# Partnership Plan
## Section 1115 Quarterly
## Demonstration Year: 15 (10/1/2012 – 9/30/2013)
## Federal Fiscal Quarter: 2 (01-01-2013 – 03/31/2013)

## 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.

## II. Enrollment

### Second 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 counties as of 10/1/06 | 1,636,689 | 23,190 | 58,449 |
| Population 2 - TANF Adults aged 21 through 64 in mandatory counties as of 10/1/06 | 485,261 | 9,093 | 27,009 |
| Population 3 – Safety Net Adults | 822,865 | 17,151 | 44,057 |
| Population 4 – Family Health Plus Adults with children | 335,235 | 5,628 | 23,611 |
| Population 5 – Family Health Plus Adults without children | 92,295 | 1,697 | 7,817 |

**Explanation of Populations:**

- Population 1 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 1 through 20
- Population 2 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 21 through 64
- Population 3 - Safety Net Adults
- Population 4 - Family Health Plus Adults with Children
- Population 5 - Family Health Plus Adults without Children

| Voluntary Disenrollments | |
|---|---|
| **Total # Voluntary Disenrollments in Current Demonstration Year[1]** | **114,500** |

Reasons for voluntary disenrollments include: enrollment in another plan; approved enrollee request to qualify as either exempt or excluded; relocation to residence outside county of enrollment; and, Local Department of Social Services (LDSS) approval to disenroll based upon appropriate cause.

| Involuntary Disenrollments | |
|---|---|
| **Total # Involuntary Disenrollments in Current Demonstration Year[1]** | **311,292** |

Reasons for involuntary disenrollments include: loss of Medicaid eligibility; eligibility transfers between Family Health Plus (FHPlus) and Medicaid; 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, mandatory Medicaid managed care programs are 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.

[1] Demonstration year to date: 10/01/2012 – 03/3012013

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). During the reporting period, the following benefits were transitioned into Medicaid managed care: Consumer Directed Personal Assistance Program (CDPAP) and Orthodontia for children with severe malocclusions.

NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 18 Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 74% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 15 consumers per work session. A work session covers a half day of work activities.

A total of 2,651 presentations were scheduled by NYMC. Of these, 678 or 26% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

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

The Department hosted three Medicaid Managed Care Coalition meetings to provide information on the following systems and program changes:

- MRT #1458, including expansion of managed care enrollment to include: Long Term Home Health Care Program (LTHHCP) recipients, and children in foster care placed in the community directly by the LDSS; and expansion of benefits to include medical social services and home delivered meals.
- Enrollment center progress on the Health Care Eligibility and Assessment Renewal Tool (HEART tool). The HEART tool is used by the Enrollment Center to do Medicaid eligibility renewals.

Several Medicaid updates were published and Managed Care Technical Advisory Group conference calls were held to update the counties on changes to the program as a result of the MRT roll-out.

## IV. Operational/Policy Developments/Issues

A. Partnership Plan Waiver Amendments

Negotiations with CMS continued during the quarter to finalize 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 will be 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 enroll in a MLTC plan approved to enroll individuals aged 18 and older, and dually eligible individuals aged 21 and under and non-duals of any age may voluntarily enroll in a MMMC plan.

The Department was also awaiting CMS authorization to enroll individuals in foster care who are placed in the community directly by LDSS. This does not extend to individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution. In addition, the Department is awaiting authorization to enroll individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program.

B. Health Plans

1. Retroactive Changes to Certificates of Authority:

   - Amerigroup New York, LLC. had an address change on February 19, 2013.
   - Amida Care, Inc. was approved for a HIV Special Needs Plan in Queens County, effective February 19, 2013.

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

   - New York State Catholic Health Plan, Inc. Follow up survey was conducted on January 18, 2013. No deficiencies were cited.
   - Affinity Health Plan, Inc. Follow up survey was conducted from February 27, 2013 to February 28, 2013. A Statement of Deficiency was issued.
   - VNS Choice. Survey was conducted from March 13, 2013 to March 15, 2013. A Statement of Deficiency was issued.
   - Amerigroup New York, LLC. Follow up survey was conducted from March 20, 2013 to March 22, 2013. A Statement of Deficiency was issued.

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 are 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. Family Health Plus Buy-in Program

Development Activities

The United Federation of Teachers (UFT) contracted with New York State and the NYS Office of Children and Family Services to provide all 25,000 of its child care providers with access to health insurance through the FHPlus Employer Buy-In program. UFT has partnered with the Health Insurance Plan of New York to provide a network of services to their members. The child care workers are licensed and registered home child care providers in New York City and provide services to low-income families. During this quarter, a total of 1077 unsubsidized UFT members were enrolled in the FHPlus Buy-In program. For child care workers who are eligible for Medicaid or FHPlus, the premium is paid through the state.

Civil Service Employees Association (CSEA) also received legislative authority and appropriations to provide health insurance coverage through the FHPlus Employer Buy-In program. CSEA is actively seeking a plan to provide coverage to its member population.

FidelisCare, present in almost all counties within the state, is seeking to contract with a vendor, U.S. Fire and Unified Life, to provide family planning services so that FidelisCare can participate in the FHPlus Employer Buy-in program. As a Catholic health plan, FidelisCare does not provide these services. U.S. Fire and Unified Life is working with the state to complete the necessary steps to be approved as a vendor for family planning with FidelisCare for the FHPlus Employer Buy-In program.

The Department continues to receive inquiries from small employers about the FHPlus Buy-in Program. However, many of these inquiries are from counties where there is no health insurance plan participation and no additional enrollments have been made.

Information on the FHPlus Employer Buy-in program for both managed care plans and potential employers is available on the Department website at: **http://www.nyhealth.gov/health_care/managed_care/family_health_plus_employer_buy-in/index.htm.**

2. Family Health Plus Premium Assistance Program

The FHPlus Premium Assistance Program (PAP), for individuals who are eligible for FHPlus and have access to cost effective health insurance went into effect on January 1, 2008. Total enrollment as of March 31, 2012 is 3,078 individuals.

| Enrollment in ESHI Through FHPlus PAP | New Enrollment 07/01/12-09/30/12 | Total Enrollment September 30, 2012 |
|---|---|---|
| FHPlus Adults with children | 111 | 711 |
| FHPlus Adults without children | 346 | 2,367 |
| Total | 457 | 3,078 |

| Age group for reporting Quarter 1/01/13-3/31/13 | Number of Enrollees |
|---|---|
| 19-44 | 2,615 |
| 45-64 | 463 |

3. 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:

  The Pacific Health Policy Group (PHPG), the contractor hired to assist the Department with multiple MEQC reviews, continued to follow up with state program and system staff to establish the proper protocols for generating the universes of cases that meet the review requirements. Availability from the Department's system staff continues to be limited because of other system priorities (i.e., system work related to ACA and the Health Benefit Exchange). System staff involvement was deemed necessary because the universe specifications for this review are more complicated than usual. Several multi-step edit processes are needed to accurately identify the universes of cases from which to pull the review samples.

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

  PHPG continued to work with Department program staff to resolve the issues that surfaced when attempting to identify the proper universes of cases. A letter was drafted for transmittal to the various local Department of Social Services (LDSS) offices to notify them that the review process would begin soon. The letter will also request that a primary and secondary contact be designated from each office to act as the liaisons for all interaction between the district and the PHPG review team.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

  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. Additionally, the Department conducted quality control reviews on a small sample of the cases to ensure that PHPG was appropriately evaluating the review cases.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

  PHPG continued to request the necessary case record information for all sample cases. In addition, PHPG continued conducting initial, peer and supervisory reviews, as well as recording the results of those reviews in their central database.

E. State Health Access Program Grant (SHAP)

As previously reported, there will be no new Health Research and Services Administrations (HRSA) appropriations to support SHAP-funded programs for years three through five; this decision affected all SHAP states. The Department received approval to use unexpended SHAP funds. SHAP funds are currently being used, in part, to help support Enrollment Center operations. The Enrollment Center began operations on June 13, 2011, and consolidated the FHPlus, Medicaid, and Child Health Plus (CHPlus) call centers. The Enrollment Center is also processing certain upstate renewals, and is preparing to expand processing to include a subset of NYC Premium Assistance cases as well as statewide presumptive eligibility Family Planning Benefit Program (FPBP) applications.

F. Benefit Changes/Other Program Changes

No benefit or other program changes this quarter.

G. Twelve Month Continuous Coverage

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide continuous coverage for certain Medicaid beneficiaries and FHPlus enrollees for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. Twelve months continuous coverage for adults will be implemented January 1, 2014 with the implementation of the New York Health Insurance Exchange.

H. Federally Qualified Health Services (FQHC) Lawsuit

CHCANYS, et al vs NYS Dept of Health -- a mixed decision was rendered by Judge Carter of the US District Court, Southern District of NY in February, 2013. The Court dismissed four of six of plaintiffs' causes of action and directed the Department to make changes in reimbursement policy/procedures in connection with the remaining two causes of action. Plaintiffs have filed an appeal with regard to those causes of action dismissed by the Court and the Department has filed a cross-appeal with regard to the Court's decision concerning the other two causes of action.

I. 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.

   - 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 Care 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 23 service area expansions, 9 new lines of business for operational MLTCPs, and 85 new certificates of authority for new partially capitated plans.

   - 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.

- 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.
- 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.

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.

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.

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** An 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 MCO 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.

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 and the completed system will be built by April 15, 2013.

     The system continues to be refined to capture critical incidences.

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

| **Period:** 10/01/12 - 12/31/12 | | | |
|---|---|---|---|
| **Grievances** | | | |
| **Total for this period:** | | **Resolved** | **Resolved %** |
| # Same Day | 2294 | 2294 | 100% |
| # Standard/Expedited | 564 | 219 | 39% |
| Total for this period: | 2858 | 2513 | 88% |

| **Appeals** | |
|---|---|
| Total appeals filed for this period: | |
| Total for this period: | 221 |

| **Period:** 01/01/13 – 03/31/2013 | | | |
|---|---|---|---|
| **Grievances** | | | |
| **Total for this period:** | | **Resolved** | **Resolved %** |
| # Same Day | 2712 | 2712 | 100% |
| # Standard/Expedited | 730 | 689 | 94% |
| Total for this period: | 3442 | 3401 | 99% |

| **Appeals** | |
|---|---|
| Total appeals filed for this period: | |
| Total for this period: | 407 |

- **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.

- **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.

- **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 3,379. Of those, only 1,504 were conducted within the 30 day time frame, 1,875 were not. This represents less than 50% compliance with the base timeframes, a significant drop from the 85% reported previously. However it appears that there are a variety of errors in plan reporting, and steps are being taken with NYMC to increase education and advise plans that the state will be taking actions if improvements are not seen immediately.

- **Referrals outside enrollment broker:** 6,580 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).

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

  For the 1,108 people, percent break out by reason(s):

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

For July - December 2012. There were 1,227 nursing home admissions (out of 78,269). Admitted to a nursing home during this time period:

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

- **Total complaints, grievances/appeals by type of issue:**

| Reason for Grievance | Total |
|---|---|
| **Dissatisfaction with quality of home care (other than lateness or absences)** | |
| # Same Day | 364 |
| # Standard | 155 |
| # Expedited | 3 |
| **Home care aides late/absent on scheduled day of service** | |
| # Same Day | 132 |
| # Standard | 28 |
| # Expedited | 0 |
| **Dissatisfaction with quality of day care** | |
| # Same Day | 5 |
| # Standard | 1 |
| # Expedited | 0 |
| **Dissatisfaction with quality of other covered services** | |
| # Same Day | 90 |
| # Standard | 34 |
| # Expedited | 1 |
| **Dissatisfaction with transportation** | |
| # Same Day | 1878 |
| # Standard | 213 |
| # Expedited | 0 |
| **Travel time to services too long** | |
| # Same Day | 3 |
| # Standard | 3 |
| # Expedited | 0 |
| **Wait too long to get appointment or service** | |
| # Same Day | 10 |
| # Standard | 3 |
| # Expedited | 0 |
| **Waiting time too long in provider's office** | |
| # Same Day | 1 |
| # Standard | 0 |
| # Expedited | 0 |
| **Dissatisfaction with care management** | |
| # Same Day | 44 |

| Reason for Grievance | Total |
|---|---|
| # Standard | 47 |
| # Expedited | 1 |
| **Dissatisfaction with member services and plan operations** | |
| # Same Day | 47 |
| # Standard | 54 |
| # Expedited | 0 |
| **Dissatisfied with choice of providers in network** | |
| # Same Day | 7 |
| # Standard | 1 |
| # Expedited | 0 |
| **Misinformed about plan benefits or rules by marketing or other plan staff** | |
| # Same Day | 0 |
| # Standard | 4 |
| # Expedited | 0 |
| **Language translation services not available** | |
| # Same Day | 9 |
| # Standard | 1 |
| # Expedited | 0 |
| **Hearing/vision needs not accommodated** | |
| # Same Day | 0 |
| # Standard | 0 |
| # Expedited | 0 |
| **Disenrollment issues** | |
| # Same Day | 2 |
| # Standard | 3 |
| # Expedited | 0 |
| **Enrollment issues** | |
| # Same Day | 0 |
| # Standard | 2 |
| # Expedited | 0 |
| **Plan staff rude or abusive** | |
| # Same Day | 4 |
| # Standard | 2 |
| # Expedited | 0 |
| **Provider staff rude or abusive** | |
| # Same Day | 12 |

| Reason for Grievance | Total |
|---|---|
| # Standard | 3 |
| # Expedited | 0 |
| **Violation of other enrollee rights** | |
| # Same Day | 0 |
| # Standard | 0 |
| # Expedited | 0 |
| **Denial of expedited appeal** | |
| # Same Day | 0 |
| # Standard | 0 |
| # Expedited | 0 |
| **Other:** | |
| # Same Day | 104 |
| # Standard | 52 |
| # Expedited | 1 |
| **Total for this period:** | |
| # Same Day | 2710 |
| # Standard | 596 |
| # Expedited | 6 |

| Reason for Appeal | Total |
|---|---|
| Denial or limited authorization of service including amount, type or level of service | |
| # of Standard Filed | 166 |
| # of Expedited Filed | 0 |
| Reduction, suspension or termination of previously authorized service | |
| # of Standard Filed | 50 |
| # of Expedited Filed | 2 |
| Denial in whole or part of payment for service | |
| # of Standard Filed | 2 |
| # of Expedited Filed | 0 |
| Other | |
| # of Standard Filed | 1 |
| # of Expedited Filed | 0 |
| Total appeals filed for this period: | |
| # of Standard Filed | 219 |
| # of Expedited Filed | 2 |

| Reason for Complaints | Total |
|---|---|
| Billing provider questions on coverage or payer | 62 |
| Dissatisfaction with quality of home care | 14 |
| Care not adequate to support client in home | 9 |
| Difficulty obtaining DME | 6 |

## 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

There was no expenditure activity for Designated State Health Programs during the quarter.

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 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 ended June 30, 2012.

The Department processed Clinic Uncompensated Care distributions in the amount of $1,790,919, $895,459 FFP, during the quarter 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 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 ended March 31, 2013.

Cumulative disbursements to date total $152,966,768, $76,483,387 FFP.

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

**Hospital-Medical Home Demonstration**

A. Program Accomplishments:

- Reviewed initial Hospital and Outpatient Site Work Plans submitted by hospitals.
- Completed and formally communicated to hospitals revision requirements.
- Reviewed and approved work plan revisions.
- Developing the quarterly and annual reporting tool.
- Received formal Patient Centered Medical Home baseline assessments for participating sites.
- Distributed first quarter of year one payment.

The Hospital-Medical Home (H-MH) Demonstration includes 63 hospitals, 32 in New York City and 30 in the rest of the state. The participating hospitals include 162 outpatient primary care training sites that will be transformed to Level 2 or 3 Patient Centered Medical Homes. Additionally, these participating hospitals have included 119 Residency Training programs: 48 Internal Medicine Residencies; 34 Pediatrics; 33 Family Medicine; and 4 Combined Internal Medicine-Pediatrics Programs.

The awards range from $120,000 to $21 million, averaging $3.9 million. The first payment distribution, 25% of the first year distribution, was made on January 3, 2013.

B. Project Status:

During the second quarter, staff conducted reviews of the hospital's electronic work plans. Hospitals and their primary care outpatient sites developed work plans describing them both in narrative and with measures and baseline data. Electronic submissions occurred in December 2012. The New York State Department of Health (NYS DOH) developed a team of eight reviewers with assistance from several clinical and administrative specialty advisors from IPRO, OMH, and within NYS DOH.

All work plan reviews were completed by the end of March 2013. Hospital teams developed innovations in residency programs, care coordination projects, and inpatient safety and quality improvement projects. With their participating outpatient sites, hospitals provided baseline data for five clinical performance metrics for each participating site that addressed disease prevalence within the sites' unique demographics. Additionally, work plans included baseline data for measures for every section of the work plan.

The hospitals and their outpatient residency sites chose measures to address a wide variety of preventative health and chronic disease issues. In adults, the measures most frequently chosen addressed issues including but not limited to diabetes care, control of high blood pressure, screening for colon, breast and cervical cancer, BMI assessment, and counseling for nutrition. Childhood immunization status, counseling for nutrition and physical activity, lead screening, and well child visits comprised a significant portion of the measures chosen for the pediatric population.

Where possible, hospitals and their participating sites were required to utilize standardized measures that have been validated by an outside professional organization. In some areas of the work plan where none exist, participants were required to develop their own measures. Overall, participants developed the ability and structure to provide outpatient and inpatient quality data for each area of their work plan.

During the work plan development and review phases, the majority of hospitals, including their outpatient primary care sites, required one-to-one coaching on how to create measure definitions, obtain baseline data for the required measures and overall develop quality improvement projects for outpatient sites. In several cases, hospitals made several revisions to their work plan prior to receiving approval. Hospitals and Department staff trained outpatient site personnel in measure reporting, including understanding standardized measure definitions, numerators, denominators and types of rates.

The hospitals' work for the Hospital-Medical Home project began January 1, 2013. Some of the activities that hospitals and their residency sites have begun include hiring care coordinators and additional medical and support staff to carry out site-specific project activities. Some hospitals have hired clinical staff to cover inpatient responsibilities that residents traditionally covered so that residents would be able to spend more time in the continuity training clinics. Additionally, hospitals hired consultants to assist residency sites in the transformation process to achieve patient centered medical home recognition. Preparations for residency program changes are under way as well as transforming the sites into patient centered medical homes.

The quarterly electronic reporting tool is currently under development with an expected completion date of June 1, 2013. The Department will hold web conferences to educate participants on using the tool and completing the quarterly report. The Department will continue meeting with hospital and residency program teams to support, educate and clarify demonstration program requirements.

Hospitals were required to submit for each outpatient site, a formal baseline patient centered medical home assessment within six months. All participating hospitals completed this requirement.

The Department is working with the Hospital Associations to facilitate work groups and other collaborative efforts to provide a platform for sharing best practices and solutions to the challenges faced by the hospitals and outpatient sites during implementation of the various parts of the H-MH demonstration project.

C. Administrative and Policy Challenges:

One of the goals of this program is to address the fragmentation of healthcare that can lead to information loss, errors, and lower quality care. There were many complexities involved in bringing many different inpatient departments of hospitals, outpatient sites, and residency programs together to work on common goals. Hospitals needed to create systems and relationships to develop communication, team-work, and data-sharing, which was a challenge for many of them. In addition, bringing so many different parts of the hospital system together required a sophisticated electronic work plan, allowing multiple users and reviewers, as well as a combination of narrative and both standardized and non-standardized measures and data. As a result, the initial iteration of this electronic tool needed further development after initial work plan submissions, and revision submissions and additional reviewer feedback were delayed as the system was redesigned.

D. Planned Actions for the Next Quarter:

- Test-Drive the quarterly reporting tool and review the instruction manual when developed by IPRO;

- Conduct web conferences for hospitals, outpatient sites, and residency programs on the quarterly reporting tool;
- Finalize the quarterly reporting tool; and
- Meet with hospital teams to address issues and challenges as they begin quarterly report submission.

**Potentially Preventable Readmissions Demonstration**

No change at this time.

## VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported **4840** complaints/action appeals this quarter, a decrease of **21%** from the previous quarter. Of these complaints/appeals, **806** were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for **33%** of the total. There were **254** complaints/appeals reported by the HIV special needs plans (SNPs). The majority of these complaints (**185**) were in the category of reimbursement/billing. The Department directly received **120** Medicaid managed care complaints and no**1** FHPlus complaints this quarter.

The top five most frequent categories of complaints were as follows:
33% Balance Billing
15% Reimbursement/Billing Issues
9% Difficulty Obtaining Emergency Services
7% Access to non covered services
7% Dissatisfaction with quality of care

Beginning in 2013, complaint categories were updated to allow reporting for disputes involving new benefits and long term care services and supports.

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 |
|---|---|
| Consumer Directed Personal Assistant | 0 |
| Home Health Care | 4 |
| Non-Permanent Residential Health Care Facility | 2 |
| Personal Care Services | 6 |
| Personal Emergency Response System | 0 |
| Private Duty Nursing | 0 |
| Total | 12 |

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 4,840 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 622 complaints and action appeals from their SSI

enrollees. This compares to 642 SSI complaints/action appeals from last quarter. The top 5 categories of complaints reported were:

| Category | Percent of Total Complaints/Appeals Reported for SSI Enrollees |
|---|---|
| Balance Billing | 19% |
| Dissatisfaction with quality of care | 12% |
| Reimbursement/billing disputes | 11% |
| Access to non covered services | 10% |
| Dissatisfaction with provider services | 10% |

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

No MMCARP meetings occurred during this quarter.

C. Managed Care Policy and Planning Meetings

Managed Care Policy and Planning meetings were held on January 17 and February 21, 2013. The January meeting included presentations on: updates to the rates for the Managed Long Term Care program, the pharmacy dashboard, updates on rates to include dental and ambulatory patient groups; response and recovery billing and payment for Super Storm Sandy Emergency/Disaster; Primary Care Physician payment increase; maternal child health home visits; transition of behavioral health services to managed care; and an update regarding the benefits and populations moving to Medicaid managed care in April 2013.

Presentations at the February meeting included: a proposed demonstration project by Memorial Sloan Kettering Cancer Center; an update on rates for Medicaid managed care, the Affordable Care Act, bump payment for primary care, and the Managed Long Term Care program; briefing on State budget initiatives affecting managed care; update on the Fully Integrated Duals Advantage (FIDA) program; Health and Recovery Plan (HARP) development; and an overview of the NY Health Benefit Exchange.

## VIII. Quality Assurance/Monitoring

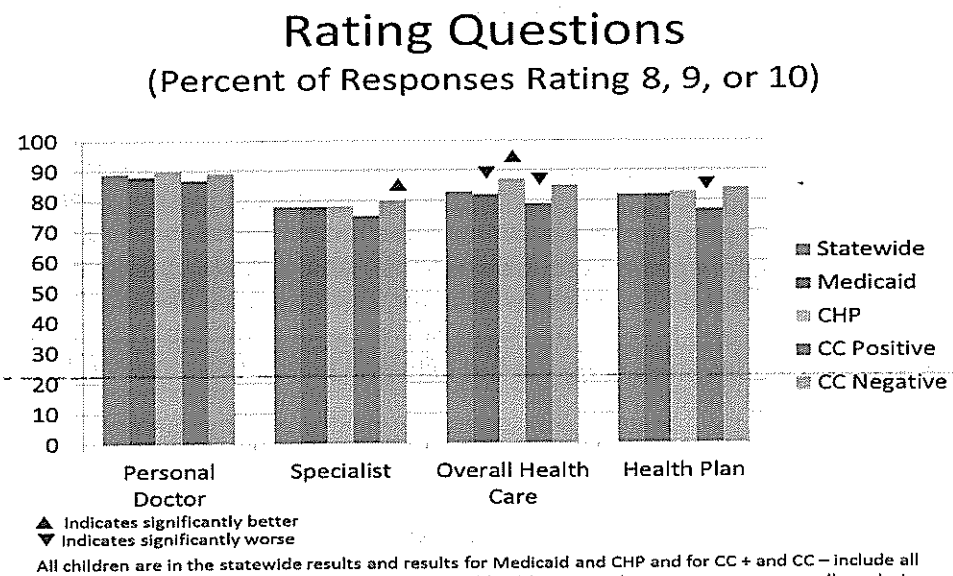
A. Quality Measurements

1. Two technical conference calls were held with health plans in January 2013; the first to review and discuss with health plans the quality reporting requirements (2013 QARR) due in June 2013 and the second to discuss care management reporting (2013 CMART) with Medicaid health plans due in April 2013. Both calls were well attended by plans.

2. Children's Experiences with Care

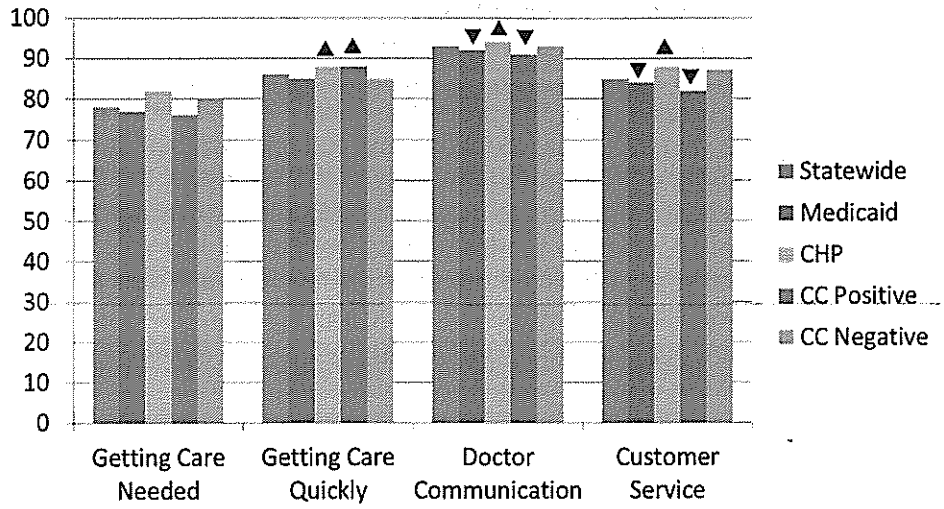
The Department conducted a satisfaction survey with parents/guardians of children enrolled in government programs in the fall 2012 to measure satisfaction with care for parents of children in Medicaid managed care and Child Health Plus programs for the Child Health Insurance Program Reauthorization Act (CHIPRA) reporting and use with comparing plans and programs.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid Child Survey with Chronic Condition module was administered to families of children enrolled in Medicaid and Child Health Plus. The administration methodology consisted of a five-wave mailing protocol, with telephone follow-up for non-responders. The overall response rate was 37 percent (with a range of 31 percent to 46 percent for response rates by plan). The findings demonstrate that parents/guardians of children have generally high levels of satisfaction with care. Families with children with (self-reported) chronic conditions were somewhat less satisfied than families with children without chronic conditions. Areas which may have opportunities to improve include: access to routine care, care from specialists, access to specialized services, and coordination of care. (See graphs with ratings and composites below.)



# Composite Questions

## (Percent of Responses 'Usually' or 'Always')




▲ Indicates significantly better

▼ Indicates significantly worse

3. Managed Long Term Care

Member Satisfaction Survey

In February 2013, the Managed Long Term Care (MLTC) satisfaction survey was mailed to a random sample of members from each plan. Members with six months or more of continuous enrollment were targeted within the 25 MLTC plans. The MLTC member satisfaction survey will provide the Department with information on member satisfaction with the quality, accessibility, and timeliness of services provided by these plans.

Transitions of Care Focused Clinical Study

The expansion of the Medicaid Section 1115 Demonstration requires NYS to conduct a validation audit to determine MLTC compliance with completion of initial assessment within 30 days of referral and to assess the continuity of care during the transition of care period. NYS DOH, with its external quality review agent, IPRO, has initiated this audit to assess both the timeliness and the continuity of care components. In February, 19 MLTC plans were sent random samples of auto-assigned and mandatory enrolled members, and are required to submit documentation to IPRO for review by the end of March.

Uniform Assessment System (UAS-NY) Transition

In July 2013, all MLTC plans will be begin using the UAS-NY for the 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, and guide the development of individualized long-term care service plans. Currently, work is being done to assist the MLTC plans for this transition. Staff is assisting with training, webinars and responses to questions.

C. Quality Outcomes Evaluation

1. Selective Contracting

Pursuant to Section 504.3 (i) of Title 18 of the New York Codes, Rules and Regulations, the New York State Department of Health has been implementing the Medicaid reimbursement restriction policy for mastectomy or lumpectomy procedures in an effort to ensure high quality health care for program beneficiaries. With Statewide Planning and Research Cooperative System data, the project reviews breast cancer surgical volumes performed at heath care facilities; identifies low volume facilities defined as an average of fewer than 30 surgeries performed annually in the course of the three years. Medicaid reimbursement restriction applies to inpatient and outpatient surgical procedures for breast cancer provided to fee-for-service patients at low volume facilities in the subsequent state fiscal year. Medicaid managed care plans are also required to contract with high volume hospitals and ambulatory surgery centers. For the 2013-2014 State Fiscal Year, 73 facilities are restricted from being reimbursed by Medicaid for breast cancer surgeries.

2. Quality Outcomes Evaluation

Potentially Preventable Hospitalizations

Staff continues to load Medicaid data with indicators for Potentially Preventable Readmissions (PPRs) and Prevention Quality Indicators (PQIs) into a database that will be widely available to Department analysts. This will allow for further analysis of these indicators to develop multifaceted approaches to reduce readmission rates and preventable hospitalizations in New York State.

Prevention Quality Indicators for Managed Care Plans

Staff presented a conference call to provide a detailed description of the analytic process and provide a general Q & A session for the plan representatives. Staff continues to work with the plans on a one-on-one basis to help them understand their data.

Nursing Home Quality Improvement

Staff has completed the analysis for the potentially avoidable hospitalizations measure. This was presented to the workgroup and final comments were made. Staff is finalizing the analysis and the first year report using benchmark data which will be released soon.

Managed Long-Term Care Quality Incentive

As part of the Department's Managed Long Term Care Quality Incentive, staff will perform the analysis of potentially avoidable hospital admissions for members of managed long term care plans. Staff has begun defining the managed long term care population and is determining the proper definition to be used to define an avoidable hospitalization in this population.

Development of Medicaid Behavioral Health Outcome Measures

Staff continues working to define measures on the utilization of behavioral health and substance abuse services for the Medicaid population.

3. Asthma Disparities Grant

Eliminating Disparities in Asthma Care (EDAC) Grant activities this quarter were focused on the following: closing out EDAC work at practice sites, finalizing the EDAC Partnership survey and entering the evaluation stage of the grant.

Formal EDAC work ended at the participating practices in December 2012. Staff drafted letters to plan-practice quality improvement teams to summarize team accomplishments, areas of opportunity and strategies for sustaining the collaboration. Letters will be completed and mailed later this spring.

The EDAC Partnership Evaluation Survey was distributed to 35 plan-practice quality improvement members on December 3, 2012. The survey was closed out in March 2013. In total, 21 completed surveys were received for a final response rate of 60 percent. The majority of survey responses, 12 (57 percent) were from practice staff. Twenty respondents (95 percent) either Agreed or Strongly Agreed with the statement, "Members of my plan-practice improvement team worked together to develop a specific AIM statement." A slightly smaller number of respondents, 19 (90 percent), either Agreed or Strongly Agreed with the statement, "I was satisfied with my plan-practice improvement team's level of collaboration." Additionally, respondents were asked to report what they considered to be both the best and most challenging aspects of participating in the EDAC partnership. A sample of responses is reported below.

Best Part

1. *The improvements in asthma management which have occurred at the site, and the team that made this possible.*
2. *The changes that were implemented as a result of the PDSA cycles. These changes have improved the way we capture/gather vital information and increased our communication with Primary Care Physicians as a result, improves the care our patients receive.*
3. *Getting the work done and seeing the success/progress being made.*
4. *Feedback from Ins. companies regarding ER visits and hospitalizations.*
5. *Working with other health plans not as competitors but as the partners that we need to be to address the needs of the populations that we serve in Central Brooklyn and the rest of NYC.*

Most Challenging Part

1. *Finding the time to dedicate to the project.*
2. *Initially, the most challenging part was having all staff (MA, Providers) to buy in and participate.*
3. *The practice site personal barriers conducting the project and managing data without the use of an EMR.*
4. *Collecting data that was used for monthly reports without a report writing software or the ability to develop registries.*

5. *Providing direction to those who do not report to you.*

The EDAC Partnership Evaluation Survey is an integral component of the EDAC Evaluation plan, the completion of which will be the major activity during the balance of the funding period.

## IX. Family Planning Expansion Program

**Family Planning Benefit Program Enrollment Summary**
**Second Quarter FFY 2013 (January 1, 2013 – March 31, 2013)**

| | Female | Male | Total |
|---|---|---|---|
| **New Enrollees This Quarter** | 6,095 | 1,983 | 8,078 |
| **Total Enrollees This Quarter** | 35,456 | 8,414 | 43,870 |
| **Enrollees Using Services This Quarter** | 10,753 | 157 | 10,910 |
| **Cumulative Enrollment Since 4/01/11** | 85,199 | 24,363 | 109,562 |
| **Enrollees Using Services Since 4/01/11** | 41,840 | 1,427 | 43,267 |
| **Continuous Enrollment Since 4/01/11** | 4,119 | 361 | 4,480 |

Source of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart, Report Date: '01-Mar-2013'

**Family Planning Benefit Program Utilization by Category of Service**
**Second Quarter FFY 2013 (January 1, 2013 – March 31, 2013)**

| | |
|---|---|
| **TOTAL Medicaid Eligibles** | **43,870** |
| **TOTAL Medicaid Recipients** | **10,910** |
| **TOTAL Medicaid Expenditures** | **2,029,100** |
| **TOTAL Medicaid Eligible Months** | **114,402** |
| **AVERAGE Expenditures per Eligible** | **46** |
| **AVERAGE Months per Eligible** | **2.6** |
| **PMPM** | **18** |

| Categories of Service (COS) | COS Dollars | COS PMPM | COS Dollars per Recipient | COS Claims / Days | | COS Claims / Days per Recipient | COS Recipients |
|---|---|---|---|---|---|---|---|
| Physician | 22,801 | 0.20 | 97 | 527 | Claims | 2 | 236 |
| Podiatrist | 46 | 0.00 | 46 | 1 | Claims | 1 | 1 |
| Eyecare | 95 | 0.00 | 95 | 1 | Claims | 1 | 1 |
| Nursing | 1,131 | 0.01 | 87 | 15 | Claims | 1 | 13 |
| OPD Clinic (hospital outpatient) | 49,072 | 0.43 | 341 | 178 | Claims | 1 | 144 |
| FS Clinic (D&T center) | 909,982 | 7.95 | 239 | 4,385 | Claims | 1 | 3,813 |
| Inpatient | 12,894 | 0.11 | 2,149 | 2 | Days | 0 | 6 |
| Pharmacy | 962,038 | 8.41 | 117 | 15,776 | Claims | 2 | 8,205 |
| Laboratory | 28,502 | 0.25 | 43 | 1,308 | Claims | 2 | 665 |
| Transportation | 867 | 0.01 | 289 | 14 | Claims | 5 | 3 |
| CTHP | 1,227 | 0.01 | 65 | 20 | Claims | 1 | 19 |
| DME and Hearing Aid | 51 | 0.00 | 17 | 6 | Claims | 2 | 3 |
| Referred Ambulatory | 39,066 | 0.34 | 106 | 531 | Claims | 1 | 367 |

source of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart, Report Date: '01-Mar-2013'

## 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.

**Attachments**

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**Albany, NY 12237**
**Phone: 518-473-5876**
**Fax: 518-473-5508**
**Submitted on: December 31, 2012**

# New York State Partnership Plan
## Projected 1115 Waiver Budget Neutrality Impact Through December 2013
## DY10 0708 21 Month Lag

| Budget Neutrality Cap (Without Waiver) | DY 1 - 8 (10/1/97 - 9/30/06) Projected | 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 | $9,861,957,505 | $11,197,206,500 | $6,105,699,488 |
| Demonstration Group 2 - TANF Adults 21-64 | | $3,045,582,094 | $3,217,134,170 | $3,723,180,372 | $4,511,421,595 | $2,467,348,368 |
| Demonstration Group 6 - FHP Adults w/Children | | $1,691,957,919 | $1,813,935,485 | $1,759,689,505 | $1,878,516,641 | $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 | $15,344,827,382 | $17,587,144,736 | $9,616,095,275 |

| Budget Neutrality Cap (With Waiver) | DY 1 - 8 (10/1/97 - 9/30/06) Projected | 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 | $3,033,275,859 | $4,144,199,750 | $1,827,792,863 |
| Demonstration Group 2 - TANF Adults 21-64 | | $2,062,992,139 | $2,222,230,858 | $1,826,307,957 | $2,619,299,634 | $1,159,889,284 |
| Demonstration Group 5 - Safety Net Adults | | $3,017,805,826 | $3,213,033,028 | $2,638,577,654 | $4,024,374,518 | $1,864,361,807 |
| Demonstration Group 6 - FHP Adults w/Children up tp 150% | | $813,927,831 | $884,575,928 | $868,666,366 | $963,020,020 | $502,539,894 |
| Demonstration Group 7 - FHP Adults without Children up to 100% | | $587,725,574 | $566,489,543 | $399,823,417 | $313,222,949 | $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 | $5,726,583 | $9,839,735 | $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 | $8,772,377,836 | $12,073,956,605 | $5,514,630,728 |
| Expenditures (Over)/Under Cap | $20,708,750,711 | $2,879,703,758 | $2,808,034,445 | $6,572,449,546 | $5,513,188,131 | $4,101,464,547 |

# New York State Partnership Plan
## Projected 1115 Waiver Budget Neutrality Impact Through December 2013
## DY10 0708 21 Month Lag

| 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 | BIPA Extension (10/1/06 - 12/31/13) Projected | DY 1 - DY 16 |
|---|---|---|---|---|---|---|
| Demostration Group 1 - TANF Children under age 1 through 20 | $6,124,850,620 | $13,425,919,749 | $14,841,351,076 | $7,943,771,145 | $87,228,576,093 | |
| Demonstration Group 2 - TANF Adults 21-64 | $2,443,271,375 | $5,369,945,414 | $5,930,750,009 | $3,168,610,456 | $33,877,243,854 | |
| Demonstration Group 6 - FHP Adults w/Children | $1,055,415,331 | $2,341,067,454 | $2,632,237,613 | $724,658,042 | $14,940,525,410 | |
| Demonstration Group 8 - Family Planning Expansion | $5,140,241 | $10,702,271 | $1,856,551 | $0 | $17,699,062 | |
| Demonstration Group 10 - MLTC Adult Age 18-64 Duals | | $247,394,784 | $1,027,336,330 | $260,284,563 | $1,535,015,677 | |
| Demonstration Group 11 - MLTC age 65+ Duals | | $2,554,212,091 | $10,820,566,375 | $2,796,750,566 | $16,171,529,032 | |
| W/O Waiver Total | **$9,628,677,568** | **$23,949,241,763** | **$35,254,097,954** | **$14,894,074,774** | **$153,770,589,127** | **$298,410,467,650** |

| 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 | BIPA Extension (10/1/06 - 12/31/13) Projected | DY 1 - DY 16 |
|---|---|---|---|---|---|---|
| Demostration Group 1 - TANF Children under age 1 through 20 | $2,939,950,571 | $6,308,398,240 | $6,952,064,209 | $3,538,354,107 | $37,162,876,540 | |
| Demonstration Group 2 - TANF Adults 21-64 | $1,689,556,014 | $3,600,327,984 | $3,971,420,054 | $2,002,396,978 | $21,154,420,902 | |
| Demonstration Group 5 - Safety Net Adults | $3,223,555,684 | $7,909,780,921 | $9,461,009,489 | $2,551,560,477 | $37,904,059,404 | |
| Demonstration Group 6 - FHP Adults w/Children up tp 150% | $500,350,859 | $1,114,110,571 | $1,247,419,773 | $342,014,780 | $7,236,626,022 | |
| Demonstration Group 7 - FHP Adults without Children up to 100% | $163,167,013 | $341,142,857 | $387,671,617 | $107,268,049 | $3,022,393,415 | |
| Demonstration Group 7A - FHP Adults without Children @ 160% | $0 | $0 | $0 | $0 | $0 | |
| Demonstration Group 8 - Family Planning Expansion | $5,460,394 | $11,576,340 | $2,045,425 | $0 | $59,882,767 | |
| Demonstration Group 9 - Home and Community Based Expansion (HCBS) | $3,699,108 | $3,699,108 | $3,699,108 | $924,777 | $12,022,101 | |
| Demonstration Group 10 - MLTC Adult Age 18-64 Duals | | $249,276,515 | $999,765,437 | $249,927,129 | $1,498,969,081 | |
| Demonstration Group 11 - MLTC age 65+ Duals | | $2,561,508,288 | $10,403,512,554 | $2,629,869,736 | $15,594,890,578 | |
| Demonstration Population 1: State Indigent Care Pool Direct Expenditures (ICP-Direct) | $2,600,000 | $14,650,000 | $13,700,000 | $3,400,000 | $34,350,000 | |
| Demonstration Population 2: Designated State Health Programs to Support Clinic Uncompensated Care Funding (ICP - DSHP) | $2,600,000 | $14,650,000 | $13,700,000 | $3,400,000 | $34,350,000 | |
| Demonstration Population 3: Designated State Health Programs to Support Medical Home Demonstration (DSHP - HMH Demo) | $0 | $133,400,000 | $133,300,000 | $33,300,000 | $300,000,000 | |
| Demonstration Population 4: Designated State Health Programs to Support Potentially Preventable Readmission Demonstration (DSHP - PPR Demo) | $0 | $5,000,000 | $6,700,000 | $1,600,000 | $13,300,000 | |
| Demonstration Population 5: Designated State Health Programs (Various) | | | | | $0 | |
| With Waiver Total | **$8,530,939,644** | **$22,267,520,825** | **$33,596,007,666** | **$11,464,016,033** | **$124,028,140,809** | **$247,959,268,621** |
| Expenditures (Over)/Under Cap | **$1,097,737,924** | **$1,681,720,938** | **$1,658,090,288** | **$3,430,058,741** | **$29,742,448,318** | **$50,451,199,029** |

# New York State Partnership Plan
# PMPM's and Member Months

## WITHOUT WAIVER PMPMS

| | DY09 2006-2007 | DY10 2007-2008 | DY11 2008-2009 | DY12 2009-2010 | DY13 2010-2011 (2 Qtrs | DY13 2010-2011 (2 Qtrs | DY14 2011-2012 | DY15 2012-2013 | DY16 2013-2014 (1 Qtr/2 Qtr) |
|---|---|---|---|---|---|---|---|---|---|
| TANF Kids | $482.15 | $514.58 | $549.19 | $585.99 | $624.67 | $624.67 | $665.90 | $709.85 | $756.70 |
| TANF Kids FSHRP | | | | | | | | | |
| TANF Adults | $661.56 | $705.21 | $751.73 | $801.34 | $852.63 | $852.63 | $907.20 | $965.26 | $1,027.04 |
| TANF Adults FSHRP | | | | | | | | | |
| FHPlus Adults with Children | $516.43 | $550.50 | $586.82 | $625.55 | $665.59 | $665.59 | $708.19 | $753.51 | $801.73 |
| Family Planning Expansion | | | | | | $20.23 | $21.06 | $21.92 | $22.81 |
| Duals 18-64 | | | | | | | $4,009.38 | $4,057.09 | $4,105.37 |
| Duals 65+ | | | | | | | $4,742.15 | $4,895.32 | $5,053.44 |

## WITH WAIVER PMPMS

| | DY09 2006-2007 | DY10 2007-2008 | DY11 2008-2009 | DY12 2009-2010 | DY13 2010-2011 (2 Qtrs | DY13 2010-2011 (2 Qtrs | DY14 2011-2012 | DY15 2012-2013 | DY16 2013-2014 (1 Qtr/2 Qtr) |
|---|---|---|---|---|---|---|---|---|---|
| TANF Kids | $223.54 | $249.89 | $168.92 | $216.88 | $187.00 | $299.84 | $312.88 | $332.51 | $337.05 |
| TANF Adults | $448.12 | $487.12 | $368.74 | $465.25 | $400.82 | $589.61 | $608.24 | $646.37 | $649.04 |
| SN - Adults | $665.55 | $699.86 | $451.22 | $539.39 | $454.35 | $764.45 | $869.46 | $965.59 | $1,032.55 |
| FHPlus Adults with Children | $248.43 | $268.45 | $289.68 | $320.69 | $320.68 | $315.54 | $337.03 | $357.09 | $378.39 |
| FHPlus Adults without Children | $307.99 | $291.75 | $313.19 | $352.04 | $361.75 | $371.24 | $367.96 | $389.57 | $412.59 |
| Family Planning Expansion | $17.53 | $23.37 | $13.02 | $20.27 | $16.39 | $21.49 | $22.78 | $24.15 | $25.60 |
| Duals 18-64 | | | | | | | $4,039.88 | $3,948.21 | $3,942.01 |
| Duals 65+ | | | | | | | $4,755.70 | $4,706.64 | $4,751.90 |

## MEMBER MONTHS

| | DY09 2006-2007 | DY10 2007-2008 | DY11 2008-2009 | DY12 2009-2010 | DY13 2010-2011 (2 Qtrs | DY13 2010-2011 (2 Qtrs | DY14 2011-2012 | DY15 2012-2013 | DY16 2013-2014 (1 Qtr/2 Qtr) |
|---|---|---|---|---|---|---|---|---|---|
| TANF Kids | 17,922,752 | 17,657,828 | 17,957,278 | 19,108,187 | 9,774,280 | 9,804,938 | 20,162,066 | 20,907,729 | 10,497,914 |
| TANF Adults | 4,603,637 | 4,561,952 | 4,952,816 | 5,629,847 | 2,893,809 | 2,865,571 | 5,919,252 | 6,144,200 | 3,085,187 |
| SN Adults | 4,534,323 | 4,590,976 | 5,847,666 | 7,460,970 | 4,103,355 | 4,216,837 | 9,097,365 | 9,798,142 | 2,471,136 |
| FHPlus Adults with Children | 3,276,258 | 3,295,069 | 2,998,687 | 3,002,984 | 1,567,102 | 1,585,684 | 3,305,705 | 3,493,301 | 903,868 |
| FHPlus Adults without Children | 1,908,233 | 1,941,703 | 1,276,603 | 889,734 | 430,909 | 439,524 | 927,125 | 995,132 | 259,985 |
| Family Planning Expansion | 597,505 | 453,527 | 439,750 | 485,446 | 254,090 | 254,090 | 508,180 | 84,697 | |
| Duals 18-64 | | | | | | | 61,704 | 253,220 | 63,401 |
| Duals 65+ | | | | | | | 538,619 | 2,210,390 | 553,435 |

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 Exchange.

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 Exchange. Applications submitted to the Exchange 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 Exchange 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)<br><br>[ s. 2001(a)(1) and (2)] | Income based on Statewide standard of need, approximately 0%-78% FPL | Medicaid | 0% ≤ 133%<br><br>Benchmark |
| Adults who were recipients of or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid (Single individuals and Childless Couples)<br><br>[ s. 2001(a)(1) and (2)] | Income above the Medicaid income standard but at or below gross 100% FPL | Family Health Plus | 0% ≤133%<br><br>Benchmark |
| Children 19 and 20 years old<br><br>[ s. 2001(a)(1) and (2)] | Income above the Medicaid income standard but at or below gross 150% FPL* | Family Health Plus | 0% ≤ 133%<br><br>Standard coverage<br><br>> 133% ≤150%<br><br>Standard coverage<br><br>>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)<br><br>[ s. 2001(a)(1) and (2)] | Income above the Medicaid income standard but at or below gross 150% FPL* | Family Health Plus | 0% ≤ 133%<br><br>Benchmark<br><br>> 133%≤150% State will pay enrollee's share of APTC premiums and seek federal participation as a designated state health program<br><br>>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<br>• 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 Exchange from October 2013 through December 2013, will have eligibility determined through the Exchange 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 Exchange before January 1, 2014.
- Beginning January 1, 2014, new applications will go through the Exchange 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 it 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. 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 Qualified Health Plan for individuals in this income group who purchase a silver plan. 19 and 20 year olds 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 Exchange 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. New York received preliminary results, but 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.

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 Exchange, 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.

# Attachment 1

## Core Provider Types for All Lines of Business.

NOTE: Data will be provided when it becomes available