

**NEW YORK Section 1115 DEMONSTRATION
FACT SHEET**

Name of Section 1115 Demonstration: **Partnership Plan**

Date Proposal Submitted: March 20, 1995
Date Proposal Approved: July 15, 1997
Date Implemented: October 1, 1997 (in phases)
Date Expires: September 30, 2015 (on temp extension)

Number of Amendments: **14**

SUMMARY

The state’s goal in implementing the Partnership Plan section 1115(a) demonstration is to improve access to health services and outcomes for low-income New Yorkers by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding access to family planning services; and
- Expanding coverage with resources generated through managed care efficiencies to additional low-income New Yorkers.

The demonstration is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. It was approved in 1997 to enroll most Medicaid recipients into managed care organizations (MCOs) (Medicaid managed care program). As part of the demonstration’s renewal in 2006, authority to require some disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP). Effective April 1, 2014, this authority was restored to this demonstration as F-SHRP was phased out.

In 2001 the Family Health Plus (FHPlus) program was implemented as an amendment to the demonstration, providing comprehensive health coverage to low-income uninsured adults, with and without dependent children, who have income greater than Medicaid state plan eligibility standards. FHPlus was further amended in 2007 to implement an employer-sponsored health insurance (ESHI) component. Individuals eligible for FHPlus who have access to cost-effective ESHI are required to enroll in that coverage, with FHPlus providing any wrap-around services necessary to ensure that enrollees get all FHPlus benefits. FHPlus expires on December 31, 2013 and became a state-only program, but federal matching funding for state expenditures for FHPlus continued to be available as a designated state health program through December 31, 2014.

In 2002 the demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services were provided to women losing

Medicaid eligibility and to certain other adults of childbearing age (family planning expansion program). The family planning expansion program expired on December 31, 2013 and became a state plan benefit.

In 2010 the Home and Community Based Services Expansion program (HCBS expansion program) was added to the demonstration. It provides cost-effective home and community based services to certain adults with significant medical needs as an alternative to institutional care in a nursing facility. The benefits and program structure mirrors those of existing section 1915(c) waiver programs, and strives to provide quality services for individuals in the community, ensure the well-being and safety of the participants and increase opportunities for self-advocacy and self-reliance.

As part of the 2011 extension, the state was authorized to develop and implement two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, provided funding and performance incentives to hospital teaching programs in order to improve the coordination, continuity and quality of care for individuals receiving primary care in outpatient hospital settings. By the end of the demonstration extension period, the hospital teaching programs which receive grants under the H-MH project should have received certification by the National Committee for Quality Assurance as patient-centered medical homes and implemented additional improvements in patient safety and quality outcomes. The demonstration ended on December 31, 2014.

The second 2011 initiative was intended to reduce the rate of preventable readmissions within the Medicaid population, with the related longer-term goal of developing reimbursement policies that provide incentives to help people stay out of the hospital. Under the Potentially Preventable Readmissions (PPR) project, the state will provide funding, on a competitive basis, to hospitals and/or collaborations or hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of PPRs for the Medicaid population. Projects will target readmissions related to both medical and behavioral health conditions. This demonstration, however, was never implemented.

Finally, in 2011 CMS began providing matching funding for the state's program to address clinic uncompensated care through its Indigent Care Pool. Prior to this extension period, the state funded (with state dollars only) this program which provides formula-based grants to voluntary, non-profit and publicly-sponsored Diagnostic and Treatment Centers (D&TCs) for services delivered to the uninsured throughout the state. This pool expired on December 31, 2014.

In 2012, New York added to the demonstration an initiative to improve service delivery and coordination of long term care services and supports for individuals through a managed care model. Under the Managed Long Term Care (MLTC) program, eligible individuals in need of more than 120 days of community-based long term care are enrolled with managed care providers to receive long term services and supports as well as other ancillary services. Other covered services are available on a fee-for-service basis to the extent that New York has not

exercised its option to include the individual in the Mainstream Medicaid Managed Care Program (MMMC). Enrollment in MLTC was phased in geographically and by group.

The state's goal specific to managed long term care (MLTC) are as follows:

- Expanding access to managed long term care for Medicaid enrollees who are in need of long term services and supports (LTSS);
- Improving patient safety and quality of care for enrollees in MLTC plans;
- Reduce preventable inpatient and nursing home admissions; and
- Improve satisfaction, safety and quality of life.

In April 2013 New York had three amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment, the Long Term Home Health Care Program (LTHHCP) participants began transitioning, on a geographic basis, from New York's 1915(c) waiver into the 1115 demonstration and into managed care. Second, this amendment eliminated the exclusion from MMMC of, both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Additionally the April 2013 amendment approved expenditure authority for New York to claim FFP for expenditures made for certain designated state health program beginning April 1, 2013 through March 31, 2014. During this period, the state was also required to submit several deliverables to demonstrate that the state was successful in its efforts to transform its health system for individuals with developmental disabilities.

A December 2013 amendment was approved to ensure that the demonstration made changes that were necessary in order to coordinate its programs with the Medicaid expansion and other changes made under the Affordable Care Act (ACA) implementation beginning January 1, 2014.

Effective April 1, 2014 CMS approved an amendment to extend several authorities that expired in calendar year 2014. As part of the amendment CMS extended authorities related to the transitioning of parents into state plan coverage and other authorities that provide administrative ease to the state's programs and continuing to provide services to vulnerable population, i.e. HCBS Expansion program and individuals moved from institutional settings into community based settings.

Also effective April 1, 2014, the Federal-State Health Reform Partnership (F-SHRP) demonstration phased out and populations receiving managed care of managed long term care in the 14 counties that encompassed the F-SHRP demonstration were moved into the Partnership Plan demonstration.

The amendment approved on April 14, 2014 allows New York to take the first steps toward a major delivery system reform to be supported by a Delivery System Reform Incentive Payment (DSRIP) program. CMS and New York reached agreement on the basic structure of Medicaid funding for New York State's longer-term transformation efforts, which aim to

significantly improve care, change how public and safety net providers are organized, and reform how Medicaid pays for health services. This amendment to the Partnership Plan demonstration provided for an Interim Access Assurance Fund (IAAF) to ensure that sufficient numbers and types of providers are available in the community to participate in the transformation activities contemplated by the DSRIP Program. The DSRIP program will incentivize providers through additional payments beginning with the 5-year renewal of the demonstration in 2015.

On December 31, 2014, CMS amended Partnership Plan to enable New York to extend long term nursing facility services to enrollees of New York's MMMC and MLTC populations, thereby removing patients in residential health care facilities (RHCF) at the time of enrollment into MMMC who are classified as permanent and recent residents of RHCF at time of enrollment into MLTC. As part of the agreement, the state also instituted an independent long term services and support (LTSS) assessment process via an enrollment broker and implemented its Independent Consumer Support Program in areas of the state where services and enrollment were being instituted. The demonstration was also temporarily extended until March 31, 2015.

On July 29, 2015 CMS approved New York's request to implement Health and Recovery Plans (HARPs) to integrate physical, behavioral health and HCBS for Medicaid enrollees with diagnosed severe mental illness (SMI) and/or substance use disorder (SUD) to receive services in their own homes and communities. Under the demonstration, HARPs are a separate coverage product that is targeted to Medicaid enrollees that meet need-based criteria for SMI and/or SUD established by the state. HIV SNP plans under MMMC will also offer BH HCBS services to eligible individuals meeting targeting, risk, and functional needs criteria. All MMMC plans will offer BH benefits in integrated plans including four new demonstration services.

The demonstration is also amended to effectuate eligibility flexibilities for the Adult Group, including allowing adults enrolled in TANF to be enrolled as a demonstration population, without a MAGI determination, extension of continuous eligibility for members of the Adult Group who turn 65 during their continuous eligibility period and temporary coverage for members of the Adult Group who are determined eligible to receive coverage through the Marketplace.

AMENDMENTS

Amendment #10

Provides authority to the state to require individuals who receive community-based long term care services in excess of 120 days enroll into managed care.

Date Amendment Submitted:	April 13, 2011
Date Amendment Approved:	August 31, 2012
Date Amendment Effective:	August 31, 2012

Amendment #11

Expands the managed long term care (MLTC) program under the demonstration, by authorizing mandatory Medicaid managed care enrollment for individuals who have been served in the state’s Long-Term Home Health Care Program, also known as the Lombardi Program, and adds medical social services and home delivered meals to the managed care benefit so that they continue to be available to this population. Allows mandatory enrollment into mainstream Medicaid managed care program (MMMC) for foster care children placed by the local Department of Social Services (DSS) and individuals who are eligible for Medicaid buy-in for the working disabled. Applies an enhanced income standard for individuals to make it easier for individuals who need nursing home level of care to remain in the community and receive services through the MLTC Program. In addition, the Partnership Plan demonstration is amended to provide expenditure authority for certain designated state health programs, which will allow the state receive federal matching dollars to support the state’s efforts to transform its developmental disability system. Federal matching dollars will be available during the period of April 1, 2013 through March 31, 2014 contingent upon the state meeting milestones outlined in the STCs.

Date Amendment Submitted: April 13, 2011 – Long Term Home Health Care Program
February 1, 2013 – Foster Care and Medicaid Buy-In for Working Disabled
March 15, 2013 – Health System Transformation for Developmentally Disabled

Date Amendment Approved: April 1, 2013

Date Amendment Effective: April 1, 2013

Amendment #12

Amends the demonstration to comply with Medicaid requirements under the Affordable Care Act (ACA). The FHPlus program is phased out and parents and childless adults with incomes up to 133 percent of the FPL are transitioned into full Medicaid coverage. Safety Net Adults are also transitioned into full Medicaid coverage under the state plan. FHPlus parents with incomes between 134 percent and 150 percent of the FPL are sent to the health

insurance marketplace and are enrolled into a premiums assistance program.

Date Amendment Submitted: July 19, 2013
September , 2013
October 9, 2013

Date Amendment Approved: December 31, 2013

Date Amendment Effective: January 1, 2014

Amendment #13

Amends the demonstration to allow the state to claim FFP for its delivery system reform efforts under its ongoing statewide Medicaid Redesign Team (MRT) initiatives. The state will receive FFP to assist in funding an Interim Access Assurance Fund to provide temporary funding to at-risk facilities in order to allow them to participate in long term delivery system reform efforts. The amendment also establishes a framework for a five year delivery system reform incentive payment (DSRIP) program, effective after the demonstration renewal, that will help the state fund a series of various projects approved by the state and administered by participating safety net providers statewide in order to effectuate health system transformation and overtime stabilize New York's health system.

Date Amendment Submitted: August 6, 2012

Date Amendment Approved: April 14, 2014

Date Amendment Effective: April 14, 2014

Amendment #14:

Amends the demonstration to effectuate several outstanding requests: 1) Allows a new waiver authority to allow the state to furnish HCBS services outside of the state plan as part of a new coverage product called Health and Recovery Plans (HARPs). 2) Temporarily allows expenditure authority to furnish members of the Adult Group who turn 65 during their continuous eligibility period a continuance of coverage for the remainder of their continuous eligibility period. 3) Temporarily furnishes coverage for individuals that are determined ineligible for Medicaid and sent to the Marketplace, but experience a one month coverage gap and 4) Temporarily extends the designated state health program that provides premium assistance to former demonstration-eligible adults that are sent to the Marketplace 5) Adds a new demonstration group for adults who receive

Temporary Assistance for Needy Families (TANF) to be seamlessly enrolled into Medicaid.

Date Amendment Submitted: December 30, 2013

July 19, 2014

Date Amendment Approved: July 29, 2015

Date Amendment Effective: July 29, 2015

ELIGIBILITY AND ENROLLMENT

Certain categories of individuals are excluded from the demonstration. These include:

- individuals receiving hospice care prior to managed care enrollment;
- individuals who are served through a Home and Community-Based Services waiver program;
- individuals who spend down and become eligible for the Medically Needy program;
- infants of incarcerated women;
- individuals expected to be eligible less than six months (e.g., seasonal agricultural workers); and
- individuals with access to cost-effective private health insurance.

Enrollment for some groups is voluntary.

New York has received Federal approval to continue its facilitated enrollment program. Under this program, health plans, community-based organizations and providers are permitted to:

- Conduct the face-to-face interview of potential beneficiaries required by New York State law;
- Review documentation needed for eligibility determination for CHIP and Medicaid;
- Assist the beneficiary in selecting a managed care organization; and
- Assist beneficiaries in maintaining eligibility by facilitating recertification for benefits.

Language in the Special Terms and Conditions governing the demonstration requires the state to closely monitor choice counseling activities to minimize adverse risk selection, and specifies that determinations of Medicaid eligibility are made solely by the local Departments of Social Services.

DELIVERY SYSTEM

The state directly contracts with commercial MCOs and state-certified Prepaid Health Services Plans (PHSPs) for the Partnership Plan. Capitated SNPs have been developed to serve individuals with HIV/AIDS who require intensive case-managed care regimens, and their

families. All beneficiaries in the demonstration must use providers within their managed care plan. The newest component of Partnership Plan implements Health and Recovery Plans, a separate line of business from the MCOs that provide mainstream managed care, but covering the same services as mainstream managed care and including an additional set of HCBS services for serious mental illness and/or substance use disorder.

BENEFITS

Managed care beneficiaries in the Partnership Plan, receive the same comprehensive benefits package available under the fee-for-service program. Certain services, such as pharmacy benefits, continue to be provided on a fee-for-service basis. Other services, such as transportation and dental care, may be provided on a fee-for-service basis or as part of the capitated managed care service package at county discretion.

The state also offers certain services on a fee-for-service wraparound basis to individuals who exceed a basic benefit threshold within their managed care plans. For example, individuals who exhaust their basic benefits as defined in the capitation rates are able to receive mental health inpatient and outpatient services, and medically necessary chemical dependency treatment services on a fee-for-service basis.

QUALITY AND EVALUATION PLAN

Under the demonstration, the state and contracting health plans are required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys and focused studies on significant health issues.

Quality monitoring consists of the following tools: Medicaid encounter data; Quality Assurance Reporting Requirements (QARR); member satisfaction surveys; and External Quality Reviews by IPRO.

COST SHARING

Medicaid state plan beneficiaries receiving benefits under the demonstration are exempt from cost-sharing.

ADDITIONAL AMENDMENTS

Amendment #1: The Family Health Plus program expands health insurance coverage to uninsured adults, whose income and/or assets exceed Medicaid eligibility requirements.

Date Amendment #1 Submitted: June 30, 2000
Date Amendment #1 Approved: June 29, 2001
Date Amendment #1 Effective: October 1, 2001

Amendment #2: The family planning expansion program provides family planning services only to certain men and women of childbearing age.

Date Amendment #2 Submitted: January 16, 2001
Date Amendment #2 Approved: September 27, 2002
Date Amendment #2 Effective: October 1, 2002

Amendment #3: Dual eligible beneficiaries in the Partnership Plan are permitted to enroll on a voluntary basis into one managed care plan for both Medicare and Medicaid services (a Medicaid MCO and a Medicare Advantage Plan).

Date Amendment #3 Submitted: April 20, 2004
Date Amendment #3 Approved: December 15, 2004
Date Amendment #3 Effective: January 1, 2005

Amendment #4: Revises conditions for Federal financial participation for the family planning expansion program by adding new service codes and procedures for which the state may receive enhanced Federal match. In addition, 45 new service codes and medications are approved at the state's regular FMAP rate.

Date Amendment #4 Submitted: June 28, 2007
Date Amendment #4 Approved: November 16, 2007
Date Amendment #4 Effective: November 16, 2007

Amendment #5: Provides authority for the state to enroll Family Health Plus-eligible individuals into employer-sponsored insurance if that coverage is more cost-effective than providing direct coverage under Family Health Plus. The state will "wrap-around" the employer benefit package to ensure that individuals have full access to Family Health Plus-equivalent benefits.

Date Amendment #5 Submitted: July 13, 2007
Date Amendment #5 Approved: December 31, 2007
Date Amendment #5 Effective: December 31, 2007

Amendment #6: This amendment contains several requests submitted on November 3, 2008, and on March 31, 2009:

- Individuals living with HIV/AIDS who can elect to enroll in an MCO would be required to enroll in either a mainstream MCO or an HIV Special Needs Plan.

- 12 months of continuous eligibility would be provided to all demonstration eligibles.
- Remove asset test from Family Health Plus eligibility criteria.
- Permit state and local government employees into Family Health Plus Premium Assistance.
- Permit managed care to expand without STC changes.
- Add new Family Planning codes

Date Amendment #6 Submitted: November 3, 2008
 Date Amendment #6 Approved: January 25, 2010
 Date Amendment #6 Effective: January 25, 2010

Amendment #7

Provides authority for the state to add the Home and Community-Based Services Expansion Program to the demonstration.

Date Amendment #7 Submitted: March 31, 2009
 Date Amendment #7 Approved: April 8, 2010
 Date Amendment #7 Effective: April 8, 2010

Amendment #8

Provides authority to the state to require mandatory managed care enrollment of populations that were previously exempt, or excluded from mandatory managed care.

Date Amendment Submitted: April 13, 2011
 Date Amendment Approved: September 30, 2011
 Date Amendment Effective: October 1, 2011

Amendment #9

Provides authority to the state to require mandatory managed care enrollment of populations that were previously exempt, or excluded from mandatory managed care.

Date Amendment Submitted: April 13, 2011
 Date Amendment Approved: March 30, 2012
 Date Amendment Effective: April 1, 2012

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