R, ABR-201204007, Middlebury Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 23, 2012.

8. SWEPI, LP, Pad ID: Hepler 235, ABR-201204008, Sullivan Township, Tioga County, Pa.; Consumptive Use of Up to 4.000 mgd; Approval Date: April 23, 2012.

9. Chesapeake Appalachia, LLC, Pad ID: Manning, ABR-201204009, Cherry Township, Sullivan County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 23, 2012.

10. EQT Production Co., Pad ID: Phoenix N (ANT6), ABR-201204010, Duncan Township, Tioga County, Pa.; Consumptive Use of Up to 3.000 mgd; Approval Date: April 27, 2012.

11. Chesapeake Appalachia, LLC, Pad ID: Simplex, ABR-201204011, Standing Stone Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 27, 2012.

12. Southwestern Energy Production Company, Pad ID: Claytor Pad, ABR-201204012, New Milford and Great Bend Townships, Susquehanna County, Pa.; Consumptive Use of Up to 4.999 mgd; Approval Date: April 27, 2012.

13. Southwestern Energy Production Company, Pad ID: Charles Pad, ABR-201204013, Jackson Township, Susquehanna County, Pa.; Consumptive Use of Up to 4.999 mgd; Approval Date: April 27, 2012.

14. Chesapeake Appalachia, LLC, Pad ID: Freed, ABR-201204014, Albany Township, Bradford County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 30, 2012.

15. Chesapeake Appalachia, LLC, Pad ID: Reilly, ABR-201204015, Colley Township, Sullivan County, Pa.; Consumptive Use of Up to 7.500 mgd; Approval Date: April 30, 2012.

16. Southwestern Energy Production Company, Pad ID: Conigliaro Pad, ABR-201204016, New Milford Township, Susquehanna County,