Application for Partnership Plan Waiver Extension

New York State Medicaid Section 1115 Demonstration

Project No. 11-W-00114/2

The Partnership Plan

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Section 1: Extension Request

New York is committed to ensuring that every Medicaid member has access to high quality, cost-effective health care that is effectively managed. The Medicaid Section 1115 Partnership Plan waiver program has been the primary vehicle used by New York State to achieve this goal. Operating since 1997, it is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. Since its inception, the Partnership Plan has been expanded to include new populations and services. Beginning in 2001 the Family Health Plus Program was added to extend health coverage to low income uninsured adults with and without dependent children and in 2002 Family Planning Expansion Program was added. Additional programs were added in 2010 to provide eligibility simplification and delivery systems enhancements. In 2011 Hospital Medical Home, the Potentially Preventable Readmissions Demonstration, Designated State Health Programs and the Indigent Care Pool were incorporated into the Medicaid Section 1115 Partnership Plan.

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York's 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period August 1, 2011 through December 31, 2014, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved two waiver amendments on September 30, 2011 and March 30, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team. New York State Department of Health (the Department) is currently in negotiations with CMS on two additional amendments, the Managed Long Term Care (MLTC) amendment and the Medicaid Redesign Team (MRT) amendment. This extension request includes no Demonstration amendment requests and requires no waiver or expenditure authorities other than those already contained in the Partnership Plan Demonstration.

The Department is working to reshape how health care is delivered and to lower Medicaid costs for the state's health care system. We anticipate that it will take New York State five years to fully implement the state's care management vision and build the infrastructure to support provisions of the ACA health care reforms. Generally, Demonstrations may be extended up to 3 years under sections 1115(a), 1115(e), and 1115(f) of the Social Security Act; however, section 1915(h), as amended by section 2601 of the Affordable Care Act, allows section 1115 demonstrations to be extended up to 5 years at the Secretary's discretion, if the demonstration provides medical assistance to dually eligible beneficiaries. Therefore, New York is requesting the Secretary to approve a five year extension in order to realize the full potential of the MRT amendment.

Section 2: Historical Narrative

The state's goal in implementing the Partnership Plan section 1115(f) Demonstration was 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 to additional low-income New Yorkers with resources generated through managed care efficiencies.

The Demonstration is designed 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 (Medicaid managed care program). As part of the Demonstration's renewal in 2006, authority to require the disabled and aged populations to enroll in mandatory managed care was transferred to a new demonstration, the Federal-State Health Reform Partnership (F-SHRP).

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 (see Attachment 2, ESHI Growth Chart). 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. The state later expanded Family Health Plus eligibility for low-income adults with children.

In 2002, the Demonstration was expanded to incorporate a family planning benefit under which family planning and family planning-related services are provided to women losing Medicaid eligibility and certain other adults (Family Planning Expansion Program).

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 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 to increase opportunities for self-advocacy and self-reliance.

In 2011, the state developed and implemented two new initiatives designed to improve the quality of care rendered to Partnership Plan recipients. The first, the Hospital-Medical Home (H-MH) project, which provides 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, will have received certification by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes (PCMHs) and implemented additional improvements in patient safety and quality outcomes.

The second initiative is 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 provides funding, on a competitive basis, to hospitals and/or collaborations of hospitals and other providers for the purpose of developing and implementing strategies to reduce the rate of PPRs for the Medicaid population. Projects target readmissions related to both medical and behavioral health conditions.

In addition, CMS is now providing funding for the state's program to address clinic uncompensated care through its Indigent Care Pool. Prior to the previous extension period, the state has 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.

In 2012, the Managed Long Term Care (MLTC) program is pending approval to be added to the Demonstration. It provides long term services and supports as well as other ancillary services to individuals in need of more than 120 days of community based long term care. The program operates both in a mandatory fashion for dual eligible individuals over 21 and a voluntary fashion for dual eligible individuals 18 – 21 and nursing home eligible non-dual individuals.

Section 3: Partnership Plan Successes

3.1 Expanding Medicaid Managed Care

New York began implementation of the Partnership Plan immediately after receiving federal approval with a geographic phase-in strategy starting with five upstate counties in October 1997. Mandatory Medicaid managed care began in New York City in August 1999. Today, New York has implemented mandatory Medicaid managed care programs in all but five upstate counties. By the end of 2012, all counties in New York State will be operating mandatory programs. Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 3.2 million as of July 2012.

The initial Partnership Plan was approved to enroll most Safety Net (SN) and Temporary Assistance to Needy Families (TANF) Medicaid beneficiaries into managed care. Effective October 1, 2006, mandatory managed care was expanded to Medicaid beneficiaries who qualify for the federal Supplemental Security Income (SSI) program or are certified as blind or disabled and to those who reside in 14 additional counties throughout the state which had not previously implemented mandatory programs. These populations were moved from the Partnership Plan to the Federal-State Health Reform (F-SHRP) waiver. As of July 2012, more

than 343,000 SSI and SSI-related individuals were enrolled in Medicaid managed care statewide, representing 79 percent of the total eligible to enroll.

Since the last extension request in 2009, the state has expanded Medicaid managed care enrollment on several fronts. Individuals living with HIV/AIDS were enrolled in New York City beginning in September 2010 and in the rest of the state starting October 2011. In 2010, New York was granted authority to expand mandatory enrollment to additional counties that meet the choice criteria established in federal law, without the need for a waiver amendment. This change facilitated the implementation of mandatory programs in 15 upstate counties between 2010 and the present, with the remaining five New York State counties scheduled to begin by the end of 2012.

In April 2011, New York submitted a request to amend the Partnership Plan to implement initiatives of the state's Medicaid Redesign Team (MRT), tasked with redesigning the provision of Medicaid services to contain costs, create efficiencies and improve the quality of care. Two major initiatives were contained in the amendment request – expanding mainstream Medicaid managed care enrollment to new, previously exempt and excluded populations and mandatorily enrolling eligible individuals into Managed Long Term Care programs.

On August 1, 2011, the state began enrolling individuals assigned to the Recipient Restriction Program, the first exempt/excluded population to be approved by CMS in a multi-year initiative that will virtually eliminate exemptions and exclusions by 2016. Adults with a Seriously and Persistently Mentally Ill (SPMI) diagnosis and children with a Seriously Emotionally Disturbed (SED) diagnosis, who were not designated as SSI or SSI-related, were enrolled starting September 2011. The homeless population was the next major population to be approved effective April 2012, with noticing and enrollment occurring on a phased-in basis in New York City throughout the summer. Other previously exempt or excluded populations enrolled since September 2011 include disabled and low birth weight babies, individuals with a diagnosis of End Stage Renal Disease (ESRD), individuals temporarily living outside their social services district, pregnant women in the care of a prenatal care provider who does not participate in any managed care plan, individuals who have a language barrier, individuals for whom a managed care provider is outside the travel time and distance standards and individuals placed in Office of Mental Health licensed family care homes.

3.2 Managed Long Term Care

New York State, through establishment of a Medicaid Review Team (MRT) consisting of stakeholders representing virtually every sector of the health care delivery system including consumers, has proposed sweeping health care reforms that will lead to improved health outcomes, as well as health care savings in years to come.

One such reform is directed to dual eligible Medicaid recipients, 21 years old and older, who are in need of home and community based care for more than 120 days. With CMS approval, New York State's approach will be two fold with respect to individuals presently receiving

community based long term care services and those new to the long term care system that will require services. This transition to a managed care model will facilitate:

- Increased access to managed long term care for Medicaid enrollees in need of long term services and supports;
- Improved patient safety and quality of care for consumers;
- Reduction of preventable acute hospital and nursing home admissions; and
- Improved satisfaction, safety and quality of life for consumers.

To achieve these objectives the state established, the Department has developed a Managed Long Term Care (MLTC) enrollment process. The enrollment process is comprised of two distinct elements focused on two target populations; the first population are individuals presently in receipt of community based long term care services and the second are individuals who will seek community based services in the future.

The first element of the enrollment plan is to transition current recipients of community long term care services to manage long term care plans. Home and community based services are defined as services and supports for adults and children of all ages and their families to enable them to remain at home or in community residential settings. In order to provide for an orderly transition, the state is initially targeting fee for service Personal Care Program recipients residing in New York City. The preference will be for recipients to make an informed choice of plan that best meets their needs. To support their choice, the Department will provide a strong information and support system through its Enrollment Broker. The Department will have the authority to assign persons who do not make a choice of plans into a managed long term care plan in New York City.

The second element is targeted at new recipients in need of community based long term care. This component will be implemented upon final written approval of the pending Partnership Plan Medicaid Section 1115 waiver MLTC amendment as well as the approval of a related amendment for the long term home health care program under 1915-c of the Social Security Act. This element will be implemented in local jurisdictions that have sufficient choice of managed long term care plans.

The enrollment process allows for a gradual transition of current recipients in long term care community based services into managed long term care plans based on areas of the state that have plan capacity. The first area targeted is New York City where between September 2012 and March 31, 2014 all personal care service program recipients will be transitioned to managed long term care. In addition, starting in January 2013, home health care over 120 days, adult day health care and Long Term Home Health Care Program participants will be transitioned.

Simultaneously, the Department intends to expand mandatory managed long term care across the state, as capacity allows:

- Nassau, Suffolk and Westchester counties in January 2012
- Rockland and Orange counties in June 2012

- Albany, Erie, Monroe and Onondaga counties in December 2013.
- Remaining counties that have sufficient capacity in June 2014.

Certain populations and programs, such as the Nursing Home Transition and Diversion (NHTD) waiver, the Traumatic Brain Injury (TBI) waiver and Assisted Living Program (ALP) participants, will be transitioned into the managed long term care plans. This transition will not occur until appropriate waiver services are incorporated into the managed long term care model.

3.3 Insuring More New Yorkers through Family Health Plus

In May 2001, CMS approved an amendment to the Medicaid Section 1115 Partnership Plan waiver to provide for implementation of Family Health Plus (FHPlus). Enacted by the state legislature in December 1999, FHPlus is a major Medicaid expansion that initially provided comprehensive health coverage to low-income uninsured adults, with and without children, who had income and/or assets greater than the Medicaid eligibility standards. As of January 2010, the state eliminated the resource test for FHPlus applicants. Under current eligibility criteria, parent(s) living with a child under the age of 21 are eligible if gross family income is up to 150% of the federal poverty level (FPL). Adults without dependent children in their households are eligible when their gross income is up to 100% of the FPL. In July 2011, CMS approved an amendment to the Partnership Plan that increased the income eligibility standard for adults with children to 160% FPL, but the state has postponed implementation in light of the Affordable Care Act. Today, FHPlus covers over 430,000 previously uninsured New Yorkers.

3.4 Partnering with Private Insurers

To increase coverage rates among uninsured but employed New York State residents with access to private insurance, state legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative. This initiative, called the FHPlus Premium Assistance Program (FHP PAP), allows individuals who are eligible for FHPlus and have access to cost effective Employer Sponsored Health Insurance (ESHI) to enroll in the employer sponsored health insurance. The state subsidizes the employee's share of the premium and reimburses any deductibles and co-payments in excess of the enrollee's co-payment obligations under FHPlus. FHPlus wrap-around benefits are provided to the extent such benefits are not covered by the enrollee's employer sponsored health plan. As of August 2012, four years after going into effect, approximately 3080 individuals are enrolled in this program.

Beginning in January 2014, no new applicants will be accepted into the FHP PAP and existing people will be re-evaluated at renewal as part of the transition to Modified Adjusted Gross Income (MAGI) under health care reform.

In July 2007, state legislation also created the Family Health Plus Buy-in Program which allows employers and Taft-Hartley plans to purchase FHPlus insurance coverage from participating health plans. Enrollment in the FHPlus Buy-in program began April 1, 2008, with Service Employees International Union (SEIU) 1199 home care union employees. Under this program, the state subsidized premiums for enrollees eligible for Medicaid, FHPlus or Child Health Plus

(CHPlus), the state's SCHIP program. For those not eligible for government programs, SEIU 1199 paid the full premium for the employees. When the SEIU withdrew from the program in November 2011, approximately 32,800 individuals were enrolled in the FHPlus Buy-in program through SEIU 1199. Of these, about 4,740 were enrolled in Medicaid managed care and FHPlus and were transferred, as appropriate, to the FHPlus Premium Assistance Program (FHPlus PAP) or to the regular Medicaid program with the state subsidizing the member contribution towards health insurance premiums. The balance of SEIU 1199 enrollees were non-subsidized and continue to have access to health insurance through the SEIU 1199.

In 2011, the United Federation of Teachers (UFT) partnered with Health Insurance Plan of Greater NY (HIP) to provide a FHPlus Buy-in program for its 25,000 child care workers in New York City. Enrollment of unsubsidized workers began in March 2012 and the subsidized members began in August 2012. Civil Service Employees Association (CSEA) is also interested in offering a FHPlus Buy-in program for its child care workers outside of New York City and is actively seeking a health plan to provide coverage. Fidelis Care (NYS Catholic Health Plan), present in almost every county in the state, is interested in partnering with CSEA and is pursuing a contract with U.S. Fire and Unified Life to provide family planning services. The employers and population who would qualify for this program will be transitioned into the exchange in 2014.

3.5 Expanding Access to Family Planning Services

The expected time line for the Family Planning Benefit Program (FPBP) to be moved into the State Plan is on November 1, 2012. Also, effective with the move to the State Plan, transportation will be added to the FPBP benefit package. The FPBP is a program for women and men who are not otherwise eligible for Medicaid but are in need of family planning services. The program is intended to increase access to family planning services and enable individuals to prevent or reduce the incidence of unintentional pregnancies. Once determined eligible, participants remain eligible for the program for 12 months, after which time recertification is required. Participation in the program has increased from 69,613 participants (59,794 women and 9,819 men) in 2008 to 80,441 (63,328 women and 17,113 men) in 2011. As the goal of the FPBP is to prevent unintended pregnancies, CMS measures program success in terms of the number of averted births. Using a methodology agreed on with CMS and using 2000 as the base year, the fertility rate for FPBP enrollees is 134.7 per thousand. Based on this fertility rate, there were 5,301 averted births in calendar year (CY) 2011.

Program policies, procedures and referral lists are in place to refer a FPBP member to primary care when family planning providers identify health care needs during a family planning visit. If a client is referred for non-family planning or emergency clinical care, the family planning agencies make the necessary arrangements and advise their patients on the importance of follow-up. Special follow-up procedures also exist for individuals with significant abnormal physical examination or laboratory test results, such as abnormal PAP tests and breast exams and diagnosed conditions such as hypertension. In 2006, the New York State Department of Health (the Department) and CMS worked together to improve the identification of family planning services using a list of CMS-approved procedure codes, which include family planning

related services (e.g., colposcopy) and follow-up visits and treatment for sexually transmitted diseases. In 2008, and again in 2010, additional CMS-approved procedure codes were added to the list of acceptable FPBP billing codes. Edits exist in the state's Medicaid Management Information System (MMIS) to ensure that only CMS-approved family planning procedures are claimed for enrollees having eligibility only under the FPBP. Additional edits ensure that the federal share is claimed appropriately (90% for some services and 50% for others) for FPBP procedures.

3.6 Increasing the Number of Health Care Providers Available to Beneficiaries

Through the Partnership Plan, the Department has greatly expanded access for Medicaid beneficiaries to appropriately credentialed physicians, nurse practitioners and physician extenders. As evidenced in the table below, the number of primary care and specialist physicians available to Medicaid beneficiaries is significantly greater in a managed care delivery system than in the state's current fee-for-service program.

Physician Participation in Medicaid, December 2010

Type of Care/Region	Participating in Fee-for-Service	Participating in Managed Care
Primary Care:		
New York City	5,271	11,117
Rest of State	5,684	9,151
Total	10,955	20,268
Specialty Care:		
New York City	11,436	20,743
Rest of State	9,156	16,524
Total	20,592	37,267

New York has a variety of mechanisms to assess the overall adequacy and capacity of Medicaid managed care plan networks. Provided to the Department quarterly, plan network submissions are reviewed to ensure plans have the appropriate provider types, comply with geographic, time and distance standards, and can support enrollment based on a standard of one primary care provider (PCP) for every 1,500 enrollees.

The provider network data is also periodically validated to ensure its accuracy. In general, audits consistently show a high degree of accuracy between what the health plans report and what health plan network physicians report as correct. For example, the most recent audit in the summer of 2010 found that provider identification variables including name, address, zip

code and license were correct at a very high level (>95%) and primary specialty was correct for 97% of PCPs and for 89% of specialists.

3.7 Hospital-Medical Home Demonstration

At the time of this extension application request of the Partnership Plan Medicaid Section 1115 waiver, the Department has done the following:

- Held meetings with representatives from the hospital associations, professional associations, and hospital and residency program administrators;
- Created an electronic application made up of both narrative and discrete searchable data element fields;
- Conducted a web conference and a teleconference to educate potential applicants in the use of the electronic application;
- Provided individual assistance through the application phase for potential applicants;
- Conducted a review of the applications; and
- Created multiple data summaries for current and future review and planning.

To date no funding allocations have been made, however, the Department is completing the review process and finalizing a funding allocation methodology for making awards. The Department plans to release awards in the late summer or early fall pending CMS approval. The Department is concurrently developing a standardized electronic work plan and template for tracking and reporting milestones and measures data for the prospective demonstration period. Submission of the work plan by awardees is set for fall 2012.

3.8 Potentially Preventable Readmissions Demonstration

The Department began the process of developing a Request for Applications (RFAs) for the Potentially Preventable Readmissions (PPR) Demonstration. While the implementation of this demonstration is compressed, the Department has developed an outline for the RFA and plans to begin the internal departmental approval process in the near future. Below is a proposed schedule of implementation based pm the requested extension.

Anticipated implementation schedule on PPR demonstration

Date	Action
2012	Begin the internal departmental approval process for an RFA and begin to develop the RFA documents
2013	Develop RFA materials and documents
2013	Announce RFA

3.9 Improving the Quality of Health Services Delivered

New York State remains dedicated to providing and maintaining the highest quality of care for enrollees in managed care plans. Improving the care provided to Medicaid recipients enrolled in managed care plans is a major accomplishment of the waiver. The plans participating under the Partnership Plan continue to demonstrate meaningful improvements across a wide range of quality and satisfaction measures, exceeding national benchmarks. This progress continues to be observed, despite the increasing number of chronically ill beneficiaries enrolled in Medicaid managed care.

Over the past 18 years, the capabilities of the Department's quality measurement and improvement systems have become more sophisticated and efficient. As a result, the Department is able to analyze the quality of care and member satisfaction of each plan certified to provide Medicaid coverage in New York State. The Department incorporates this information into the Medicaid Managed Care Regional Consumer Guides, which contain information about the quality of care offered by the different plans, member opinions about the care and services plans provide. These brochures assist Medicaid enrollees in making an informed decision on which plan to choose for their care. The Department also recently developed a Guide for Managed Long-Term Care (MLTC) enrollees to inform enrollees as the state phases in a mandatory MLTC program.

Assessing Quality of Care

Medicaid Managed Care

Overall, access and quality of care have improved over time, particularly with regard to weight assessment for children and adults, adolescent preventive care, prenatal care and follow-up after a hospitalization for mental illness. The 2011 National Committee on Quality Assurance's (NCQA) annual report, *The State of Health Care Quality,* indicates that New York's Medicaid managed care plans continue to exceed national benchmarks for preventive care and acute and chronic disease assessment and management. New York State Medicaid managed care plans exceeded national benchmarks in six domains of care: 1) Managing Acute Illness; 2) Chronic Illness; 3) Monitoring Medications; 4) Children's Preventive Health Services; 5) Women's Preventive Health Services; and, 6) Behavioral Health. Attachment 1 shows the 2010 Medicaid managed care performance results compared to national benchmarks.

HIV Special Needs Plan Quality of Care

In 2008, the Department incorporated a subset of measures from the HIV Special Needs Plans (SNPs) into the annual Quality Assurance Reporting Requirements (QARR). In 2010, the HIV SNPs were required to expand their reporting to include all QARR measures. The performance of the HIV SNPs for 2010 measurement year is in Attachment 1 (*italicized)*. Generally, results for the HIV SNPs were comparable to traditional Medicaid managed care plans; often exceeding managed care results for measures of chronic conditions.

Managed Long Term Care

In 2011, the Department issued a Managed Long Term Care (MLTC) Report on quality, satisfaction and utilization, available to MLTC plans. This report as well as regional consumer guides (NYC, Long Island, and Hudson Valley regions) will be available to the public in 2012. Performance of the managed long term care plans is evaluated through select process measures, such as annual flu shots, safety measures (e.g., percentage of enrollees who had falls), and measures of improvement in activities of daily living and cognitive functioning. The table below depicts the member quality and utilization results for MLTC members.

Snapshot of MLTC Member Quality and Utilization Results	
Select Quality and Utilization Measures	**Percentage of MLTC Membership Statewide**
Members who received an annual flu shot	72%
Members with one or more falls in the past six months	15%
Members who received emergent care in a hospital in the past six months	17%
Members with one hospital admission in a six month period	8%
Members with one nursing home admission in a six month period	2%
Members whose frequency of pain was stable or improved over a six or twelve month period	81%
Members whose overall functional ability was stable or improved over a six or twelve month period	90%

Care Management

In 2011, the Department collaborated with a subset of managed care plans that volunteered to participate on a collaborative work group to develop data collection measures for care management. As of 2010, Medicaid plans submit data on their care management programs, which allows for the development of process measures such as enrollment rates, number of interventions and duration of care management services. Since 2010, 200,000 plan members were identified as eligible for care management; 65,000 of those members actually participated in a care management program. Of those care management members, a decrease in inpatient and emergency room utilization in the 12 months following enrollment in care management was observed. However, utilization patterns varied by program; high risk obstetrics and oncology experienced minimal change in inpatient utilization, whereas behavioral health and adult chronic conditions experienced reductions in inpatient utilization. The programs with the

highest number of care management members were chronic conditions (adult) and high risk obstetrics.

Assessing Satisfaction with Care

To assess all dimensions of quality, the Department administers a biennial survey to measure member satisfaction, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Since 2000, adults and children enrolled in Medicaid managed care are surveyed using the CAHPS tool. In 2011, the Department piloted the CAHPS Clinician and Group survey in New York City. Adult Medicaid managed care and fee-for-service members with visits to one of ten selected large health centers in New York City were surveyed.

Medicaid Adults CAHPS Survey

For Medicaid adults, the CAHPS survey assesses plan members' experience accessing health care services, providers and the plan. The Department selects a sample of 1,500 adult members from each plan. Overall, adult members are largely satisfied with their experiences of care. Members living outside of New York City (ROS) tend to be more satisfied with their health care experiences than those living in New York City (NYC). The table below depicts the results of the survey for 2010 and 2012.

	2010			2012		
	NYC	**ROS**	**STW**	**NYC**	**ROS**	**STW**
Access to Care						
Getting Care Needed (Usually or Always)	69.4	78.3	73.9	72.0	77.2	74.8
Getting Care Quickly (Usually or Always)	70.7	82.8	77.0	71.5	80.1	76.1
Experience with Care						
Doctor Communication (Usually or Always)	85.2	87.5	86.4	86.7	88.0	87.4
Rating of Personal Doctor (8, 9, or 10)	72.9	75.7	74.3	72.0	74.3	73.3
Rating of Specialist (8, 9, or 10)	63.6	70.7	67.2	65.4	72.6	69.2
Rating of Overall Healthcare (8, 9, or 10)	61.9	68.4	65.2	64.0	68.9	66.6
Satisfaction with Health Plan						
Customer Service (Usually or Always)	78.1	82.3	79.9	81.8	81.5	81.5
Rating of Health Plan (8, 9, or 10)	67.1	71.6	69.3	69.4	72.0	70.7

CAHPS Clinician and Group (C&G) Survey Pilot

In 2011, the Department conducted a pilot study to assess member satisfaction and the utility of a standard tool for measuring provider-level surveys. Ten large health centers in New York City with high volumes of Medicaid patients were selected as study centers and 1,000 Medicaid enrollees with at least one primary care visit at one of the ten centers were randomly selected to be part of the study population. To be eligible, members had to be enrolled in Medicaid for at least five of the six months prior to the study.

Overall, members appeared relatively satisfied with their experience of care at large health centers in New York City. Variation in scores among the ten centers was noted, as illustrated in the table below. As was seen with the CAHPS managed care plan survey data, C&G survey data also identified adults as having higher levels of satisfaction with care received from their primary doctor.

	Overall Rate	**Range**
Getting Appointments and Care When Needed (Usually or Always)	55.6%	48.9 - 64.5
How Well Doctors Communicate (Usually or Always)	83.5%	76.9 - 88.9
Collaborative Decision Making (Yes)	85.7%	80.3 - 90.4
Courteous and Helpful Office Staff (Usually or Always)	72.7%	66.1 - 78.9
Rating of Health Center (8, 9, or 10)	65.7%	54.9 - 74.1

Managed Long Term Care Survey

In 2007, the Department developed a satisfaction survey for MLTC plan enrollees. The survey addressed the respondents' satisfaction with access to and timeliness of plan services as well as overall satisfaction with the plan and providers. The survey was repeated in 2011 and the Department anticipates administering it on a biennial basis. A summary of 2011 results are shown in the table below.

MLTC Member Satisfaction	
Satisfaction Measures	**Rate of MLTC Members Statewide**
Rating of Health Plan (Good or Excellent)	85%
Rating of Care Manager (Good or Excellent)	87%
Rating of Regular Visiting Nurse (Good or Excellent)	86%
Would Recommend Their Plan to a Friend (Yes)	91%
Access to Urgent Care with a Dentist (Same Day)	26%
Spoke to Their Health Plan About Advanced Directives (Yes)	63%

Plan Performance Improvement Projects and Quality Improvement Initiatives

New York's Medicaid managed care plans are required to conduct annual Performance Improvement Projects (PIPs). These projects have been reviewed by IPRO, the external quality review organization for New York State. In the past, projects have encompassed a wide range of topics important to the health and well-being of New York State residents. Each year, plans receive a compendium of results from all plans as a way of sharing best practices. Previous and ongoing PIP projects are described below:

1) <u>Pediatric Obesity (PIP)</u>

The Department chose pediatric obesity as the common-themed PIP for 2009 and 2010, due to the escalating childhood obesity epidemic, particularly among publicly insured children in New York State. The aim of this PIP was to foster improvement in the prevention, identification and management of childhood obesity. Eighteen plans participated in this collaborative learning experience, and each identified plan-specific target populations, interventions and measures. In addition, each plan was required to design and develop interventions to impact health care providers, patients and families and community organizations/schools. The vast majority of plans used the following HEDIS® measures to address pediatric obesity: 1) Weight Assessment; 2) Counseling for Nutrition for Children/Adolescents; and, 3) Counseling for Physical Activity for Children/Adolescents. According to the 2010 Managed Care Plan Performance report for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents measures, New York State Medicaid managed care plans outperformed the national average based on 2009 data from the National Committee for Quality Assurance. For Weight Assessment, the New York Medicaid managed care statewide average is 51% compared to the national average of 30%. For Counseling for Nutrition, the New York Medicaid managed care

statewide average is 61% compared to the national average of 42%. For Counseling for Physical Activity, the New York Medicaid managed care statewide average is 48% compared to the national average of 33%. An April 2011 conference entitled, Weighing the Challenges and Opportunities: New York State Medicaid Managed Care Conference on Pediatric Obesity Performance Improvement 2009-2010, summarized the two-year PIP. A compendium of PIP results was also distributed to the plans and is available at the Department's website at: http://www.health.ny.gov/health_care/managed_care/reports/docs/2009_pip_abstract_compendium_final.pdf

2) Eliminating Disparities in Asthma Care (PIP)

From 2010 through 2012 six Medicaid managed care plans partnered with practices in New York City to participate in a two year PIP, Eliminating Disparities in Asthma Care (EDAC).

The purpose of the EDAC project was to have each plan identify key strategies to reduce racial/ethnic disparities in clinical outcomes, and to improve care for African American patients with asthma residing in Brooklyn. This work is currently being implemented and the final EDAC PIP Report is due in July 2013.

3) Reducing Potentially Preventable Readmissions (PIP)

This two-year PIP for Medicaid Managed Care Plans began in 2011 and will continue through 2012. The objective of this PIP is to reduce potentially preventable readmissions by implementing proven interventions such as early hospital discharge planning, post-hospital follow-up and enhanced care coordination. The ten plans participating on this project are responsible for conducting the following: an investigation into the root causes of potentially preventable readmissions within their provider networks; and, identifying barriers and designing appropriate interventions to affect change. Plans are partnering with one or more hospitals and high volume primary care practices. The choice of measurement performance indicators is individualized by plan, allowing plans to customize performance measures to their individual interventions. The primary outcome measure of interest is readmission rates. Plans were given the opportunity select their targeted population, such as members with specific chronic conditions that confer high risk for hospital readmission. Throughout this two-year period, plans participate in multi-plan calls to report on lessons learned, progress, and/or barriers encountered. The plans' final reports are due of July 2013.

In addition to the PIPs, IPRO also performs ad hoc studies of quality of care to obtain a greater understanding of the processes and quality of care provided by the Medicaid managed care plans. In doing so, IPRO is active in conducting medical records review and analyzing and synthesizing data to determine areas of greater need. Once identified, IPRO and the Department conduct a focused clinical study. Below are descriptions of the studies:

4) Use of Clinical Risk Groups to Enhance Identification and Enrollment of Medicaid Managed Care Members in Case Management (Focused Clinical Study)

The Department, in collaboration with IPRO, conducted an analysis of Medicaid managed care members to further understand the New York Medicaid case-managed population. This study used a predictive modeling system, Clinical Risk Groups (CRGs), to illustrate who is currently enrolled in Medicaid managed care case management programs relative to categories.

Data from this study found that pregnant women and those with chronic conditions receive the largest benefit from care management.

This study demonstrated a notable overlap of members targeted for case management by plans and members identified to have high complexity/ high severity conditions by CRGs, consistent with the aim of identifying potential high resource utilizers. However, there were a number of cases where members were enrolled despite not being in the more complex CRGs, so clearly there are risk factors identified by managed care for case management that are not evident in the CRG algorithm. Conversely, there were members identified as high risk by the CRG grouper that were not triggered or enrolled in case management by the plans. There was wide variation in plan triggering practices, enrollment criteria and focus of plans case management programs, resulting in variation in scope and CRG distribution across plans. This focused study was the impetus for the development of the case management reporting system.

5) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Focused Clinical Study)

The Department, in collaboration with IPRO, conducted a clinical study on the HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB). The purpose of this study was to evaluate demographic and clinical factors associated with antibiotic prescribing for acute bronchitis in adults, to better understand observed clinician prescribing patterns and inform improvement efforts. The Department observed antibiotic prescribing rates were higher for adults with acute bronchitis than those based on the HEDIS AAB measure; and, over half of adult Medicaid managed care members presenting with acute bronchitis had a major chronic condition as defined by CRG health status. Few clear clinical drivers of antibiotic prescribing were identified; however, prescribing was associated with purulent sputum and a longer duration of cough, potentially indicating providers' concerns with non-viral etiologies. Members who did not receive antibiotics were more likely to be seen in the emergency department, where in receipt of chest X-ray, presumably to rule out pneumonia, and were associated with avoidance of antibiotics. Since there may be some subsets of patients who might benefit from antibiotics, further study of members with co-morbidities, older members, members with longer duration of illness, and members without upper respiratory infection may be conducted.

Implementing New Standards for Care

Patient Centered Medical Home

In 2010, the Department implemented its patient-centered medial home initiative. Providers who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) now receive additional payment for primary care services provided to both fee-for-service (FFS) and managed care beneficiaries. The reimbursement amounts differ by provider type and level of recognition as described in the Medicaid Update: http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-12spec.htm. As of January 2013, providers will no longer receive enhanced reimbursement or fees if they are recognized at Level 1.

Prenatal Care Standards Development

Prenatal care standards in New York State (10 NYCRR, Part 85.40) were developed in early 1990 in response to the creation of the Prenatal Care Assistance Program (PCAP), a prenatal care program developed to provide comprehensive prenatal care to low income, high risk pregnant women. The clinical standards of prenatal care have not been revised since the year 2000, highlighting a need to review Part 85.40 standards to compare them to current professional standards of practice. In order to accomplish this task, the Department partnered with IPRO to review the existing PCAP standards and compare them to current American Congress of Obstetricians and Gynecologists (ACOG) guidelines[1], new recommendations in prenatal care, as well as other national guidelines of obstetric practice to determine the need to modify the prenatal standards as they are applied to all Medicaid prenatal providers.

The revised Medicaid Prenatal Care Standards were published in February of 2010, in response to new legislation enacted in New York State in 2009 (Section 365-k of the Social Services Law and Section 2530-a (2) and (3) of the Public Health Law).[2] New York State's prenatal care standards include evidence-based procedures and practices appropriate to the needs of pregnant women who qualify for Medicaid, regardless of provider or delivery system. They integrate updated standards and guidance from the American Congress of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP). The standards provide a comprehensive model of care, including, but not limited to: comprehensive prenatal risk assessment; psychosocial risk assessment; prenatal diagnostic and treatment services; nutritional screening and counseling; health education; care coordination and postpartum services.

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[1] American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (AAP/ACOG). *Guidelines for Perinatal Care, Sixth Edition.* October, 2007.

[2] New York State Medicaid Prenatal Care Standards – November 2009: http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

2011 Prenatal Care Study

The Department and IPRO conducted a study of prenatal/postpartum care received by women enrolled in Medicaid in New York State with regard to the new Medicaid Prenatal Care Standards. The goal of this study was to determine providers' practices relative to the newly developed prenatal standards. A baseline assessment was conducted through a retrospective review of 601 medical charts to assess Medicaid provider adherence to key elements in the new standards. The results have not yet been finalized, but will be used to inform provider training/education and the development of improvement interventions. A final report is being prepared by IPRO.

Selectively Contracting with Providers

As part of the effort to ensure the purchase of quality, cost-effective care for Medicaid beneficiaries, the Department conducts initiatives to review and, as warranted, limit the providers with which it contracts for certain services. Two such initiatives are currently in effect. The first initiative limits the number of providers who may perform mastectomy and lumpectomy procedures within New York State and the second limits the surgical centers that may perform bariatric surgery for weight loss. These initiatives apply to patients both in the Medicaid FFS program and in managed care. The goal for these initiatives is to channel beneficiaries to experienced providers where they will receive the best care and have the best outcomes.

- **Breast Cancer Surgery:** Section 504.3 (i) of Title 18 of the New York Codes, Rules and Regulations provides the authority to limit the number of providers that perform inpatient and outpatient surgical procedures for breast cancer.

  The Department stopped reimbursing for mastectomy and lumpectomy procedures associated with breast cancer at low-volume hospitals and ambulatory surgery centers as of March 1, 2009. The Department examines the all payer surgery volume annually and modifies the list of hospitals and ambulatory surgery centers with which Medicaid contracts for such surgery accordingly. Medicaid managed care plans may not use these restricted facilities. Plans are required to contract with eligible facilities or provide out-of-network authorization to those facilities for their members in need of breast cancer surgery.

- **Bariatric Surgery:** Bariatric surgery emerged as an alternative method of weight loss and long term weight maintenance for many obese and morbidly obese individuals for whom diet, exercise, and the normally prescribed medical therapies have proven ineffective. While there are benefits to this procedure, there are also substantial potential risks. Recent research conducted by the Department illustrated a significant postoperative complication rate following bariatric surgery, as well as a substantial hospital 30 day readmission rate following discharge for such surgeries. This research has also found tremendous variation in the risk-adjusted complication and readmission rates among hospitals. Given such wide variation in hospital performance, the Department restricts Medicaid reimbursement for bariatric surgical services to those hospitals achieving CMS certification as a Bariatric

Surgical Center. Currently, approximately 40 hospitals in New York State achieved such certification; only these hospitals may be reimbursed for bariatric surgical services, for both managed care and FFS Medicaid recipients. This restriction is intended to ensure that Medicaid recipients receive bariatric surgical services at hospitals with the best outcomes.

Rewarding Quality

Since 2001, the Department provides a financial incentive to Medicaid managed care plans performing well on a set of quality, satisfaction, regulatory compliance (such as timeliness of data submissions and accuracy of reporting) and efficiency measures – Prevention Quality Indicators. Medicaid managed care plans are eligible to receive a 0%, 1%, 2% or 3% premium increase per member per month depending on overall performance in these four areas. Receiving an incentive greater than 0% also ensures that the plan is eligible to receive auto-assigned members. In the most recent cycle, one plan earned 3%, five plans earned the 2%, six plans earned the 1% and six plans did not receive any incentive. In addition, as per the Department's contracts with the plans, the Department has the authority to exclude those plans that fail to receive the minimum level of the incentive for three consecutive years from the Medicaid managed care program.

Section 4: Program Evaluation

The Partnership Plan Special Terms and Conditions (STC 75) require that an Interim Evaluation Report be included in any extension requests. 42 CFR 431.412(c)(2)(vi) requires that the state submit an evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions. This extension request contains no amendments or modifications to the Partnership Plan.

The New York State Department of Health has a contract with Island Peer Review Organization, Inc. (IPRO) which includes a provision that states that IPRO staff will provide implementation and monitoring support for Medicaid Redesign Team initiatives and other Medicaid related activities. IPRO has prepared the Evaluation Report.

Section 5: Compliance with Special Terms and Conditions

New York State has successfully completed all deliverables required by the Partnership Plan Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements.

5.1 Program Monitoring

Through ongoing dialogue, program monitoring and regular and extensive reporting, New York State has assured CMS that it remains in compliance with the Partnership Plan terms and conditions.

The state employs a multi-prong approach to monitoring program compliance. Program reviews of local district operations are conducted when new counties transition to mandatory implementation of managed care to assess program implementation and operations. County staff and service providers are trained on changes and have the opportunity to provide input on the impact. State staff continue to assist county staff after implementation providing technical assistance where needed. Regular conference calls are conducted among the Department, the enrollment broker and the New York City Human Resources Administration (HRA) to discuss operational issues, resolve problems and discuss program improvements. Periodic coalition meetings, facilitated by state staff, are conducted with regionally-based groups of local districts and managed care plans to share program information and provide technical assistance. Statewide conference calls and Webinars have been conducted for local districts, Managed Care Organizations (MCOs), providers and other stakeholders with the implementation of MRTs to provide information and update all parties on the status of the rollout. HRA assists the state with conducting on-site monitoring of the enrollment broker's operations.

Auto-assignment rates continue to be monitored on a monthly basis for all mandatory counties and technical assistance is provided to counties as necessary to help maintain high rates of choice. Monthly Policy and Planning Meetings are held with managed care plans to provide timely information and technical assistance in the many MRT-related programmatic changes taking place.

The state oversees MCO's compliance with state and federal statute and regulations and adherence to the Medicaid/ Family Health Plus model contract. This is accomplished through bi-annual onsite operational surveys of the MCOs. On the alternate years, a follow up survey is conducted to review any areas that were not in compliance or in need of improvement.

In addition, focused surveys are conducted for each MCO at regular intervals each year. The focused surveys review: whether the MCO's web based and printed provider directories correctly lists the participating providers; member services departments to test for the degree of difficulty of members to reach a live voice and if appropriate information is being provided in response to questions asked; and the Access and Availability Survey which evaluates whether timely appointments for care from primary, obstetric or dental providers can be scheduled by new members.

CMS assesses state compliance with the terms and conditions in numerous ways. Conference calls are conducted on a weekly or monthly basis as needed to discuss any outstanding amendment requests and significant actual or anticipated developments affecting the program. The state submits to CMS both quarterly and annual operational reports presenting an analysis of and the status of various operational areas and program accomplishments. Quarterly CMS-64 reports are provided to report total expenditures for services under the Partnership Plan. The state also provides CMS with any other reports, studies and materials related to the program. CMS staff monitors regular meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP), an advisory body appointed by the Governor and the New York State legislature.

As required by the Special Terms and Conditions, the state submitted a final evaluation report on the Partnership Plan demonstration on January 28, 2010. The report, prepared by Delmarva Foundation based on data from 2006 - 2008, concluded that the state has met its objectives in that, "Provider networks have remained sufficient to meet accessibility standards; quality of care measures are not only reflecting improvement over time, but suggest that care is being delivered in a manner more consistent with commercial plan performance; and member satisfaction, while reportedly less favorable than among commercial plan members, remained relatively steady."

5.2 Financing Mechanisms

In the past, the state established premium rates for the managed care program through individual negotiations with each participating plan. These negotiations were based on the plans' historical cost experience and projections made by the plans for the rate year. Every two years, the rates were trended to reflect predicted changes in medical costs and operational efficiencies.

In April 2008, the Department began phasing in a risk-adjusted rate setting methodology whereby capitation rates are established based on the relative medical acuity of each plan's membership compared to the regional average. Using 3M's Clinical Risk Group (CRG) software, each member of a health plan is assigned a risk score based on their health status as determined by encounter and claims data. The risk score of all members enrolled in a plan are used to derive a plan risk score, or case mix. Plans with a higher than average case mix are reimbursed more; plans with lower than average case mix are reimbursed less. This change in methodology allows the state to more fairly reimburse plans with a more severe case mix of members. It also ensures that variation in reimbursement from plan to plan is based on the health status of their members rather than inefficiencies. In the first year of the phase in, the rates are a blend of 25% risk based and 75% trended negotiated rates; in year two the blend will be 50%-50%, year three 75%-25% and in year four, beginning in April 2011, 100% risk based rates were in place. The Department will monitor the efficacy of the CRG risk model in predicting medical costs and will make adjustments as needed.

5.3 Financial Monitoring

The Department monitors the financial solvency of health plans on a quarterly basis via a review of plans' financial reports, including revenue and expense statements and balance sheets. These reports measure the plans' compliance with minimum net worth (contingent reserve) and cash escrow fund requirements.

Under New York State regulation, the contingent reserve is equal to 12.5% of premium revenue for the previous calendar year for all product lines except Medicaid Managed Long-Term Care (MLTC) products, which is fixed at five percent. Plans are allowed to phase in the contingent reserve beginning at 5% of premium revenue in year one, 6.5% in year two and thereafter in 1% increments per year until the full reserve of 12.5% is reached. The contingent reserve for most plans in 2012 is equal to 11.5% of 2011 premium revenue for commercial and Medicare

products, 7.25% for mainstream Medicaid and 5% for Medicaid MLTC. The escrow fund is a cash requirement equal to 5% of projected medical expenses for the coming year. The cash deposits are held in a Deed of Trust regulated by the State Department of Financial Services (DFS), and withdrawals from the fund may not be made without DFS approval.

The Department compares the required reserves to the amounts reported on the plan's balance sheets quarterly. Failure to meet the reserve requirements results in the Department issuing a Statement of Deficiency and the plan must then submit a Plan of Correction that demonstrates how the reserve requirements will be met. Plans must also submit bank statements on an annual basis showing that the Deed of Trust escrow accounts area is fully funded.

New York continues to pay supplemental rates to Federally Qualified Health Centers (FQHCs) under the requirements of federal law (42 U.S.C. §1396a(bb)(5)(A)). By June 1, 2008, FQHCs operating in mandatory counties and/or where a plan offers a FHPlus product, were required to document that contracts were in place with all managed care plans operating in the county. The initial Partnership Plan waiver included a Supplemental Transitional Payment Program (STPP) under which the state made supplemental payments directly to non-FQHC comprehensive health centers that primarily serve Medicaid and indigent populations. A transitional payment program reimbursed up to 90% of the per visit difference between the amount the health center would have received under its FFS rates and the amount it received under its managed care contracts. The STPP ended on September 30, 2006.

Section 6: Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver cannot be more than the cost that would have occurred without the waiver. The state has demonstrated to CMS that the waiver has been successful in not only achieving budget neutrality but in realizing savings for the state and federal government.

6.1 Budget Neutrality Monitoring

The neutrality formula consists of two components: Without Waiver expenditures and With Waiver expenditures. Budget neutrality is continuously updated and monitored to ensure that the projections are current and that the waiver is budget neutral.

Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGs) times the trended per member per month allowance agreed to with CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. Medical costs represent a combination of managed care capitation payments for waiver eligible recipients enrolled in managed care and FFS payments for recipients who are not enrolled in managed care plans or for services that are carved out of the managed care

benefit package. Examples of these services include certain mental health and substance abuse services. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future medical costs.

The With Waiver methodology includes expenditures related to previously approved programs such as family planning expansion and the Community Health Care Conversion Demonstration Project (CHCCDP). Also incorporated are new programs such as the Hospital Medical Home and Potentially Preventable Readmissions (PPR) Demonstrations and Clinic Uncompensated Care funding which were approved as part of an amendment in October 2011. The goals of these demonstrations range from improving the coordination and quality of care for individuals receiving primary care in settings used by teaching hospitals, to testing strategies for reducing the rate of preventable readmission within the Medicaid population. Furthermore, the new Uncompensated Care funding will allow the state to double the amount of grants provided through its current Clinic Indigent Care program through a federal match.

6.2 Budget Neutrality Summary

The Partnership Plan waiver has always demonstrated significant savings. A chart showing the calculation of the budget neutrality savings is included as Attachment 3, Projected 1115 Waiver Budget Neutrality Impact through 2013. Savings are expected to grow even more during the waiver extension period (see Attachment 3A, Projected 1115 Waiver Budget Neutrality Impact through 2017).

Section 7: Public Notice Procedures

7.1 Public Notice

New York followed requirements of the Centers for Medicare and Medicaid Services (CMS) final rule to establish a process to promote State and Federal Transparency for Medicaid and Children's Health Insurance Program (CHIP) Demonstrations issued on February 22, 2012 and effective April 27, 2012 (42 CFR 431.408 state public notice process).

The public notice was posted for 30 days on the Department of State's Register website (refer to Attachment 4 Public Notice). Two public hearings in two separate locations and one webinar are scheduled to gather feedback and assure public input on the waiver extension request. All interested speakers will be given an opportunity to express their views which will be documented and incorporated into the final waiver extension application. No pre-registration is necessary for the public hearings.

7.2 Tribal Nations

New York State is home to nine federally-recognized Tribal Nations:

Cayuga Nation of Indians
Onondaga nation
Seneca Nation of Indians
Tonawanda Band of Senecas
Unkechaug Indian Nation
Oneida Indian Nation of New York
St. Regis Mohawk Nation
Shinnecock Nation
Tuscarora Indian Nation

In accordance with 42 CFR 431.408(b), on August 17, 2012 (60 days prior to submission of the waiver extension application to CMS) the Department of Health advised the above mentioned tribes by letter of our intent to request an extension of the 1115 waiver, the Partnership Plan (refer to Attachment 5 Tribal Letter). In addition, tribal representatives were given an opportunity to attend a phone conference on Friday, August 24, 2012 at 9:00 a.m.

Attachments

1 QARR/National Benchmark Comparison 2010

2 ESHI Growth Chart

3 Projected 1115 Waiver Budget Neutrality Impact through 2013

3A Projected 1115 Waiver Budget Neutrality Impact through 2017

4 Public Notice

5 Tribal Notification Mailed on August 17, 2012

Attachment 1: QARR/National Benchmark Comparison 2010

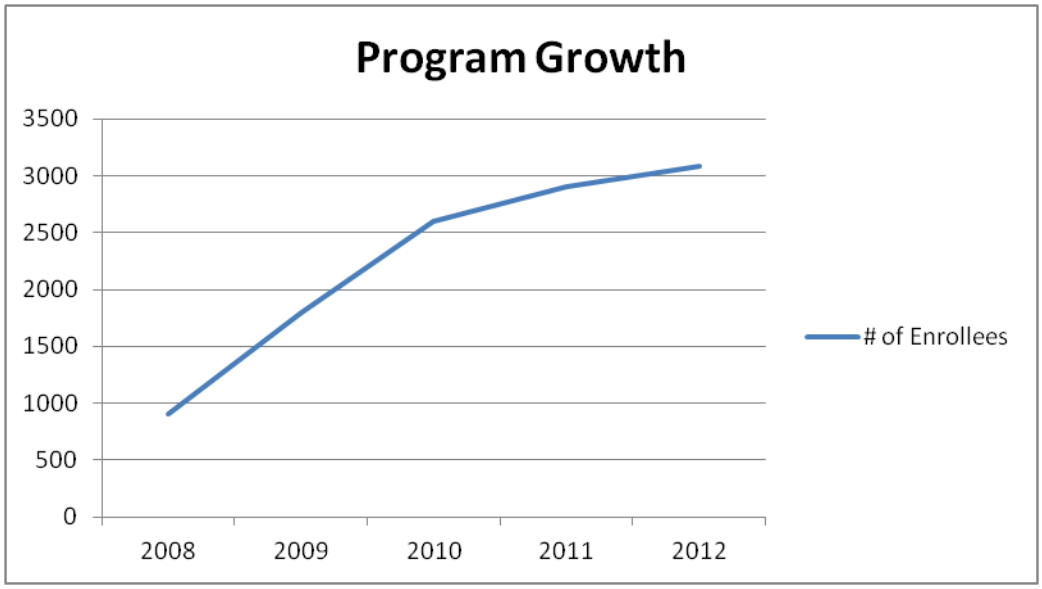
Eighteen Medicaid managed care plans and three Medicaid Special Needs plans submitted 2010 QARR data in June 2011. All plan data was audited by NCQA licensed audit organizations prior to submission. The results for the two products for 2010 are displayed in the following table. As indicated by green shading, NYS Medicaid managed care average exceeded the national benchmarks for 39 of 42 measures (gray cells indicate that national benchmarks were not available). Yellow shading indicated NYS' average was equal to national benchmarks, while red shading indicated NYS' average was below national benchmarks. Medicaid plans submitted 2011 data in June 2012. Data is being finalized and NCQA's report with national benchmarks for 2011 data is expected in October 2012.

Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Children and Adolescents' Access to PCPs Ages 12-19 Yrs	88	92	92
Children and Adolescents' Access to PCPs Ages 12-24 months	96	96	88
Children and Adolescents' Access to PCPs Ages 25 Mos-6 Yr	88	93	83
Children and Adolescents' Access to PCPs Ages 7-11 Yrs	90	95	91
ADHD Continuation	44	64	SS
ADHD Initiation	38	58	SS
Adolescents' Assessment or Counseling or Education- Substance Use		60	71
Adolescents' Assessment or Counseling or Education- Depression		52	51
Adolescents' Assessment or Counseling or Education- Sexual Health		60	70
Adolescents' Assessment or Counseling or Education- Tobacco Use		64	66
Adults' Access to Care Age 20-44 Yrs		82	97
Adults' Access to Care Age 45-64 Yrs		89	99
Adults' Access to Care Age 65 and over		89	97
Adult BMI Assessment (ABA)	42	70	82
Ambulatory Follow-Up After Hosp for Mental Illness-30 Days	64	84	49

Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Ambulatory Follow-Up After Hosp for Mental Illness-7 Days	45	70	25
Antidepressant Medication Management-180 Day Effective Phase Treatment	34	35	40
Antidepressant Medication Management-84 Day Acute Phase Treatment	51	52	52
Drug Therapy in Rheumatoid Arthritis	70	76	N/A
Use of Appropriate Asthma Medications (Ages 12-50)	86	88	82
Use of Appropriate Asthma Medications (Ages 12-50) 3+ Controllers		77	76
Use of Appropriate Asthma Medications (Ages 5-11) 3+ Controllers		76	SS
Use of Appropriate Asthma Medications (Ages 5-50) 3+ Controllers		76	77
Use of Appropriate Asthma Medications (Ages 5-11)	92	92	SS
Use of Appropriate Asthma Medications (Ages 5-50)	88	90	82
Use of Imaging Studies for Low Back Pain	76	79	74
Avoidance of Antibiotics for Adults with Acute Bronchitis	24	27	N/A
Cervical Cancer Screening	67	72	86
Chlamydia Screening (Ages 16-20)	55	67	75
Chlamydia Screening (Ages 16-24)	62	68	75
Chlamydia Screening (Ages 21-24)	58	69	76
Annual Dental Visit(Ages 2-18)		54	N/A
Annual Dental Visit(Ages 2-21)		53	N/A
Frequency of Ongoing Prenatal Care 81-100%	61	74	63
Controlling High Blood Pressure (Ages 18-85)	56	67	59
HIV/AIDS Comprehensive Care- Engaged in Care		80	92
HIV/AIDS Comprehensive Care- Syphilis Screening Rate		58	74
HIV/AIDS Comprehensive Care- Viral Load Monitoring		58	85
Breast Cancer Screening	51	68	69
Annual Monitoring for Patients on Persistent Medications- ACE inhib/ARBs	86	91	98

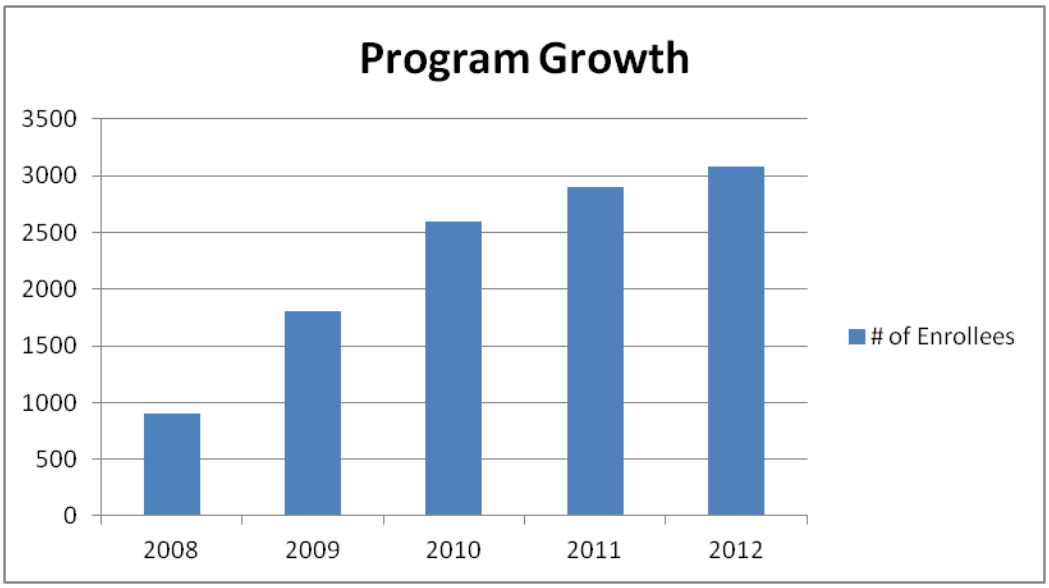
Measure	NCQA SOHC 2011 Medicaid Average*	2010 NYS Medicaid Managed Care Average	2010 NYS Medicaid HIV SNP Average
Annual Monitoring for Patients on Persistent Medications- Anticonvulsant	68	67	58
Annual Monitoring for Patients on Persistent Medications- Combined	84	89	97
Annual Monitoring for Patients on Persistent Medications- Digoxin	90	94	SS
Annual Monitoring for Patients on Persistent Medications- Diuretics	86	90	98
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	82	85	91
Pharmacotherapy Management of COPD Exacerbation- Corticosteroid	65	66	52
Appropriate Testing for Pharyngitis	65	84	SS
Postpartum Care	64	73	49
Timeliness of Prenatal Care	84	90	80
Use of Spirometry Testing for COPD	31	46	26
Appropriate Treatment for URI	87	91	98
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	72	80	76
Adolescent Well-Care Visits	48	56	52
5 or More Well-Child Visits in the First 15 Months of Life	76	77	61
Weight Assessment for Children and Adolescents	37	65	79
Weight Counseling for Nutrition for Children and Adolescents	46	71	71
Weight Counseling for Physical Activity for Children and Adolescents	37	58	53
SS - sample size less than 30			
N/A - not applicable to the product			
*National benchmarks from NCQA's 2011 State of Health Care Quality report			

Attachment 2: ESHI Growth Chart



year 1 growth (1800 - 900 = 900 900/900 = 1 * 100 = 100%)	100%
year 2 growth (2600 - 1800 = 800 800 / 1800 = .444 * 100 = 44.4%)	44%
year 3 growth	11.50%
year 4 partial year growth	6.20%

18.5% 2010-2012



Attachment 3: Projected 1115 Waiver Budget Neutrality Impact through 2013

ATTACHMENT 3
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013

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 10 - MLTC Adult Age 18-64 Duals					$247,394,784	$1,027,336,330	$260,284,563	$1,535,015,677
Demonstration Group 11 - MLTC age 65+ Duals					$2,554,212,091	$10,820,566,375	$2,796,750,566	$16,171,529,032
W/O Waiver Total	**$187,390,575,140**	**$17,587,144,736**	**$9,616,095,275**	**$9,638,453,340**	**$23,949,611,226**	**$35,259,505,743**	**$14,898,066,164**	**$110,948,876,485**

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 10 - MLTC Adult Age 18-64 Duals					$249,276,515	$999,765,437	$249,927,129	$1,498,969,081
Demonstration Group 11 - MLTC age 65+ Duals					$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
With Waiver Total	**$157,629,949,646**	**$15,093,295,780**	**$8,465,916,988**	**$8,581,872,826**	**$22,157,595,820**	**$33,133,282,590**	**$11,449,784,449**	**$98,881,748,455**
Expenditures (Over)/Under Cap	**$29,760,625,494**	**$2,493,848,956**	**$1,150,178,287**	**$1,056,580,514**	**$1,792,015,405**	**$2,126,223,153**	**$3,448,281,715**	**$12,067,128,030**

Attachment 3A: Projected 1115 Waiver Budget Neutrality Impact through 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 10 - MLTC Adult Age 18-64 Duals	$781,863,611	$1,057,240,682	$1,072,731,995	$1,087,682,991	$275,376,201	$4,274,895,480	
Demonstration Group 11 - MLTC age 65+ Duals	$8,401,081,221	$11,588,978,472	$11,995,853,907	$12,408,289,303	$3,204,829,126	$47,599,032,029	
W/O Waiver Total	**$22,528,471,375**	**$39,634,980,845**	**$41,927,182,248**	**$44,331,742,115**	**$11,710,292,809**	**$160,132,669,391**	**$458,472,121,016**

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 10 - MLTC Adult Age 18-64 Duals	$747,134,811	$1,036,369,614	$1,059,388,516	$1,091,815,996	$286,255,977	$4,220,964,914	
Demonstration Group 11 - MLTC age 65+ Duals	$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	
With Waiver Total	**$23,277,743,956**	**$36,791,674,342**	**$38,848,426,849**	**$41,122,288,029**	**$10,925,468,101**	**$150,965,601,276**	**$407,477,299,377**
Expenditures (Over)/Under Cap	**($749,272,581)**	**$2,843,306,503**	**$3,078,755,399**	**$3,209,454,086**	**$784,824,708**	**$9,167,068,115**	**$50,994,821,639**

Attachment 4: Public Notice

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 431.408 the Department of Health hereby gives notice of the following:

New York State requests that the federal government extend New York State's Medicaid Section 1115 Demonstration, Partnership Plan (11-W-00114/2) for an additional five years. No other changes to the Partnership Plan will be requested in the extension application, and as such, current program features of the Plan will remain the same.

The complete extension application, which includes an interim evaluation of the Partnership Plan which assesses the degree to which the Demonstration goals have been achieved and the hypothesis and parameters of the demonstration, can be found on the MRT Waiver Extension website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

Operating since 1997, New York State's Medicaid Section 1115 Partnership Plan waiver program has played a critical role in improving access to health services and outcomes for the poorest and most at risk residents. The waiver allows the state to operate a mandatory Medicaid managed care program designed to: improve the health of recipients by providing comprehensive and coordinated health care; offer comprehensive health coverage to low-income uninsured adults who have income and/or assets above Medicaid eligibility standards (Family Health Plus Program); and provide family planning services to women losing Medicaid eligibility at the conclusion of their postpartum period and certain other adults of child bearing age (Family Planning Expansion Program).

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved an extension of New York State's Medicaid Section 1115 waiver, known as the Partnership Plan, for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal of the Partnership Plan for the period 8/1/11 through 12/31/14, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved two waiver amendments on September 30, 2011 and March 30, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team. New York State Department of Health (NYSDOH) is currently negotiating with CMS on two additional amendments, the Managed Long Term Care (MLTC) amendment and the Medicaid Redesign Team (MRT) amendment.

The MRT amendment to the Partnership Plan waiver will allow the state to reinvest in its health care infrastructure as well as the freedom to innovate. The waiver extension will also allow the state to prepare for implementation of national health care reform as well as effectively reduce health care costs. We anticipate that it will take New York State five years to fully implement its care management vision.

The public is invited to review and comment on the state's proposed waiver extension request. Public Hearings and webinar are scheduled for:

Waiver Extension Public Hearing - Albany

September 20, 2012, 1 PM - 4 PM

University at Albany
School of Public Health Auditorium
1 University Place
Rensselaer, New York

Waiver Extension Public Hearing - Brooklyn

September 25, 2012, 11:30 AM - 2:30 PM

New York City College of Technology
Auditorium - Klitgord Center
285 Jay Street
Brooklyn, NY

Waiver Extension Public Hearing - Webinar

September 27, 2012, 1 PM - 4 PM

Registration information will be made available on the Waiver Extension website http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

Comments (including comments sought through the public engagement process) concerning the state's plan to submit a waiver extension request can be sent to the e-mail or postal addresses below for a period of thirty (30) days from the date of this notice.

- mrtwaiver@health.state.ny.us
- *Attn: Jason Helgerson*
  Office of Health Insurance Programs
  New York State Department of Health
  1 Commerce Plaza, Suite 1211
  Albany, NY 12224

Details on the waiver extension request, full public notice and more information on the state's public engagement process are available at the state's MRT waiver extension website at

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver_ext_info.htm.

Attachment 5: Tribal Notification Mailed on August 17, 2012

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

August 17, 2012

Latasha Austin
Keeper of Records
Unkechaug Indian Territory
PO Box 86
Mastic, NY 11950

Dear Ms. Austin:

In July 1997, New York State received approval from the federal government of its Section 1115 waiver request, known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. On September 29, 2006, The Center for Medicare and Medicaid (CMS) approved an extension of the Partnership Plan for the period beginning October 1, 2006 and ending September 30, 2010. CMS subsequently approved a series of short term extensions while negotiations continued on renewing the waiver into 2014. On July 29, 2011, CMS approved a renewal for the period August 1, 2011 through December 31, 2014.

This letter is to notify you that New York State will request an extension of the existing 1115 Partnership Plan waiver from the federal government. As indicated in our June 6, 2012 letter, New York is already pursuing an amendment to the state's Partnership Plan. This extension will allow the state to fully implement its care management vision set out by the Medicaid Redesign Team (MRT).

Details about the MRT waiver are available on the state's MRT waiver website at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_waiver.htm. The full extension request will be posted to this site shortly. Additionally, you are 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 .

As you know, under the state's Section 1115 Demonstration programs, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. This waiver extension request will not alter this exemption from mandatory enrollment for Native Americans. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued. We anticipate this extension will have minimal impact on Tribal Nations.

My office has scheduled a conference call to provide an overview of the waiver extension process and to take any questions you may have.

The call is scheduled for Friday, August 24, 2012 at 9:00 a.m. If you would like to participate, please use the following call-in information:

Call-in #: 1-866-394-2346
Conference Code: 105 726 8043#

If you're not able to participate, or have additional comments, please forward any questions or input regarding this waiver extension to my office by Tuesday, August 28, 2012. We look forward to your continued collaboration.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosure

cc: Vennetta Harrison
Karina Aguilar