27. FEDERAL-STATE HEALTH REFORM PARTNERSHIP (F-SHRP)

Overview

On September 29, 2006, the Centers for Medicare and Medicaid Services (CMS) approved New York State's request to join in a partnership to reform and restructure the State's healthcare delivery system. To accomplish the reform and restructuring, CMS has approved a new five-year 1115 demonstration entitled Federal-State Health Reform Partnership (F-SHRP). The waiver is effective October 1, 2006.

F-SHRP Goals and Objectives

The goals of this reform partnership are to promote the efficient operation of the State's health care system; consolidate and right-size New York's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the adoption of advanced health information technology and improve ambulatory and primary care provision.

Under F-SHRP, the federal government will invest up to $1.5 billion ($300 million per year) in agreed upon reform initiatives. The primary focus of these initiatives will be to right-size and restructure the acute and long-term care delivery systems, expand the use of e-prescribing, foster the implementation of electronic medical records and regional health information organizations and expand ambulatory and primary care services.

The federal investment in these reforms is conditioned upon the following:

- The F-SHRP waiver must generate federal savings sufficient to offset the federal investment
- The State must meet a series of established performance milestones set forth in the waiver terms and conditions

Savings

The reform initiatives to right-size and restructure the State's health care delivery system and to expand use of health information technology are expected to generate significant savings to both the State and federal government. However, these reforms will be implemented over a number of years and although some of the savings are expected to accrue in the next 5 years, much of the savings will be long term. In order to generate sufficient federal Medicaid savings to offset its investment, CMS has agreed to count savings in two areas – savings generated due to decreased hospital utilization resulting from eliminating excess acute care capacity and savings generated through Medicaid managed care expansions. The managed care expansions include the current implementation of mandatory SSI enrollment and expansion of mandatory Medicaid enrollment in additional counties. Counting these managed care savings for F-SHRP required moving these populations from the existing 1115 Partnership Plan to the new F-SHRP waiver.

The State is required to generate $3 billion in gross Medicaid savings ($1.5 billion federal) over the 5-year waiver. Should the State not achieve these savings by the end of the waiver, it will be required to refund to the federal government the difference between the federal investment in the F-SHRP reforms and the federal savings generated.

Performance Milestones

The State is also required to meet a number of significant performance milestones. These milestones are as follows:

1. **Fraud and Abuse Recoveries.** By the end of the demonstration, the State will be responsible for increasing its Medicaid fraud and abuse recoveries to at least 1.5 percent of its total Medicaid expenditures for FFY 2005. The first year of the demonstration requires development of an audit plan to increase recoveries. Specific dollar recovery targets have been established for years 2 through 5 starting with $215 million in annual recoveries for year 2 and increasing to $644 million in recoveries for year 5. Failure to meet these targets will result in a penalty to be paid to the federal government equal to the difference between the actual and target recoveries. However, the penalty cannot exceed on an annual basis the FFP claimed for F-SHRP programs and the penalty is also limited to $500 million over the five-year waiver term.

2. **Preferred Drug List**. The State must implement a PDL for Medicaid. This PDL must be continued over the life of the demonstration.

3. **Baseline Data and Reporting**. The State must report to CMS by November 30, 2006 baseline data including hospital and nursing home discharge and debt data and managed care expenditure data.

4. **Employer Sponsored Insurance.** By January 1, 2008, the State must implement a program to increase the number of currently uninsured but employed New York residents with private insurance coverage. By January 1, 2009, the State must document some increase in the rates of private insurance for such individuals.

5. **Programmatic Changes**. By October 31, 2006, the State must have implemented the Medicaid cost containment initiatives enacted in New York's 2005/2006 State Budget relevant to demonstration programs including changes in FHP, increased Medicaid pharmacy copayments, a one year Managed care premium freeze and cap on administrative costs, expansion of managed long term care and pay for performance demonstrations. By February 1, 2007, the State must implement at least one new Medicaid cost efficiency initiative.

6. **Improvement in ADA Compliance**. By March 31, 2007, the State must submit a report outlining the State's plan for updating its on-site reviews of ADA compliance.

7. **Single Point-of-Entry.** By April 1, 2008, the State must have implemented a program to create a single-point-of-entry for Medicaid recipients needing long-term care in at least one

region of the State.

8. **Commission on Health Care Facilities in the 21st Century (Commission).** By January 31, 2007, The State must submit a report indicating that there are no State statutory impediments to implementation of the Commission's recommendations, steps taken to implement the recommendations and a timeline for implementation.

   By July 15, 2008, a final report on implementation of the Commission's recommendations is required.

With the exception of the targets for audit recoveries, failure to meet any milestone results in termination of the demonstration.

Funding

The mechanics of the how federal funds will flow to the State are as follows. Under the waiver, the State will be entitled to federal matching (FFP) for approved designated State health programs (DSHP). Approved programs include certain HCRA programs as well as health care programs administered by other State agencies such as the offices of Mental Health, Mental Retardation and Developmental Disabilities, Aging, Alcohol and Substance Abuse Services and Children and Family Services. These programs are not Medicaid programs and normally do not qualify for federal matching. The State will be eligible for 50% federal matching on State expenditures for these programs up to $300 million per year. This means the State must incur annual expenditures of $600 million to be entitled to the full $300 million in federal funds. After incurring the DSHP expenditures, the State may draw down the federal matching funds only as it is ready to expend State funds on the actual reform initiatives. For example, as the State expends money on HEAL-NY grants it can simultaneously draw down the equivalent amount of federal funds and use those funds on any of the reform initiatives. Federal funding is limited to $300 million annually and must be used for reform expenditures incurred in that year. The federal funds cannot be rolled over into subsequent years. However, the State has two years after each demonstration year to claim federal funds and pay for investment expenditures incurred during the demonstration year.

Evaluation

F-SHRP is a five-year demonstration that will end on September 30, 2011. Over the five-year term, the State will be required to report quarterly and annually to CMS on progress of the waiver. Reporting will include a number of quantifiable metrics to assist CMS in evaluating the effectiveness of the State's reforms including grant activity, data on hospital and nursing home utilization and debt, progress on implementation of Commission recommendations and managed care enrollment information. In addition to reporting, a formal evaluation of the demonstration is required with a report due to CMS when the demonstration expires.