Partnership Plan
Section 1115 Quarterly
Demonstration Year: 16 (10/1/2013 – 9/30/2014)
Federal Fiscal Quarter: 1 (10/01/2013 – 12/31/2013)

I. Introduction

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 8/1/11 through 12/31/14, with some waiver components expiring earlier to reflect implementation of the Affordable Care Act (ACA). CMS approved three waiver amendments on September 30, 2011, March 30, 2012 and August 31, 2012, incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team.

In addition, on September 29, 2006, New York State received approval for a five-year 1115 demonstration entitled Federal-State Health Reform Partnership (F-SHRP). This was effective October 1, 2006 through September 30, 2011. On March 31, 2011 F-SHRP was extended for three years, April 1, 2011 through March 31, 2014. This demonstration will expire on that date.

Currently, a Phase-Out Plan proposing the transition of the remaining populations in F-SHRP to the Partnership Plan and addressing the continuation or expiration of the other F-SHRP components was submitted to CMS on November 27, 2013. Implementation of this Phase-Out Plan is pending.

II. Enrollment : First Quarter

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	# Voluntary Disenrolled in Current Quarter	# Involuntary Disenrolled in Current Quarter
Population 1 -TANF Child under 1 through 20 in mandatory MC counties as of 10/1/06	1,677,293	34,389	66,505
Population 2 - TANF Adults aged 21 through 64 in mandatory MC counties as of 10/1/06	494,154	12,683	21,913
Population 3 - SN Adults	840,605	21,405	29,610
Population 4 - FHPlus Adults with children	335,967	7,327	20,913
Population 5 – FHPlus Adults without children	96,224	2,126	6,552

Partnership Plan Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in Current Demonstration Year[1]	**53,595**

Reasons for voluntary disenrollments include: (LDSS) approval to disenroll based upon appropriate cause, client request exclusion/exemption, moved, client enrolled in another plan and undetermined cause.

Involuntary Disenrollments	
Total # Involuntary Disenrollments in Current Demonstration Year[1]	**168,501**

Reasons for involuntary disenrollments include: loss of Medicaid eligibility, eligibility transfers between Family Health Plus (FHPlus) and Medicaid, plan termination, inappropriate enrollment and death.

III. Outreach/Innovative Activities

The New York State Department of Health (the Department), Maximus and the local departments of social services (LDSS) continue to provide education and outreach in the areas of enrollment and health plan selection to Medicaid eligible individuals that are not enrolled in managed care.

A. Progress of Mandatory Managed Care Expansion

As of November 2012, the expansion of mandatory Medicaid managed care is complete, with programs operating in all counties of the state, including New York City. During this quarter, staff continued to provide technical support to both county staff and providers in all counties. The counties opting to utilize the assistance of the enrollment broker also received support from Maximus staff.

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.1 million. Currently, 2.2 million are enrolled in a managed care plan, including eligible SSI recipients.

The Medicaid Redesign Team (MRT) changes implemented during the reporting period had a significant impact on the work of New York Medicaid Choice (NYMC).

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 17 Job Centers.

The Education and Enrollment Driven Referral (EED) process was responsible for 84% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 14 consumers per work session. A work session covers a half day of work activities.

[1] Demonstration year to date: 10/01/2013– 09/30/2014

A total of 2,649 presentations were scheduled by NYMC. Of these, 584 or 22% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

There were no additional updates this past quarter.

C. New York State (outside of NYC) Outreach Activities

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on MRT #1458, Care Management Population and Benefit Expansion, Access to Services, and Consumer Rights, including expansion of the Medicaid managed care benefit package to include: Adult Day Health Care, AIDS Adult Day Health Care, and Directly Observed Therapy for Tuberculosis.

There were no additional updates this past quarter.

IV. Operational/Policy Developments/Issues

A. Partnership Plan Waiver Amendments

The Department finalized and received CMS approval of the Special Terms and Conditions (STCs) for enrollment of individuals in the Long Term Home Health Care Program (LTHHCP), 1915(c) waiver program offering home based care to individuals who would otherwise be admitted to a nursing home. Dually eligible LTHHCP participants over age 21 are required to enroll in a MLTC plan based on a phase-in schedule approved by CMS. Dually eligible LTHHCP participants aged 18 through 20 may choose to sign up for an MLTC plan approved to enroll individuals aged 18 and older and dually eligible individuals aged 21 and under. Non-duals of any age may voluntarily enroll in a MMMC plan.

CMS granted the Department authorization for MMMC enrollment of individuals in foster care who are placed in the community directly by LDSS. This does not extend to: 1) individuals in foster care in a waiver program; 2) those placed through a contracted agency; 3) those housed in an institution. In addition, the Department received CMS authorization for managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

There were no additional updates this past quarter.

B. Health Plans

1. Changes to Certificates of Authority:

- SCHC Total Care COA updated 10/18/2013
  Acquired by Today's Options of New York, Inc.

- Name change for Total Care. The COA was updated 12/02/2013
  The new name is Syracuse Community Health Center Managed Care Holding Company, Inc. added a limitation to the COA
  -precluded from marketing and enrollment. Run out activities only.

- Today's Options of New York, Inc. DBA Total Care was issued COA on 10/18/2013.
  Acquired SCHC Total Care, Inc.
  Approved for Medicaid, FHP and CHP in Cortland, Onondaga and Tompkins

Counties.
Approved for CHP in Oswego County.

- UnitedHealthcare of New York, Inc had COA amended on December 1, 2013 to reflect its service area expansion for the Medicaid, Family Health Plus programs to the following Counties:
  Lewis, Ontario, Seneca, and Wayne.
  Also as of December 1, 2013 they added a MLTC Partially Capitated line of Business for Albany, Broome, Erie, Monroe, Oneida, Onondaga, Orange and Rockland Counties.

- MVP had its COA updated on December 17, 2013 to reflect the service area expansion to Genesee, Livingston, Monroe, and Ontario Counties for Child Health Plus.

2. Routine surveillance activity for the quarter included operational surveys for the following plans:

   - VNSNY Choice SNP: the survey was conducted December 4-5, 2013 and the plan was found to be in substantial compliance.

   - Independent Health Inc.: The survey was conducted November 18-22, 2013. Correspondence issuing the results in pending.

   No problems were found with access to health plan telephone lines during the Member Services phone survey conducted during the Period of October 1, 2013 to December 31, 2013.

3. Routine provider directory surveys were conducted for health plans in the first half of 2013 with the following results. Where deficiencies were found, plans were required to provide plans of corrections.

   The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:

   Amerigroup New York, LLC.
   Amida Care, Inc.
   HealthFirst PHSP, Inc.
   Health Insurance Plan of Greater New York.
   Hudson Health Plan, Inc.
   Independent Health Association, Inc.
   Metro Plus Health Plan, Inc.
   Metro Plus Health Plan SNP, Inc.
   MVP Health Plan, Inc.
   Neighborhood Health Providers, Inc.
   New York State Catholic Health Plan, Inc.
   UnitedHealthcare of New York, Inc.
   VNS Choice
   Wellcare of New York, Inc.

Beginning in the second quarter of 2011, the Department delegated the member services survey to its agent, IPRO. No problems were found with access to health plan telephone lines.

C. Fiscal Year (FY) 2013 State Budget Changes to Medicaid

Under the FY 2013 New York state budget, all previously existing exclusions or exemptions from mandatory enrollment into Medicaid managed care were eliminated. The Commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits were in place. Two additional capitated programs were created within the Medicaid program: Fully Integrated Duals Advantage plans (FIDAs), and Developmental Disability Individual Support and Care Coordination Organizations (DISCOs). The budget also provides the Commissioner of Health with the authority to include additional services in the Medicaid managed care plan benefit package.

D. Waiver Deliverables

1. Medicaid Eligibility Quality Control Plan (MEQC)

- MEQC 2008 – Appropriateness of Applications Forwarded to LDSS Offices by Enrollment Facilitators:

  Review activities were transitioned to the Department review staff for completion because the project agreement that supported this review expired. During the reporting period, the Department continued to compile the review results and draft a final summary.

- MEQC 2009 – Review of Medicaid Eligibility Determinations and Redeterminations for Single and Childless Couple Individuals Determined Ineligible for Temporary Assistance:

  With CMS approval, the Pacific Health Policy Group (PHPG), the contractor hired to assist the New York State Department of Health with multiple MEQC reviews, began implementing an alternate approach for generating the necessary universes of cases. A revised approach was necessary because availability of DOH system staff continued to be limited due to other system priorities (i.e., system work related to ACA and the Health Benefit Exchange).

  Implementation of the revised approach began in September 2013. Progress continues to be made with several of the universes; however, the process is labor intensive and very time consuming. A letter requesting copies of case records will be issued to the appropriate districts once the universes are successfully generated.

- MEQC 2010 – Review of Medicaid Eligibility Determinations and Redeterminations for Persons Identified as Having a Disability:

  Initial, peer, supervisory and quality assurance reviews have been completed. PHPG is in the process of drafting a summary report for review by the

Department. It is expected that the final summary report will be issued on or about January 31, 2014.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

  A summary report was issued to the regional CMS office on June 28, 2013.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

  A summary report was issued to the regional CMS office on July 25, 2013.

- MEQC 2013 – Review of Documentation Used to Assess Immigration Status and Coding

  PHPG continued to finalize all reviews (initial, peer and supervisory), and record the results in their central database. PHPG also prepared an interim analysis for discussion purposes. It is expected that the Department will conduct quality control reviews in January 2014 and that a final summary report will be issued on or about March 31, 2014.

2. Health Systems Transformation for Individuals with Developmental Disabilities (DD Transformation).

   See Attachment 3 – DD Transformation.

E. Benefit Changes/Other Program Changes

Hospice: Effective October 1, 2013, the provision of Hospice services to enrollees in Medicaid managed care organizations was added to the benefit package. Individuals in receipt of Hospice services prior to October 1, 2013, regardless of enrollment status, will continue to be covered under the fee for service Medicaid program for the duration of their approved Hospice services. Managed care plans are responsible for Hospice services for enrollees new to Hospice care on and after October 1, 2013.

F. Federally Qualified Health Services (FQHC) Lawsuit

CHCANYS, et al vs NYS Dept of Health -- The case remains pending on appeal before the Second Circuit Court of Appeals (federal court), with both sides having filed appeals from different elements of District Court Judge Carter's February, 2013 decision.

G. Managed Long Term Care Program

CMS provided approval for the mandatory enrollment of dual eligible recipients, 21 years of age or older receiving more than 120 days of community based long term care services, into a Managed Long Term Care Plan (MLTCP) on August 31, 2012. The initiative offers three (3) models of MLTCPs: partially capitated; the Program of All-Inclusive Care for the Elderly (PACE); and, Medicaid Advantage Plus (MAP). Both PACE and MAP include Medicare and Medicaid covered services in the benefit package and require the participant to be nursing home eligible; partially capitated plans include only Medicaid covered benefits. Recipients must choose a plan to receive services. If no choice is made, the recipient is enrolled into a partially capitated plan.

The mandatory enrollment process began in New York County in June 2012 with announcement letters notifying recipients of fee for service personal care services (of at least 120 days and 120 days of Medicaid eligibility) that the Medicaid program was changing, the recipients then received a mandatory notice and materials to start the choice period. Recipients eligible were given sixty (60) days to choose a plan. The enrollment process has followed the enrollment plan submitted with the Partnership Plan amendment, by New York City borough (Bronx, Brooklyn, Queens and Staten Island) through December 2012. The population seeking services is now directed by Health Resources Administration (HRA) case workers to New York Medicaid Choice (NYMC), the New York State enrollment broker, which provides information and counseling to consumers, facilitates enrollment, educates plans and supports the state with data gathering.

All MLTCP models provide a person-centered plan of care, integration of health care, environmental and social services and a supportive transition from the previous, fragmented, FFS process to coordinated managed care.

1. Accomplishments

   - Mandatory enrollment process initiated and continuing in all five boroughs. Due to the length of the prior authorization and Medicaid eligibility periods, additional cohorts from all NYC counties will continue to be identified for the enrollment process; the anticipated time frame to transition all personal care cases in the five boroughs is June 2013. The mandatory transition process for Personal Care Services in NYC counties was essentially completed as of September 2013.

   - Expanded the scope of the mandatory enrollment initiative by incorporating additional benefits into the MLTC benefit package. Recipients receiving services through the Consumer Directed Personal Care Program can now receive that benefit through a MLTCP and are included in the mandatory enrollment population. This was made effective in November of 2012. (See separate section below).

   - Completed systemic process to identify recipients receiving Private Duty Nursing (PDN) and/or Adult Day Health Care services and include these consumers in the mandatory enrollment cohort. A systemic process to identify recipients receiving Certified Home Health Agency (CHHA) services is in development. The LTHHCP population can be identified and will be transitioned when CMS approval is received.

   - Expanded MLTCP availability by approving 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority since September 2012. During the period October 2013 through December 2013, MLTCP availability was expanded by approving 2 service area expansions.

   - Developed, in consultation with local officials and NYMC, processes for Nassau, Suffolk and Westchester local social services districts to commence notification to participants in January 2013.

   - Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued to plans, Care Management Administrative Services Contract Statement and Certification, Standard Clauses for Care Management

Administrative Services Contract, and Care Management Administrative Services Contract Guidelines for MLTC Plans, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the managed long term care process.

- New York's Enrollment Broker, NYMC, conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant. For the period from October 2013 to December 2013 post enrollment surveys were completed for 193 enrollees and 88% of the respondents are receiving services from the same home attendant.

- Expanded the scope of the transition of community based services to include Certified Home Health Agency care, Private Duty Nursing and Adult Day Health Care services in mandatory counties beginning in February 2013.

- Expanded the geographic transition region to include Nassau, Suffolk and Westchester counties in February 2013 with CMS approval. The transition expanded to Rockland and Orange counties as of September 2013.

- Continued to develop reporting mechanisms with Enrollment Broker and Computer Sciences Corporation to assure information is gathered as required as transition moves forward.

- Expanded Department's complaint hotline staffing and developed and implemented a new standardized database for tracking complaints and resolution.

- Additional education was developed and shared with MLTC Plans addressing Consumer Directed Personal Assistance Services and its use.

- Entered into discussion to initiate a Member Services survey of all MLTC Plans on a semi-annual basis by the State's contractor to assure information shared with potential enrollees is accurate and helpful.

- Developed, with the Enrollment Broker, training for local social services in the transition process, identifying the districts ongoing role during the transition, establish clear communication mechanisms with MLTC plans, SDOH and stakeholders to ease transitions, addressing potential systemic issues and ensure informed choice by stakeholders and enrollees.

- Initiated activities for expansion of transition to Albany, Erie, Onondaga and Monroe counties in December 2013.

2. Significant Program Developments

   - Initial mandatory enrollment process completed in NYC.

   - Mandatory initiative moving into Nassau, Suffolk and Westchester counties.

- Continued incorporation of community based LTSS into the MLTC benefit package – CDPAP, PDN, Adult Day Health Care (ADHC), and CHHA.
- Expanded MLTCP capacity in all mandatory counties and building capacity for future counties.
- Continuity of care assured through transition period.
- Monitoring of network capacity, delivery systems and coordination of care.
- Development of data gathering systems to meet terms and conditions reporting requirements.
- Development and submission of waiver amendments for the 1915(c) LTHHCP.
- Created study protocol with External Quality Review Organization (EQRO) to review auto-assigned cases to meet reporting requirement related to transition of care.
- Developed and expanded information available to participants selecting plans to include a Consumer Guide for Plans in NYC based on assessment data submitted. This Consumer Guide is also being developed for other regions of the state.
- Established mechanism for ongoing policy directives to MLTCs for clarification and consistency in MLTC transitions and ongoing implementation and expansion.
- Improvement to network reporting guidelines for all MLTCs.
- Initiated training for use of the mandatory Uniform Assessment System for New York State which will replace the Semi Annual Assessment of Members tool previously utilized by MLTC assessors.
- Developed Guidelines for MLTC plans and the State's Enrollment Broker on Involuntary Disenrollment to assure appropriate notice and ongoing care as needed to support health and safety of enrollees in the community.
- Further clarified the definition of community based long term care services to address Medicaid recipients in need of housekeeping services.
- Enhanced monitoring of MLTC Provider Networks where deficiencies are identified and action taken.
- Enhanced oversight of Social Day Care utilization and plan contract monitoring continues.
- Developed preliminary 2014 MLTC transition plan to expand mandatory to remainder of the State.
- Submitted preliminary proposal to develop independent clinical assessment process for MLTC enrollment.

3. Issues and Problems

Hurricane Sandy had a devastating impact on New York State's health resources and the aftermath of the storm continues to affect health care needs and outcomes.

- It was necessary to pause the implementation and processing of auto-assignments in New York City during November due to disruptions caused by Hurricane Sandy. This resulted in delays in issuing announcement and mandatory enrollment notices to targeted consumers during November; however schedules were back on track by December of 2013.

- NYMC, the Department enrollment broker, had to redeploy systems and resources due to storm damage at their main facility.

- The Department's ability to systemically identify certain transition populations was delayed.

- In response to various allegations of improprieties relating to utilization of Social Day Care in MLTC, SDOH, the Attorney General's Office and the Office of the Medicaid Inspector General are cooperating in ongoing audits and investigations. Focused activities are being expanded on an ongoing basis as issues are identified.

4. Summary of Self Directed Options

To minimize disruption and promote continuity for members receiving Consumer Directed Personal Assistance Service (CDPAS) a policy for the transition of CDPAS into MLTC and the MCO benefit package was created. Self-direction gives individuals and families greater control over the services they receive, how they receive them and who provides them and a clear direction to both the MLTC plans and MCOs supports its success.

This policy document was created in conjunction with a CDPAS Workgroup reflective of numerous stakeholders that met a number of times to discuss issues and develop policies for this new benefit:

- **Contracting During the Transition Period**: For the period October 1 2012-September 30, 2013 (Transition Period), Health Plans are required to contract with FIs that currently have a contract or MOU with a LDSS and currently provide fiscal intermediary services to the health plan's member(s). The rate of payment must be at least the FFS rate of payment provided for in the contract or MOU between the FI and the LDSS. The MLTC/MCO is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the MLTC/MCO maintains two (2) FIs for each county. To adequately meet the needs of members who are newly assessed and considered eligible to receive CDPAS, the MLTC/MCO may also include in the MLTC/MCO's network FIs that do not have a contract or MOU with the LDSS.

- **Consumer Continuity of Care and Choice During the Transition Period**: The Department provided a list of FIs currently providing FI services to FFS and MCO's enrolled members. To promote and maintain consumer choice, members may, during the Transition Period, change to any FI in the county that has a contract with the MCO.

  If, at the time of transition, an FI serves less than five (5) members in a county, MLTC/MCOs may encourage the members to use an alternative FI to minimize the number of FIs an MLTC/ MCO must have under contract. However, during the transition period, the expectation is that a member is not required to transition

to a different consumer directed personal assistant due to the lack of an MLTC/MCO/FI contract. MLTC/ MCOs are prohibited from coercing or threatening the member or the worker to change FIs.

- **Network Adequacy During the Transition Period**: A MLTC/ MCO that does not have members participating in CDPAS in a particular LDSS must have at least two (2) FI contracts. This will ensure that members will have the option to participate in CDPAS.

- **FI Contracting and Network Adequacy After the Transition Period**: Beginning October 1, 2013, MLTC/MCOs may contract with two (2) FIs to cover members in multiple counties.

- **Model FI Contract and Department of Health Review**: The Department supports the use of the MLTC/MCO/FI model contract developed by the parties. However, each MLTC/MCO/FI may negotiate the terms of the model contract, except that no agreement may contain provisions that would be considered management functions under 10 NYCRR 98-1.11 or a provider agreement per 10 NYCRR 98-1 and the Provider Contract Guidelines without the express written approval of the Department. The MCOs were required to submit to the Department the name(s) of the contracted FIs for each county prior to October 1, 2012 and the fourth quarter of each year thereafter, or upon request of the Department.

- **Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative**: Each member prior to receiving CDPAS must sign a consumer acknowledgement of the roles and responsibilities of the MLTC/MCO and the member. The Department has provided a sample acknowledgment form with the minimum requirements for its use by the MLTC/MCO.

- Transition of Consumer Direct Services continues throughout the mandatory counties.

- Department is preparing guidelines to share with all MLTCs regarding Consumer Direct Services to supplement existing educational materials shared previously.

- Posting of Consumer Direct Services guidelines to the Department of Health website for clarification.

5. Required Quarterly Reporting

   - **Critical incidents:** The most significant critical incident for the reporting period was Hurricane Sandy. In order to assure ongoing connection to members the Department required Plans: to provide working phone numbers available 24/7 and alternate working email addresses; to make member service representatives available beyond office hours; to perform outreach to members to assess their safety and location; and to authorize out of network coverage for services to assure that members could continue services in alternative locations due to evacuations. In addition NYMC had to make adjustments due to being evacuated from their workplace such as shifting consumer representative phone lines, delaying mandatory mailings, and creating alternate access to systems. During recovery, Plans, the Department, the HRA and NYMC have continued to

identify issues (i.e. mailing addresses; out of service area members) to assure ongoing continuity. Also during this time the Department, in partnership with NYMC is developing the critical incident reporting structure. Due to Hurricane Sandy, additional time is needed to complete the system.

The system continues to be refined at this time, with an anticipated completion in the fall of 2013.

The electronic reporting system has been implemented and will continue to be refined as needed. There were 85 critical incidents reported to the Department for the fourth quarter utilizing the enhanced system.

- **Grievance and appeals:** The number and types of grievance and appeals for this population filed and/or resolved within the reporting quarter:

Period: 10/01/13 - 12/31/13			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	3027	3027	100%
# Standard/Expedited	715	746	104%
Total for this period:	3742	3773	101%

Period: 10/01/13 - 12/31/13	
Appeals	
Total appeals filed for this period:	
Total for this period:	287

Period: 10/01/13 – 12/31/13	
Grievances	
Reason for Grievances	**Total**
Dissatisfaction with quality of home care (other than lateness or absences)	**740**
# Same Day	563
# Standard	175
# Expedited	2
Home care aides late/absent on scheduled day of service	**794**
# Same Day	730
# Standard	64
# Expedited	0

Period: 10/01/13 – 12/31/13	
Dissatisfaction with quality of day care	**72**
# Same Day	39
# Standard	33
# Expedited	0
Dissatisfaction with quality of other covered services	**369**
# Same Day	282
# Standard	86
# Expedited	1
Dissatisfaction with transportation	**1191**
# Same Day	1011
# Standard	179
# Expedited	1
Travel time to services too long	**52**
# Same Day	45
# Standard	7
# Expedited	0
Wait too long to get appointment or service	**24**
# Same Day	19
# Standard	5
# Expedited	0
Waiting time too long in provider's office	**35**
# Same Day	21
# Standard	14
# Expedited	0
Dissatisfaction with care management	**91**
# Same Day	60
# Standard	31
# Expedited	0
Dissatisfaction with member services and plan operations	**42**
# Same Day	25
# Standard	17
# Expedited	0
Dissatisfied with choice of providers in network	**18**
# Same Day	11
# Standard	7
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**3**
# Same Day	1
# Standard	2
# Expedited	0
Language translation services not available	**1**
# Same Day	1
# Standard	0
# Expedited	0

Hearing/vision needs not accommodated	**2**
# Same Day	1
# Standard	1
# Expedited	0
Disenrollment issues	**8**
# Same Day	2
# Standard	6
# Expedited	0
Enrollment issues	**12**
# Same Day	6
# Standard	6
# Expedited	0
Plan staff rude or abusive	**24**
# Same Day	11
# Standard	13
# Expedited	0
Provider staff rude or abusive	**37**
# Same Day	29
# Standard	8
# Expedited	0
Violation of other enrollee rights	**0**
# Same Day	0
# Standard	0
# Expedited	0
Denial of expedited appeal	**0**
# Same Day	0
# Standard	0
# Expedited	0
Other:	**250**
# Same Day	189
# Standard	58
# Expedited	3
Total for this period:	**3742**
# Same Day	3027
# Standard	706
# Expedited	9

Period: 10/01/13 – 12/31/	
Reason for Appeal	**Total**
Denial or limited authorization of service including amount, type or level of service	**183**
# of Standard Filed	183
# of Expedited Filed	0
Reduction, suspension or termination of previously authorized service	85
# of Standard Filed	72
# of Expedited Filed	13
Denial in whole or part of payment for service	**1**
# of Standard Filed	1

# of Expedited Filed	0
Failure to provide services in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon grievance or appeal of grievance in a timely manner	**1**
# of Standard Filed	1
# of Expedited Filed	0
Failure of plan to act upon appeal of plan action in a timely manner	**1**
# of Standard Filed	0
# of Expedited Filed	1
Other	**2**
# of Standard Filed	1
# of Expedited Filed	1
Total appeals filed for this period:	**273**
# of Standard Filed	258
# of Expedited Filed	15

Period: 10/01/13 – 12/31/13	
Fraud and Abuse Complaints Reported during Quarter	21

Period: 10/01/13 – 12/31/13	
Reason for Complaints	**Total**
Home Health Care- unspecified	34
Billing- provider questions on coverage/payer	26
Transportation- dissatisfaction services non-ER	12
Dental Care	7

- **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 15,382, with 721 individuals who did not qualify to enroll in an MLTC plan. For the fourth quarter of 2013, the total number of assessments for the enrollment performed by the plans is 15,966, with 1,791 individuals who did not qualify to enroll in an MLTC plan.

- **Referrals and 30 days assessment:** This was the first quarter for Plans to report to the enrollment broker (New York Medicaid Choice) the number of individuals they received referral on from outside NYMC and the time frame in which assessments were completed. The establishment of the reporting system and training of Plans to assure data completeness and quality is an ongoing effort. This quarter there were 1,604 reported referrals with 1,362 dates of assessment within the 30 day time frame. This represents an 85% rate of assessment completion based on data elements submitted. The remaining 242 reported referrals had errors in the data that resulted in an inability to calculate a date for assessment. NYMC is reaching out to Plans to improve the data reporting. The State will review the finalized data to determine if actions need to

be taken. For the quarter from July to September, the Department continues to track the data provided by NYMC and will continue to identify areas that need improvement. For the fourth quarter of 2013, total assessments conducted by MLTC plans during the period are 2579. 50% were conducted within the 30 day time frame. Noncompliance is specific to 5 plans. Quality of data will be verified then remedial action pursued.

- **Consistency of reporting has improved over the last quarter of 2012, but data discrepancies indicate that continued education and refining instructions is necessary.** Raw data shows total assessments conducted by MLTC plans during the period is 3,491. Of those, only 1,598 were conducted within the 30 day time frame, 1,899 were not. This represents less than 50% compliance with the base timeframes, however non compliance is appears to be isolated to certain plans. The State's enrollment broker NYMC has provided additional education regarding reporting and a steady improvement in quality and timelines is apparent. The Department issued notification that effective next quarter (July) plan specific remedial actions will be taken as indicated.

- **Referrals outside enrollment broker:** 6,580 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials. During the fourth quarter of 2013, 7,763 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Referrals outside enrollment broker (consumers who were referred but did not qualify for the 30 day age calculation because of bad dates in date field):** 158 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

- **Rebalancing efforts:** Due to delay in reporting of the current assessment data from SAAM (Semi-Annual Assessment of Members), the following data reflects activities prior to implementation of mandatory enrollment. This is statewide data for managed long term care plans, therefore a subset of individuals enrolled during that period (1,108 out of 58,846).

F. For the January – June 2012 reporting period, the MLTC population had 1,108 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	59
Respite	4
Permanent Placement	34
Unsafe home	5.7
Other	2.9

G. For July - December 2012 reporting period, there were 1,227 nursing home admissions (out of 78,269). Percent admitted by reason:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30
Unsafe home	6.4
Other	3

For the January – June 2012 reporting period, the MLTC population had 1,108 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	59
Respite	4
Permanent Placement	34
Unsafe home	5.7
Other	2.9

For July - December 2012 reporting period, there were 1,227 nursing home admissions (out of 78,269). Percent admitted by reason:

Therapy/Rehab	62
Respite	3.7
Permanent Placement	30
Unsafe home	6.4
Other	3

For the January - June 2013 reporting period, the MLTC population had 1,422 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	64
Respite	3
Permanent Placement	27
Unsafe home	5.6
Other/Unknown	6

For the January - June 2013 reporting period, the MLTC population had 1,422 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	64
Respite	3
Permanent Placement	27
Unsafe home	5.6
Other/Unknown	6

For the January - June 2013 reporting period, the MLTC population had 1,422 people admitted to a nursing home during the same time period. Percent admitted by reason:

Therapy/Rehab	64
Respite	3
Permanent Placement	27
Unsafe home	5.6
Other/Unknown	6

Quarterly reporting of Rebalancing Efforts has been implemented, effective with fourth quarter 2013 data submission. Previous data reported was based on a semi-annual data collection cycle.

Period: 10/1/13-12/31/2013	
Rebalancing Efforts	
Number of Individuals enrolled in the plan from a nursing home	234
Number of Enrollees admitted to a nursing home but returned to the community	618
Number of Enrollees permanently admitted to a nursing home	349

V. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

See Attachment 1. NYS Partnership Plan Projected 1115 Waiver Budget Neutrality Impact.

B. Designated State Health Programs

Total value for Designated Year 7 is $76,880.897.

C. Hospital Demonstration and Clinic Uncompensated Care

The Department processed Clinic Uncompensated Care distributions in the amount of $34,165,504, $17,082,754 FFP, during the quarter that ended March 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $9,196,209, $4,598,105 FFP, during the quarter that ended June 30, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $1,790,919, $895,459 FFP, during the quarter that ended September 30, 2012.

Cumulative distributions to date total $45,152,632, $22,576,316 FFP.

The Department processed Clinic Uncompensated Care distributions in the amount of $79,428,341, $39,714,171 FFP, during the quarter that ended December 31, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $28,385,795, $14,192,898 FFP, during the quarter that ended March 31, 2013.

The Department processed Clinic Uncompensated Care distributions in the amount of $896,912, $448,456 FFP, during the quarter that ended June 30, 2013.

Cumulative disbursements to date total $153,863,680, $76,931,843 FFP.

The Department processed Clinic Uncompensated Care distributions in the amount of $108,751,308, $54,375,690 FFP, during the quarter that ended December 2013.

VI. Update on Progress Activities Related to Quality Demonstrations and Clinic Uncompensated Care Funding

Hospital-Medical Home Demonstration

The Hospital-Medical Home Demonstration announced awards for funding and participation to 64 hospitals in early October 2013. Hospitals submitted work plans on December 3, 2012 for review. Hospitals officially began work plan implementation on January 1, 2013. One year into the project, hospitals continue actively implementing residency changes, patient-centered medical home transformation of participating outpatient sites, and the chosen care coordination and inpatient projects contained in their work plans to meet the program requirements.

Program Accomplishments:

- Reallocation of funding among the 62 hospitals continues to occur based on program changes, hospital closures and mergers, and residency program and clinic changes.
- Continuous clinical and technical support to 62 hospitals and 160 sites

- Conducted weekly meetings with a Work Plan Review Team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from IPRO and within the Department;
- Clarified definition of a continuity site and re-assessed hospital applications and work plans for compliance with that definition. Developed re-allocation formula to ensure only outpatient sites meeting the definition are included in the award calculation. Corrections to funding amounts are being made going forward.
- Implemented a process for all sites participating in the Care Coordination and Integration: Medication Reconciliation project to submit Patient Lists, allowing the NYSDOH to link reported data with claims data and begin validating and analyzing the submitted lists. Information will be used to evaluate the impact of medication reconciliation on outpatient avoidable readmissions.

- According to hospital submissions in this Q1 time frame:
    - 25% of all sites have achieved either level 2 or level 3 NCQA PCMH Recognition under the 2011 standards
    - 59% of sites working on increasing the number of residents in the ambulatory clinic showed an increase since the previous quarter.
    - The majority of sites (over 50% of sites) reported improved rates since the previous quarter for the following measure categories: tracking adult BMI measurements/nutrition counseling, breast cancer screening, cervical cancer screening, child immunization status, colorectal cancer screening, controlling high blood pressure, dilated eye exams for diabetics, lipid profiles for diabetics, nephropathy testing for diabetics, HbA1c testing in diabetics, tobacco use assessment, and well child assessments.
    - The number of sites reporting data correctly has grown each quarter. All hospital-reported data submitted through the web tool is now being aggregated in summary reports for each domain. Summary reports are used to determine the quality and completeness of reporting as well as site progress. The content in the reports vary by domain, but generally display the number of sites improving on certain metrics since the previous quarter, the number of sites reporting on a given metric, and the number of site answering either 'yes' or 'no' to required questions about meeting milestones in each domain)
    - Received and reviewed the second quarterly data submissions from sites and provided feedback to the hospitals regarding the quarterly submission
- Convened a conference planning committee for January 2014 statewide conference by meeting weekly ensure appropriate experts are invited to present on critical components of this demonstration and further explore the innovations for improving the primary health care for Medicaid members and improve workforce training and measure reporting capabilities.
- Surveyed hospitals on their educational and training needs for the annual conference.
- Poster subcommittee developed poster session guidelines, chose 30 posters of 71 for presentation at annual meeting. Poster sessions detailed project initiatives, best practices, and other innovative ideas that hospitals have implemented as a result of the demonstration.
- Developed and administered a survey to all hospitals to gather input on future coaching educational training for the various hospital projects

- Began conducting site visits throughout NYS to learn about the
- accomplishments, changes and challenges hospitals are facing during this demonstration program.
- Conducted web conferences and a teleconference to educate participants in the completion of the 2nd quarter reporting material as well as upcoming changes for quarter 3; provided opportunities for question and answer to all hospitals/sites involved in project.
- Developed and coordinated webinar to all participants of the Hospital-Medical Home Demonstration Program who selected the Behavioral Health project on PSYCKES – a database that tracks metabolic conditions, prescription history, and other information to improve care for Medicaid members with behavioral health condit
- Developed and coordinated Best Practice Learning Seminar training for sharing ideas and approaches on Care Transitions.

Administrative and Policy Changes:

- Hired full-time Program Manager for Hospital Medical Home Demonstration.
- Refinements to the Patient List specifications (a required submission in the Care Coordination and Integration: Medication Reconciliation project) have been developed based on feedback received from hospitals and sites. The next data submission will more clearly specify the look back period for hospital discharges.
- Technical assistance is provided to hospitals regarding challenges in documenting Detailed narrative reporting of the progress of projects within some hospitals.

Planned Actions For the Next Quarter:

- Receive and process re-formatted goal rates from all hospitals and sites for metrics related to clinical performance, resident continuity, care coordination and integration, and inpatient projects. Reformatted goal rates will allow for comparison between the rate being reported for each measure and that measure's goal.
- Ongoing support and education regarding reporting process.
- Annual Conference on 1/23/14.
- Receive and review 4th Quarter and Annual Report.
- Continue site visits with hospitals and outpatient primary care sites.
- Implement regular educational coaching calls as a result of survey feedback.
- Hospitals submit NCQA PCMH final application by end of Q2.

VII. Consumer Issues

A. Complaints

Effective November 1, 2013, a new bureau, the Bureau of Consumer Services, was formed in the Division of Health Plan Contracting and Oversight, to focus existing staff resources and improve consistency in response and investigation of consumer and provider managed care complaints.

Medicaid managed care plans reported 4,468 complaints/action appeals this quarter, a decrease of 2% from the previous quarter. Of these complaints/appeals, 651 were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for 31% of the total. There were 418 complaints/appeals reported by

the HIV SNPs. The majority of these complaints (333) were in the category of reimbursement/billing. The Department directly received 288 Medicaid managed care complaints and 0 FHPlus complaints this quarter.

The top 5 most frequent categories of complaints were as follows:

31% Balance Billing
18% Reimbursement/Billing Issues
8% Dental or Orthodontia Services
8% Emergency Services
7% Quality of Care

This quarter, mainstream Medicaid managed care plans reported the following complaints and action appeals regarding long term services and supports. The Department did not identify any overall trends impacting enrollees' access to services:

Long Term Services and Supports	Number of Complaints/Action Appeals Reported
AIDS Adult Day Health Care	0
Adult Day Care	1
Consumer Directed Personal Assistant	0
Home Health Care	1
Non-Permanent Residential Health Care Facility	0
Personal Care Services	14
Personal Emergency Response System	0
Private Duty Nursing	1
Total	17

B. Medicaid Managed Care Advisory Review Panel (MMCARP) Meetings

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 19, 2014. The meeting included presentations on: Statutory Language; Managed Long Term Care Update; Auto-Assignment Rates; Explanation of Spenddown Process and Technical Problems with Spenddown; and Mail Order Pharmacy Issues.

C. Managed Care Policy and Planning Meetings

The Managed Care Policy and Planning meetings were held on July 18, August 15 and September 19, 2013. The July meeting included presentations on: Finance and Rate Development, Average Acquisition Cost (AAC)/Cost of Dispensing (COD), OPWDD DISCO/FIDA Update, Discussion of Exchange/Medicaid Update, Behavioral Health Update, and Early Intervention/Fiscal Agent.

The August meeting agenda included: Finance and Rate Development, FIDA Update, Behavioral Health/HARP Update, OMIG Managed Care Review Activities, and Encounter Data Monitoring.

Presentations at the September meeting included: Emergency Preparedness, Finance and Rate Development, FIDA Update, New York City Flu Immunization Program,

Behavioral Health/HARP, Discussion of Basic Benefit Information, Encounter Data Monitoring, and an update on New York State of Health Exchange for the Medicaid/Child Health Plus Programs.

VIII. Quality Assurance/Monitoring

A. Quality Measurements

CAPHS^{R}
DataStat administered a CAHPS^{R} 5.0 survey to adult Medicaid members in managed care plans between September and December 2013. Reports are being prepared for managed care plans with anticipated distribution in February 2014.

B. Managed Long Term Care

UAS-NY Transition
On October 1, 2013 all MLTC plans transitioned to the UAS-NY for physical assessment of their members. The UAS-NY is a web-based software application that will provide a comprehensive assessment system to evaluate individuals' health status, strengths, care needs, and preferences to guide the development of individualized long-term are service plans.

The NYS Department of Health is finalizing the MLTC report for public release. This report describes New York's approved MLTC plans at the time of data collection and presents information about the quality of care they provide and enrollee's satisfaction with the plan. The Department is also finalizing the release of the MLTC Consumer Guides. These guides serve to summarize quality of care and satisfaction measures, and present the results pictorially.

C. Quality Improvement Activities

External Quality Review
Approval was obtained to extend the current External Quality Review contract with the Island Peer Review Organization (IPRO) for an additional 12 month period. The contract extension will run from April 1, 2013 through March 31, 2014. A Request for Proposals is currently being prepared to solicit bids for a five year contract to conduct Medicaid managed care external quality review (EQR) as per the Balanced Budget Act of 1997 and CMS published EQR regulations. The new contract will be in effect April 1, 2014.

Health plans participated in a variety of quality improvement activities including performance improvement projects, and special studies.

Patient-Centered Medical Home (PCMH) Satisfaction
The Department is currently overseeing a satisfaction study involving Medicaid managed care members who have had visits with providers certified by NCQA as PCMH providers. In the summer of 2013, the Department and IPRO began planning a study to look at the differences in experience of care between patients who had visits with a PCMH provider and those with visits to a provider without the PCMH designation. The Clinician and Group CAHPS^{R} survey including the PCMH module is the survey instrument. A random sample of 6,000 Medicaid members was selected, divided equally between children and adults, and between those with a visit to a PCMH provider and a visit with a non-PCMH provider. Surveys were sent to enrollees following a combined mail and phone methodology in

September 2013, resulting in 35.4 percent response rate. Data cleansing and calculations are in progress, with a final report anticipated by February 2014.

Asthma Disparities Grant

The Department calculated and posted quarterly Group III measures (Brooklyn Community Data) to the Institute for Healthcare Improvement (IHI) Extranet in November 2013. This included both quarterly measures as well as trended data using the cohort of continuously enrolled Medicaid managed care members with persistent asthma residing in Central Brooklyn. African-Americans as of the 9th measurement period were significantly more likely to have had at least one inpatient hospitalization event with a primary diagnosis of asthma than all other racial/ethnic groups combined; however, the cohort of all other racial/ethnic groups combined was small (N=3). There was no significant difference noted between African-Americans and all other racial/ethnic groups combined for emergency department visits with a primary diagnosis of asthma.

Breast Cancer Selective Contracting

Staff worked on the analysis of all-payer Statewide Planning and Research Cooperative System (SPARCS) data for 2010-2012 to identify low-volume facilities with a three-year average of fewer than 30 breast cancer surgeries.

During this period, a letter to administrators of low-volume facilities was drafted. The intent of the letter is to notify facility administrators that the Department will not reimburse claims submitted for mastectomy and lumpectomy procedures provided to Medicaid fee-for-service beneficiaries during fiscal year 2014-15; facilities will, however, have an opportunity to appeal this decision.

Performance Improvement Projects (PIPs)

For 2013-2014, a collaborative PIP includes two parts. Part 1, the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD), includes testing the effectiveness of patient incentives on improving health behaviors and outcomes in the following clinical areas: diabetes prevention and management, smoking cessation and hypertension management. Part 2 focuses on implementing interventions to improve care in one of the four clinical areas noted above. For Part 1, MIPCD five plans have begun to implement their interventions for the testing of patient incentives through diabetes prevention programs. To date, 25 Medicaid recipients are enrolled in the study. For Part 2, IPRO is conducting periodic conference calls with the health plans to monitor their progress. All plans are on track with proposed interventions.

IX. Family Planning Expansion Program

Family Planning Benefit Program Enrollment Summary
Third Quarter FFY 2013 (July 1, 2013 – September 30, 2013)

	Female	Male	Total
New Enrollees This Quarter	7,607	2,029	9,636
Total Enrollees This Quarter	38,543	9,115	47,658
Enrollees Using Services This Quarter	12,815	173	12,988
Cumulative Enrollment Since 10/01/11	91,553	24,487	116,040
Enrollees Using Services Since	47,297	2,043	49,340

10/01/11			
Continuous Enrollment Since 10/01/11	3,898	350	4,248

Source of Data: DOH/OMM Audit, Fiscal and Program Planning Data Mart (Report Date: 01-Dec-2013)

Family Planning Benefit Program Utilization by Category of Service
Third Quarter FFY 2013 (Oct 1, 2013 – Dec 31, 2013)

TOTAL Medicaid Eligibles	**47,658**
TOTAL Medicaid Recipients	**12,880**
TOTAL Medicaid Expenditures	**2,670,880**
TOTAL Medicaid Eligible Months	**121,388**
AVERAGE Expenditures per Eligible	**56**
AVERAGE Months per Eligible	**2.5**
PMPM	**22**

Categories of Service (COS)	COS Dollars	COS PMPM	COS Dollars per Recipient	COS Claims / Days		COS Claims/ Days per Recipient	COS Recipients
Physician	16,053	0.13	69	414	Claims	2	232
Psychology	31	0.00	31	1		1	1
Eyecare	5	0.00	5	1	Claims	1	1
Nursing	435	0.00	73	7	Claims	1	6
OPD Clinic (hospital outpatient)	152,605	1.26	347	527	Claims	1	440
ER	500	0.00	125	4		1	4
FS Clinic (D&T center)	1,498,777	12.35	252	7,102	Claims	1	5,953
Inpatient	1,184	0.01	1,184	0	Days	0	1
Pharmacy	860,216	7.09	117	14,834	Claims	2	7,349
Laboratory	57,598	0.47	47	2,687	Claims	2	1,238
Transportation	1,888	0.02	99	85	Claims	4	19
CTHP	1,731	0.01	87	22	Claims	1	20
DME and Hearing Aid	105	0.00	21	13	Claims	3	5
Referred Ambulatory	79,209	0.65	102	1267	Claims	2	774

Source of Data: DOH/OMM Audit, Fiscal and Program Planning Data Mart, (Report Date: 6/1/13)

X. Transition Plan Updates

Attachment 2 contains the Department's updated Transition Plan indicating how New York State will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Partnership Plan demonstration.

XI. Other

Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract

On June 21, 2013, the Department received CMS approval of the October 1, 2012 amendment to the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract. This amendment modifies the previously approved August 1, 2011 version of the model contract and includes contract language changes related to implementation of various Medicaid Redesign Team initiatives, other programmatic changes and a one-year extension of the contract through February 28, 2014. The contract amendment was sent to MCOs for signature on June 27, 2013.

Attachments

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Date Submitted to CMS:

February 28, 2014

ATTACHMENT 1

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013
DY10 0910 21 Month Lag first 2 quarter only

Budget Neutrality Cap (Without Waiver)	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	DY 17 (1/1/14-3/31/14) Projected	BIPA Extension (10/1/06 - 3/31/14) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$6,124,915,586	$13,431,555,927	$14,853,389,777	$3,975,139,194	$3,975,139,194	$87,452,124,549	
Demonstration Group 2 - TANF Adults 21-64	$2,443,182,702	$5,362,266,874	$5,914,379,682	$1,579,889,213	$1,579,889,213	$33,983,682,792	
Demonstration Group 6 - FHP Adults w/Children	$1,055,415,331	$2,341,067,454	$2,632,237,613	$724,658,042	$0	$14,923,713,183	
Demonstration Group 8 - Family Planning Expansion	$5,140,241	$10,702,271	$1,856,551	$0	$0	$17,699,062	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$247,394,784	$1,027,336,330	$260,284,563	$260,284,563	$1,795,300,240	
Demonstration Group 11 - MLTC age 65+ Duals		$2,554,212,091	$10,820,566,375	$2,796,750,566	$2,796,750,566	$18,968,279,598	
W/O Waiver Total	**$9,628,653,860**	**$23,947,199,400**	**$35,249,766,328**	**$9,336,721,578**	**$8,612,063,536**	**$157,140,799,425**	**$301,780,677,948**

Budget Neutrality Cap (With Waiver)	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	DY 17 (1/1/14-3/31/14) Projected	BIPA Extension (10/1/06 - 3/31/14) Projected	DY 1 - DY 16
Demostration Group 1 - TANF Children under age 1 through 20	$2,801,314,813	$6,274,647,760	$6,920,891,478	$1,841,829,404	$1,840,421,312	$39,246,022,915	
Demonstration Group 2 - TANF Adults 21-64	$1,546,569,069	$3,469,798,151	$3,820,998,638	$1,019,514,707	$1,019,416,724	$21,588,134,330	
Demonstration Group 5 - Safety Net Adults	$2,829,518,468	$6,893,620,899	$8,184,495,364	$2,210,213,971	$0	$36,256,179,698	
Demonstration Group 6 - FHP Adults w/Children up tp 150%	$553,389,253	$1,173,058,139	$1,313,450,137	$360,124,780	$0	$7,461,293,807	
Demonstration Group 7 - FHP Adults without Children up to 100%	$173,575,211	$352,894,110	$401,041,648	$110,970,648	$0	$3,076,851,953	
Demonstration Group 7A - FHP Adults without Children @ 160%	$0	$0	$0	$0	$0	$0	
Demonstration Group 8 - Family Planning Expansion	$6,573,308	$13,934,296	$2,462,132	$0	$0	$71,178,785	
Demonstration Group 9 - Home and Community Based Expansion (HCBS)	$3,699,108	$3,699,108	$3,699,108	$924,777	$924,777	$12,946,878	
Demonstration Group 10 - MLTC Adult Age 18-64 Duals		$249,276,515	$999,765,437	$249,927,129	$249,927,129	$1,748,896,210	
Demonstration Group 11 - MLTC age 65+ Duals		$2,561,508,288	$10,403,512,554	$2,629,869,736	$2,629,869,736	$18,224,760,313	
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)	$2,600,000	$10,583,000	$10,583,000	$10,583,000		$34,349,000	
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)	$2,600,000	$10,583,000	$10,583,000	$10,583,000		$34,349,000	
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)	$0	$100,000,000	$100,000,000	$100,000,000		$300,000,000	
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)	$0	$4,433,000	$4,433,000	$4,433,000		$13,299,000	
Demonstration Population 5: Designated State Health Programs (Various)						$0	
With Waiver Total	**$7,919,839,230**	**$21,118,036,266**	**$32,175,915,496**	**$8,548,974,151**	**$5,740,559,677**	**$128,068,261,888**	**$251,999,389,700**
Expenditures (Over)/Under Cap	**$1,708,814,629**	**$2,829,163,133**	**$3,073,850,831**	**$787,747,428**	**$2,871,503,859**	**$29,072,537,537**	**$49,781,288,248**

ATTACHMENT 1

New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through December 2013
DY10 0910 21 Month Lag first 2 quarter only

Budget Neutrality Cap (Without Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$8,641,454,877	$9,086,365,132	$10,048,004,954	$11,210,460,422	$6,105,699,488
Demonstration Group 2 - TANF Adults 21-64		$3,045,582,094	$3,217,134,170	$3,856,757,531	$4,517,252,946	$2,467,348,368
Demonstration Group 6 - FHP Adults w/Children		$1,691,957,919	$1,813,935,485	$1,746,457,301	$1,874,936,618	$1,043,047,420
Demonstration Group 8 - Family Planning Expansion						
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
W/O Waiver Total	$144,639,878,523	$13,378,994,889	$14,117,434,787	$15,651,219,785	$17,602,649,986	$9,616,095,275

Budget Neutrality Cap (With Waiver)	DY 1 - 8 (10/1/97 - 9/30/06) Actual	DY 9 (10/1/06-9/30/07) Actual	DY 10 (10/1/07-9/30/08) Actual	DY 11 (10/1/08-9/30/09) Actual	DY 12 (10/1/09-9/30/10) Actual	DY 13A 10/1/10-3/31/11) Actual
Demostration Group 1 - TANF Children under age 1 through 20		$4,006,367,977	$4,412,472,964	$4,828,196,168	$4,492,088,177	$1,827,792,863
Demonstration Group 2 - TANF Adults 21-64		$2,062,992,139	$2,222,230,858	$2,553,996,035	$2,712,728,726	$1,159,889,284
Demonstration Group 5 - Safety Net Adults		$3,017,805,826	$3,213,033,028	$3,818,572,584	$4,224,557,751	$1,864,361,807
Demonstration Group 6 - FHP Adults w/Children up tp 150%		$813,927,831	$884,575,928	$894,902,321	$965,325,522	$502,539,894
Demonstration Group 7 - FHP Adults without Children up to 100%		$587,725,574	$566,489,543	$412,034,961	$316,237,864	$155,882,395
Demonstration Group 7A - FHP Adults without Children @ 160%		$0	$0	$0	$0	$0
Demonstration Group 8 - Family Planning Expansion		$10,471,785	$10,598,020	$11,138,799	$11,835,960	$4,164,485
Demonstration Group 9 - Home and Community Based Expansion (HCBS)		N/A	N/A	N/A	N/A	N/A
Demonstration Group 10 - MLTC Adult Age 18-64 Duals						
Demonstration Group 11 - MLTC age 65+ Duals						
Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct)						
Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP)						
Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo)						
Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo)						
Demonstration Population 5: Designated State Health Programs (Various)						
With Waiver Total	$123,931,127,812	$10,499,291,132	$11,309,400,341	$12,518,840,867	$12,722,773,999	$5,514,630,728
Expenditures (Over)/Under Cap	$20,708,750,711	$2,879,703,758	$2,808,034,445	$3,132,378,919	$4,879,875,987	$4,101,464,547

Attachment 2

New York State

Partnership Plan Medicaid Section 1115 Demonstration

Transition Report

I. Introduction

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).

On January 1, 2014, New York will have made considerable progress in implementing the ACA. Specifically, New York will have expanded coverage, made changes to access to care, and reforms to the payment and delivery system. The ACA expands Medicaid eligibility for individuals under the age of 65, with income at or below 133 percent of the Federal Poverty Level (FPL). In New York State, some of these individuals are currently eligible under New York's Partnership Plan 1115 Waiver.

II. Transition Plan

Nearly 90 percent of individuals currently covered under New York's Partnership Plan 1115 waiver will transition to a State Plan eligibility group with coverage through an Alternative Benefit Plan as a result of the Medicaid expansion authorized by the ACA and adopted by New York. For most enrollees in Family Health Plus, the transition to Medicaid using MAGI eligibility rules will occur at renewal. Ideally, the State would choose to switch coverage for the waiver population from Family Health Plus to Medicaid on January 1, 2014. However, this is not possible for all enrollees because not enough information is known to the system about parent/caretaker enrollees to automatically switch them to a MAGI budget on January 1, 2014.

New York intends to stop accepting new applications for Family Health Plus after December 31, 2013. Anyone who submits an application prior to or on that date and are found eligible, will be enrolled in Family Health Plus for 12 months. Effective January 1, 2014, new applications will be evaluated using MAGI eligibility rules, and if eligible, applicants will be enrolled in Medicaid under an Alternative Benefit Plan. New York has chosen the Medicaid State Plan benefit (without institutional long-term care) as its Alternative Benefit Plan and will be submitting a SPA for Secretary Approval as soon as the SPA templates are available from CMS.

Family Health Plus single and childless couples will have their coverage changed to the Alternative Benefit Plan effective January 1, 2014. Family Health Plus parents and caretaker relatives with income up to 138% FPL will transition to the Alternative Benefit Plan as they renew, effective April 1, 2014. Family Health Plus parents and caretaker

relatives with income over 138% FPL to 150% FPL will transition to a qualified health plan, however the State will pay the enrollee's share of the premium, this does not include the individual's cost sharing.

Using existing rules, individuals renewing coverage from October 1, 2013 through March 31, 2014, if determined eligible, will enroll in the current plan under the waiver (e.g. Family Health Plus or Medicaid) for twelve months but no longer than through December 31, 2014 for Family Health Plus. Individuals determined ineligible from October 1, 2013 through March 31, 2014, will be sent a notice referring the person to apply for coverage through the Marketplace.

New York is building a new eligibility system that automates the MAGI eligibility rules for Medicaid, CHIP, and Advance Premium Tax Credits. The State anticipates over one million individuals are eligible to obtain coverage during the open enrollment period that begins October 1, 2013, and even more may apply. Given the complexity of the system build, the short time for adequately testing all the eligibility permutations and the data services available through the Federal Hub (and the reality that rules and interfaces will continue to be built 3-6 months after open enrollment), New York has decided to mitigate risk by maintaining current Medicaid enrollees in the legacy system until the State is confident it has the automation and system stability to transition over three million current enrollees without a disruption in coverage. New York is prioritizing the ability to provide coverage on January 1, 2014 to the newly eligible populations while doing no harm to current Medicaid enrollees.

To maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI eligibility using the current legacy system for those individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI rules in the legacy system for at least six months or until the new eligibility system is fully automated and is stable enough to handle the transition of over 3 million current recipients. The legacy logic will include:

- No longer counting child support as income
- Not applying income disregards/deductions
- Increased federal poverty levels to comply with ACA income levels
- New AID categories for claiming
- Revised client notices

The current renewal form will be used.

New applications submitted to local departments of social services from October 2013 through December 2013, will have eligibility determined under existing rules in the legacy system and, if eligible, individuals will be enrolled for 12 months of coverage. Individuals that are not eligible due to income will be instructed to reapply through the Marketplace. Applications submitted to the Marketplace from October 2013 through December 2013, will be determined using MAGI rules and if determined eligible,

coverage will be effective January 1, 2014. Applications submitted on or after January 1, 2014, will have eligibility determined through the Marketplace under the ACA rules. Individuals who have medical bills or are in need of coverage in the three month period prior to January 1, 2014, will be referred to the local department of social services for a determination of eligibility for payment/reimbursement of medical bills.

Although New York will transition individuals from the waiver to coverage under the ACA, the State intends to maintain the authority included in the waiver to mandatorily enroll individuals into managed care in counties **other than** Allegany, Cortland, Duchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

Table 1: Individuals Enrolled in Medicaid Managed Care

Current State Plan Mandatory and Option Groups	Current FPL and/or other qualifying criteria
Pregnant women	Income up to 200%
Children under age 1	Income up to 200%
Children 1 through 5	Income up to 133%
Children 6 through 18	Income up to 133%
Children 19-20	Income at or below the monthly income standard
Parents and caretaker relatives	Income at or below the monthly income standard

A. Seamless Transitions

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65, regardless of disability status with income at or below 133 percent of the FPL;

The following chart outlines the current waiver population, current coverage, and the coverage options for individuals between 133% FPL and 150% FPL currently enrolled in Family Health Plus. These options include transitioning Family Health Plus enrollees to Advanced Premium Tax Credits. Regardless of which options are available in 2014, all populations will have eligibility determined under the ACA.

Table 2: Groups Transitioning from Demonstration to ACA

Demonstration Eligible Group	Current Federal Poverty Level	Current Coverage	2014 Coverage
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income based on Statewide standard of need, approximately 0%-78% FPL	Medicaid	0% ≤ 133% Benchmark
Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 100% FPL	Family Health Plus	0% ≤133% Benchmark
Children 19 and 20 years old [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Standard coverage > 133% ≤150% Standard coverage >150% APTC
Parents and caretaker relatives of a child under the age of 21 (who could otherwise be eligible under section 1931 of the Medicaid State Plan) [s. 2001(a)(1) and (2)]	Income above the Medicaid income standard but at or below gross 150% FPL*	Family Health Plus	0% ≤ 133% Benchmark > 133%≤150% State will pay enrollee's share of APTC premiums and seek federal participation as a designated state health program >150% APTC (no state assistance)

*The current Partnership Plan 1115 approved NYS comparing income to 160% FPL, but this has not been implemented.

ii. Identify Demonstration populations not eligible for coverage under the ACA and explain what coverage options and benefits these individuals will have effective January 1, 2014;

All populations currently covered under the waiver will have coverage options under the ACA. In addition, New York plans to implement 12-months of continuous coverage for adults in conjunction with the implementation of the ACA.

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide a 12-month continuous eligibility period to the groups of individuals specified in Table 2, regardless of the delivery system through which they receive Medicaid benefits. Once the State begins exercising this authority, each newly eligible individual's 12-month period shall begin at the initial determination of eligibility. For those individuals who are redetermined eligible consistent with the Medicaid State plan, the 12-month period begins at that point. At each annual eligibility redetermination thereafter, if an individual is redetermined eligible under the Medicaid State plan, the individual is guaranteed a subsequent 12-month continuous eligibility period.

This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Authority for this population's eligibility during the 12 month continuous eligibility period is only in the 1115 waiver and therefore, individuals during this period would be eligible for expanded Medicaid levels and benchmark under ACA, and are also subject to continuous coverage. The Department is in the process of exploring the necessary system and program changes and anticipates implementing in January 2014.

Table 3: Groups Eligible for a 12-Month Continuous Eligibility Period

State Plan Mandatory and Optional Groups	Statutory Reference
Pregnant women aged 19 or older	• 1902(a)(10)(A)(i)(III) or (IV); and • 1902(a)(10)(A)(ii)(I) and (II)
Children aged 19 or 20	1902(a)(10)(A)(ii)(I) and (II)
Parents or other caretaker relatives aged 19 or older	1902(a)(10)(A)(ii)(I) and (II)
Members of low-income families, except for children	1931 and 1925

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility;

- Local departments of social services will process new applications for Medicaid using current eligibility rules through December 31, 2013.
- New applications submitted to the Marketplace from October 2013 through December 2013, will have eligibility determined through the Marketplace under ACA rules and, if eligible, enrollment will be effective January 1, 2014. The acceptance notice will inform individuals who have medical bills or are in need of coverage prior to January 1, 2014 to apply at the LDSS. Applicants will be informed of this process online so they may go directly to the LDSS rather than apply through the Marketplace before January 1, 2014.
- Beginning January 1, 2014, new applications will go through the Marketplace and will be processed through the new integrated eligibility system.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the ACA and the authorities the State identifies that may be necessary to continue coverage for these individuals;

Nearly all of the populations covered under the waiver will be covered under the ACA and those populations who are subject to continuous coverage will also have authority applied under the waiver.

Parents/caretakers with MAGI income between 138% and 150% of FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for a tax credit under the ACA provided they do not have access to affordable coverage. The State will be seeking authority through an amendment to the Partnership Plan waiver, for federal financial participation for an affordability wrap for those individuals who would have been eligible for Family Health Plus prior to January 1, 2014 and who are now able to purchase Qualified Health Plans (QHPs). The goal is to mitigate the increased costs for these individuals as they move from the Medicaid waiver to the QHP. The State intends to implement an affordability wrap to pay the premium for the QHP for individuals in this income group who purchase a silver plan. Beneficiaries between 19 and 20 years of age who are living with parents with MAGI income between 138% and 150% of the FPL will no longer be eligible for a Medicaid waiver category, but will be eligible for Medicaid under MOE requirements.

v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

New York is developing a new eligibility system that will automate program eligibility based on the MAGI eligibility rules as defined by CMS. All applications submitted to the Marketplace after January 1, 2014 will be processed using the MAGI eligibility rules in the new system.

As described above, to maintain stability in coverage for the over three million Medicaid enrollees whose eligibility will be determined under MAGI, the current legacy system will be modified to calculate budgets using MAGI rules to the maximum extent possible. Effective April 1, 2014, local districts will be able to determine MAGI eligibility using the current legacy system for individuals renewing coverage. Local districts will continue to renew existing enrollees using MAGI rules in the legacy system for at least six months, or, until the new eligibility system is fully automated and is stable enough to handle the transition of over three million current recipients.

New York opted for CMS to develop a modified adjusted gross income (MAGI) equivalency level for converting existing net eligibility levels to MAGI eligibility levels. While New York received preliminary results, the State is waiting for the re-run results for children along with the weighted averages for the separate applicant and beneficiary results.

B. Access to Care and Provider Payments

i. Provider Participation. The State must identify the criteria that will be used for reviewing provider participation in (e.g. demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition;

The service delivery network for a Managed Care Organization ("MCO") is county specific and is comprised of primary, specialty and ancillary providers as well as related institutions consistent with the benefit package. Each county network must include at least one hospital, one inpatient and outpatient mental health facility as well as at least one substance abuse inpatient and outpatient facility. This applies to HMOs participating in government programs and those that have exclusive commercial membership.

The behavioral health network is required to have both individual providers, outpatient facilities and inpatient facilities. The facilities must include mental health and substance abuse services. In the case of outpatient mental health, at least one facility in the county must be licensed by the Office of Mental Hygiene pursuant to Article 31 of the Mental Hygiene Law, or be a facility operated by the Office of Mental Hygiene. The mental health inpatient facility can be either a psychiatric center under the jurisdiction of the Office of Mental Hygiene, or, a unit or part of a hospital operating under Article 28 of the Public Health Law.

The provision of alcohol and substance abuse services must also be provided in an outpatient facility and an inpatient facility. These facilities must have the capacity to provide substance abuse treatments. The inpatient facilities must have the capacity to provide detoxification and rehabilitation services.

In addition to the above, Medicaid networks must also include traditional Medicaid providers, i.e., presumptive eligibility providers, Designated AIDS Centers and Federally Qualified Health Centers (FQHCs), where available.

With the implementation of the homeless population into Medicaid managed care, we also require the MCO to contract with available federally qualified 330 providers in every county they are available in.

All additional providers that have been required to be added to the MCO provider network as part of the transition of new benefits into Medicaid managed care were reviewed prior to the implementation and quarterly thereafter.

On October 1, 2012 Orthodontia for children was transitioned into Medicaid managed care. The network requirement that is established for this benefit is to have a minimum of two orthodontists in each county of the MCOs approved service area, if available.

On November 11, 2012, the Consumer Directed Personal Assistance Services was transitioned into the Medicaid managed care program. MCOs were require to contract with a fiscal intermediary to ensure payment for the the services.

On April 1, 2013, the Long Term Home Health Care Program and non-agency foster care children living in the community in the upstate counties were transitioned into Medicaid managed care. As a result, additional provider network requirements were made. In the Long Term Home Health Care Program, MCOs were required to contract with certified home health care agencies, nursing homes and hospitals that provided the Long Term Home Health Care Program.

The addition of the non-agency foster care children required MCOs to augment their provider network where necessary to include fee for service health care providers who have traditionally treated this population. We also strongly encouraged MCOs to contract with specific specialty health care providers for intake and ongoing comprehensive assessments for children in foster care.

On August 1, 2013, the Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AADHC) benefit were transitioned into Medicaid managed care. Consequently, MCOs were required to add these providers to their network of contracted providers. MCOs operating in NYC, Nassau, Suffolk and Westchester Counties are required to contract with a minimum of three ADHC providers and two AADHC providers where available. In the rest of State the requirement is two ADHC providers and one AADHC providers where available.

On August 1, 2013 the Directly Observed Therapy for Tuberculosis/Inpatient TB therapy Ordered by Local Health Commissioners was also transitioned into Medicaid managed care. MCOs are required to include in its benefit package the observation of dispensing of medication, assessing any adverse reactions to the medications and case follow up. This is conducted as follows: □ Upstate location of services is the local health department (LHD), or in the home/other community setting; □ New York City locations are Department of

Health and Mental Hygiene (DOHMH) clinics and approved Health and Hospitals Corporation (HHC) hospitals (Bellevue, Elmhurst, Kings County) or in the home/other community setting.

MCOs have been required to amend existing provider contracts or enter into new contractual arrangements with LHDs.

On October 1, 2013 the hospice benefit was transitioned to Medicaid managed care. This has resulted in requiring MCOs to contract with multiple hospice agencies that are currently in operation. Each MCO must contract with at least 2 providers. In counties where there is only 1 provider, the MCO must contract with that agency.

ii. Adequate Provider Supply. The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013;

The MCO is required to have the full array of contracted providers in each county. However, in rural counties, this may not be possible due to a lack of resources within the county. When there is a lack of a provider type in a county, the MCOs may contract with providers in adjacent counties, or service area, to fulfill the network requirements. In some cases where counties border neighboring states and the normal access and referral pattern for obtaining medical services in those areas is to go across state boundaries, MCOs may request approval to augment their networks by adding those out of state providers. Attachment 1 provides a listing of the core provider types for all lines of business.

In addition to the full array of required health care providers, the network must include sufficient numbers of each provider type, be geographically distributed and ensure choice of primary and specialty care providers. The Public Health Law requires the MCO member a choice of at least three geographically accessible primary care providers. It is the department's policy that MCOs are required to contract minimally with two of each required specialist provider types per county. However, additional providers may be required based on enrollment and to ensure geographic accessibility.

The Department of Health has developed time and distance standards for provider networks to which MCOs are required to adhere. For all Medicaid, HIV Special Needs Plans, and Child Health Plus health products, the time and distance standard is as follows:

- metropolitan areas - 30 minutes by public transportation;
- non-Metropolitan areas - 30 minutes or 30 miles by public transportation or by car;
- in rural areas transportation requirements may exceed these standards if justified.

The provider networks for the Medicaid, HIV Special Needs Plans, and Child Health Plus managed care products are reviewed on a quarterly basis. The Department of Health maintains a database and MCOs are required to submit their networks electronically at schedule dates. The submitted data goes through an editing process to ensure the data contains all required information prior to accepting the network. Prior to a network analysis the information is matched against state and federal disciplinary files to remove providers unauthorized from participation in government programs. Subsequently, the network is analyzed for the presence of core provider types and sufficient numbers of providers to ensure choice of primary and specialty providers.

The first part of the review is an electronic analysis based upon program parameters established by the Department to determine if each county has an adequate number of the required core providers. The second part of the analysis is a manual review of reports that are produced. Examples of these reports include whether there are a sufficient number of providers in the county to provide a choice of primary and specialty providers and a comparison of providers not contracting with a specific MCO but who have contracts with other MCOs in the same county. The reports are then summarized and MCOs are notified of any access issues identified within their certified areas of operation. MCOs are required to review the summaries and report back to the Department. The Department will then have MCOs sign an attestation that members may obtain services on an out of network basis to the nearest provider, but not greater than 30 minutes or 30 miles from the members' residence. This attestation remains in place until the MCO is able to successfully address the noted provider inadequacy.

iii. Provider Payments. The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive rate (e.g., certain Indian Health providers);

The State will pay the PPS rate through the eMedNY FFS system for eligible Medicaid enrollees. For enrollees in Medicaid managed care, the State will make supplemental payments to eligible FQHC/RHC's to make up the difference between the PPS rate and the average managed care payment.

C. **System Development or Remediation. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include: i. Replacing manual administrative controls with automated processes to help support a smooth interface among coverage and delivery system options that is seamless to beneficiaries;**

New York is working to simplify and align both our rules and processes in accordance with the ACA requirements, and to automate MAGI eligibility

determinations and verifications to the maximum extent practicable, and to promote a more seamless customer experience.

D. Progress Updates. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed;

The State will provide quarterly and annual reports.

E. **Implementation**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Marketplace, or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application;

As described above, New York will transition eligible childless adult enrollees in the Demonstration to Medicaid on January 1, 2014. Parents/caretakers will be transitioned at their renewal beginning April, 2014 to either Medicaid or QHP coverage.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees;

New York plans to provide appropriate notices that minimize demands on enrollees to the maximum extent possible.