

## **New York State's Section 1115 Waiver Demonstration Programs**

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

There are two types of Medicaid authority that may be requested under Section 1115:

- Section 1115(a)(1) – allows the Secretary to waive provisions of section 1902 to operate demonstration programs (Statewide, Freedom of Choice and Medicaid Eligibility and Quality Control), and
- Section 1115(a)(2) – allows the Secretary to provide Federal financial participation for costs that otherwise cannot be matched under Section 1903.

Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral" over the life of the project, meaning they cannot be expected to cost the Federal government more than it would cost without the waiver.

### **A. The Partnership Plan**

The State's goal in implementing the Partnership Plan is to improve the health status of low-income New Yorkers by:

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

The Partnership Plan Section 1115 Demonstration uses 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. The initial Partnership Plan demonstration was approved in 1997 to enroll most Safety Net and TANF Medicaid beneficiaries into managed care organizations (Medicaid managed care program), either on a mandatory or voluntary basis, and to provide 24 months of family planning services, only, to women losing Medicaid eligibility after giving birth. In 2001, accrued savings under the Partnership Plan allowed the State to implement the Family Health Plus (FHPlus) program under an amendment to the demonstration. FHPlus provides comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than Medicaid eligibility

standards. In 2002, the demonstration was further amended to provide family planning services to certain adults of childbearing age (family planning expansion program).

Since then, mandatory enrollment has been extended to additional populations. Beginning in 2005, mandatory enrollment of SSI-eligible individuals began in New York City, and was completed statewide as of December 2008. Medicaid beneficiaries with both SSI and serious mental illness began enrolling in 2007. The SSI population was shifted to the F-SHRP waiver in 2006 (see below). Mandatory enrollment of the HIV/AIDS population was extended to beneficiaries in New York City in September 2010. Medicaid Redesign Team initiatives will eliminate most excluded and exempt populations over the next three years.

As of April 2011, 2.9 million individuals are enrolled in the Medicaid managed care program and over 400,000 are enrolled in the FHPlus program.

Budget Neutrality is a requirement of Section 1115 waivers and limits federal funding to the amount that would have occurred absent of the waiver. The analysis compares without-waiver expenditure limits to with-waiver expenditures. The without-waiver amount is an estimated amount for persons eligible for the waiver using the initial PMPMs trended forward by trends included in the terms and conditions times the eligibles. The with-waiver amount is equal to the actual expenditures for eligibles. The cost before the waiver (without-waiver) must also be greater than the with-waiver to have budget neutrality. As there is no allowance for expenditures for Safety Net or FHPlus members without children, these must be funded with the savings. All persons eligible for the waiver are included in the budget neutrality formula whether or not they are enrolled in managed care. Budget neutrality is calculated over the entire demonstration, not for each year of the demonstration. The current savings for the Partnership Plan waiver is \$51B (estimated through 12/31/13, the expiration date of the proposed extension). However, this amount is overstated since CMS requires the amounts to match the CMS64 which understates the with-waiver amounts because it uses some time frames with little or no lag.

#### B. Federal-State Health Reform Partnership (F-SHRP)

The goal of F-SHRP is to promote the efficient operation of the State's health care system by: reducing excess capacity in the acute care system; shifting emphasis in long-term care from institutional-based to community-based settings; expanding the adoption of advanced health information technology, including e-prescribing, electronic medical records and regional health information organizations; and, improving ambulatory and primary care provision.

Under F-SHRP, the federal government will invest up to \$1.5 billion in agreed upon reform initiatives. The federal investment in these reforms is conditioned upon the F-SHRP waiver generating federal savings sufficient to offset the federal investment and the State meeting certain performance milestones, including:

- Increasing fraud and abuse recoveries to 1.5% of the State's FFY 2005 total Medicaid expenditures by the end of the Demonstration:
- Implementing a preferred drug program for the entire Medicaid program;
- Implementing an employer-sponsored insurance program;
- Implementing a single point of entry system for long term care service assessment; and
- Implementing the Medicaid cost containment and reform initiatives.

Much of the savings associated with F-SHRP reforms will accrue over the long term. To generate short term savings to invest in health care reform initiatives, the federal government agreed to count savings generated through: decreased hospital utilization resulting from eliminating excess acute care capacity; and, expansion of mandatory Medicaid managed care enrollment to the SSI and SSI-related population statewide and to individuals in 14 upstate New York counties. The Budget Neutrality savings for the F-SHRP waiver is \$18B (estimated through 3/31/14, the expiration date of the extension).

Federal funds flow to the State as federal match on expenditures for Designated State Health Programs (DSHPs), which include certain HCRA programs (e.g., Healthy New York, ADAP, Tobacco Prevention, Telemedicine demonstration, pay for performance) as well as health care programs administered by other State agencies, such as SOFA, OMH, OPWDD, OASAS and OCFS. DSHPs are not Medicaid programs and would not ordinarily qualify for federal match. The State is eligible for 50% federal match on DSHP expenditures up to \$300 million per year. After incurring DSHP expenditures, the State may draw down the federal matching funds only as it is ready to expend the same amount of State funds on reform initiatives. Federal funding is limited to \$300 million per year, must be used for reform expenditures in that year, and may not be rolled over into subsequent years. On March 31, 2011, the State received federal approvals for an extension of the F-SHRP waiver through 3/31/14 to permit the State to continue its health care system restructuring activities and to benefit from the temporary increase in its FMAP rate under the American Recovery and Reinvestment Act.