NEW YORK
state department of
HEALTH

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Commissioner

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Executive Deputy Commissioner

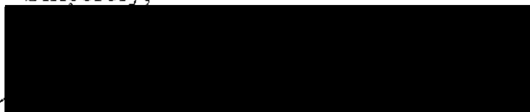
February 28, 2013

Jessica Woodard
Project Officer
Division of State Demonstrations and Waivers
Centers for Medicaid, CHIP and Survey & Certification, CMS
MS S2-01-16, 7500 Security Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Woodard:

Enclosed is the New York State Department of Health's 2013 first quarter Quarterly Report for the Section 1115 Partnership Plan, covering the period October 1, 2012 through December 31, 2012.

Sincerely,



Gregory S. Allen, Director
Division of Program Development & Management
Office of Health Insurance Programs

Enclosure
cc: M. Melendez

Partnership Plan
Section 1115 Quarterly/Annual Report
Demonstration Year: 15 (10/1/2012 – 9/30/2013)
Federal Fiscal Quarter: 1 (10/01/2012 – 12/31/2012)

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 November 19, 2012 incorporating changes resulting from recommendations of the Governor's Medicaid Redesign Team.

II. Enrollment

Fourth 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	1,601,400	23,079	63,168
Population 2 - TANF Adults aged 21-64 in mandatory counties	476,900	9,261	24,850
Population 3 – Safety Net Adults	810,662	17,858	34,851
Population 4 – Family Health Plus Adults with children	338,229	5,803	21,073
Population 5 – Family Health Plus Adults without children	93,080	1,740	6,407

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 1-20
- Population 2 - TANF enrolled in the 14 mandatory counties prior to 10/1/06 and all TANF outside of the 14 mandatory counties - aged 21-64
- 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]	57,741

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]	150,349

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 eligibles 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 every county of the state, including New York City. Lewis, Jefferson, Warren and St. Lawrence counties implemented mandatory programs on October 1, 2012 and the last voluntary county (Chemung) began its mandatory program on November 1. See **Attachment 1**: NYS Medicaid Managed Care Map.

During this quarter, staff was involved in training for both county staff and providers in each of the counties preparing for implementation of mandatory programs. Chemung, Jefferson, Lewis, St. Lawrence and Warren counties chose to accept the assistance of the enrollment broker.

[1] Demonstration year to date: 10/01/2012 – 09/30/2013

B. New York City (NYC) Outreach Activities

The total Medicaid eligible population in NYC is approximately 3.5 million, of which almost 2.3 million are eligible for Medicaid managed care. Eleven percent or approximately 257,000 of the consumers eligible for Medicaid managed care are SSI recipients. 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 six (6) HIV/AIDS Services Administration (HASA) sites, thirteen (13) Medicaid offices and seventeen (17) Job Centers. The Education and Enrollment Driven Referral (EED) process was responsible for 60% 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 2,580 presentations were scheduled by NYMC. Five hundred and eight (508) or 20% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

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

During the quarter, five counties implemented mandatory Medicaid managed care programs. At the request of counties, training was held with county staff to provide an overview of the Medicaid managed care program.

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

- MRT # 1458, including: orthodontics for children with severe handicapping malocclusions included in the benefit package of all Medicaid managed care plans as of October 1; and, Consumer Direct Personal Care Services (CDPAS) included in the benefit package effective November 1.
- Status of the 1115 waiver and implementation of new mandatory counties.
- 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

On November 19, 2012, CMS approved a waiver amendment authorizing the state to: establish the Managed Long-Term Care (MLTC) program; mandatorily enroll previously exempt or excluded populations into mainstream Medicaid managed care (MMMC); and, implement a housing disregard for certain individuals. The MLTC program expands mandatory Medicaid managed care enrollment to dually-eligible individuals age 21 or over who receive community-based long-term care services in excess of 120 days and provides dually-eligible individuals age 18 - 21, as well as nursing home eligible non-dual individuals age 18 and older, the option to enroll in the MLTC program. Individuals whose needs are similar to: 1) residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) facility; and 2) participants receiving services through a Medicaid home and community based waiver, including the Long Term Home Health Care Program (LTHHCP), are no longer exempt from the MMMC program. In addition, the amendment authorizes the state to implement a recent state law change in which individuals discharged from a nursing facility who enroll in the MLTC program may qualify for a housing disregard, under which these individuals will qualify for Medicaid eligibility under a special income standard.

Negotiations continued during the quarter to authorize enrollment of individuals in the LTHHCP, a 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. Dual eligible LTHHCP participants aged 18 through 20 may choose to enroll in an MLTC plan approved to enroll individuals aged 18 and older, and dual eligibles aged 21 and under and non-duals of any age may voluntarily enroll in a MMMC plan.

B. Health Plans

1. Retroactive Changes to Certificates of Authority:

    - The New York Presbyterian Community Health Plan, which has no members and exists for claims run-out only, changed its name to New York Presbyterian Plan Management LLC, effective June 1, 2012.

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

    - MVP Health Plan, Inc. Survey was conducted on October 9, 2012 to October 12, 2012. A Statement of Deficiency was issued. A plan of correction has been received but not yet accepted.

    - SCHC Total Care, Inc. Survey was conducted on October 11, 2012 to October 15, 2012. A Statement of Deficiency was issued. A plan of correction has been received and accepted. SCHC Total Care, Inc. also had a follow up survey on November 14, 2012 to November 15, 2012. A Statement of Deficiency was issued. A plan of correction has been received but not yet accepted.

    - Neighborhood Health Providers, Inc. Survey was conducted on November 23, 2012 to October 16, 2012. No deficiencies were cited.

- HealthFirst PHSP, Inc. Survey was conducted on June 25, 2012 to June 28, 2012. A Statement of Deficiency was issued. A plan of correction has not yet been received.

- Hudson Health Plan, Inc. Survey was conducted on December 11, 2012 to December 12, 2012. No deficiencies were cited.

3. Routine provider directory/participation surveys were conducted for health plans in the second half of 2012 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 Information Survey:

     HealthNow New York, Inc.

     MVP Health Plan, Inc.

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

     HealthNow New York, Inc.

     MVP Health Plan, Inc.

     Independent Health Association, Inc.

4. Routine member services surveys were conducted. No problems were found with access to health plan telephone lines.

C. 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 their child care providers with access to health insurance through the FHPlus Employer Buy-In. UFT will partner 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 897 unsubsidized UFT members were enrolled in the FHPlus Buy-In Program. For child care workers who are eligible for Medicaid or FHPlus, the premium will be 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 their member population.

FidelisCare, present in almost every county of 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 December 31, 2012 is 3,132 individuals.

New York developed and tested a new software tool, the Health Insurance Premium Payment (HIPP) Calculator, designed to assist LDSS and New York Health Options with evaluating the cost-effectiveness of a third-party health insurance product to determine whether individuals ought to be enrolled in the FHP-PAP and to facilitate the issuance of premium payments. This standardization of cost-effectiveness analyses through HIPP will improve quality control statewide. To date, a full-day training was been provided to Enrollment Center and local district staff in 21 counties on how to use the tool.

Enrollment in ESHI Through FHPlus PAP	New Enrollment 07/01/12-09/30/12	Total Enrollment September 30, 2012
FHPlus Adults with children	107	722
FHPlus Adults without children	387	2,410
Total	494	3,132

Age group for reporting Quarter 07/01/12-09/30/12	Number of Enrollees
19-44	2,619
45-64	513

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 Re-Determinations 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 work with state program and system staff to establish proper protocols for generating the universes of cases that meet the review requirements. These protocols are more complicated than usual because 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:

  Additional issues were identified with some of the universe specifications. PHPG worked with the Department program staff to resolve the issues. It is expected that remaining samples will be pulled and the corresponding case records will be requested from the appropriate LDSS offices during the next reporting quarter.

- MEQC 2011 – Review of Medicaid Self Employment Calculations

  PHPG continued to request eligibility records from the appropriate LDSS offices. In addition, PHPG continued conducting initial, peer and supervisory reviews, and recording the results in their central database.

- MEQC 2012 – Review of Medicaid Income Calculations and Verifications

  PHPG worked with the Department to identify the universe of cases from which to pull the active sample. Once the active sample was generated, PHPG requested copies of the case record documentation from the appropriate LDSS office. Additionally, PHPG continued to work with the Department to identify the universe of cases from which to pull the negative case sample.

D. 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.

E. Benefit Changes/Other Program Changes

1. Benefit Changes

- Orthodontia

The orthodontic benefit was added to the Medicaid managed care benefit package effective October 1, 2012. Medicaid managed care enrollees who were prior approved for orthodontic treatment prior to 10/1/12 will continue to be covered under the Medicaid fee for service (FFS) program for the duration of their treatment and retention. Medicaid managed care plans are responsible for enrollees approved for treatment by the plans on and after 10/1/12.

- Consumer Directed Personal Assistance Services

CDPAS were included in the Medicaid managed care benefit package effective November 1, 2012. CDPAS includes some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative.

In preparation for including the CDPAS in the Medicaid managed care benefit package, the Department worked with consumers of CDPAS services who are enrolled in managed care, fiscal intermediaries (FIs) and managed care organizations (MCOs) to facilitate a smooth transition. An acknowledgment of the member/MCO responsibilities was developed based on the model memorandum of understanding (MOU) used by the local social services districts and FIs. A model agreement between the MCOs and the FIs was developed with the assistance of the plan associations and the Consumer Directed Personal Assistance Association of New York State (CDPAANYS).

Based on information provided by the Department regarding MCO members currently in receipt of CDPAS, including the associated FI, MCOs identified each FI they have a contract with by county.

The Department issued a transitional policy to the MCOs, FIs and the consumer directed advocacy group outlining policies and procedures to assure that there was no interruption in CDPAS to members.

- Podiatry for Diabetics

Effective December 1, 2012, the Medicaid managed care and FHPlus benefit packages were expanded to cover the services of a podiatrist for adult enrollees diagnosed with diabetes mellitus. This service was previously covered only for children and, on a case-by-case basis, adult managed care enrollees when determined medically necessary by the enrollee's health plan.

- Outpatient Services for Potentially Preventable Conditions

Effective November 1, 2012, reimbursement was eliminated for ambulatory provider-preventable events, including surgical and anesthesiology services, performed in hospital outpatient, ambulatory surgical and office based settings under Medicaid

managed care and FHPlus. Provider-preventable events ("never events") are: surgery or invasive procedure on wrong body part; surgery on wrong patient; wrong surgery on patient.

- Interpretation Services

  Effective December 1, 2012, Medicaid managed care and FHPlus plans are responsible for reimbursing the costs of interpretation services provided in outpatient settings, including facility and office based settings. Covered services are interpretation services for patients with Limited English Proficiency (LEP) and communication services for people who are deaf or hard of hearing.

F. 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.

G. Federally Qualified Health Services (FQHC) Lawsuit

Community Health Care Association of New York State (CHCANYS), et al vs NYS Dept of Health, et al is currently pending in federal court (U.S. District Court, Southern District of NY). It remains pending for decision (each side has moved for "summary judgment") before Judge Carter of the US District Court, Southern District of NY.

H. 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 16 service area expansions, 8 new lines of business for operational MLTCPs, and 5 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.

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:

- **<u>Contracting During the Transition Period.</u>** For the period October 1 2012-September 30, 2013 (Transition Period), Health Plans were 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.

- **<u>Consumer Continuity of Care and Choice During the Transition Period.</u>** 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.

- **<u>Network Adequacy During the Transition Period</u>**. 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.

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

- **<u>Model FI Contract and Department of Health Review.</u>** 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.

- **<u>Acknowledgement of the Roles and Responsibilities of the Consumer/Designated Representative.</u>** 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.

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 build by April 15, 2013.

- **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

- **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 9,893, with 42 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.

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

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

Reason for Grievance Dissatisfaction with quality of home care (other than lateness or absences)	Total
# Same Day	372
# Standard	155
# Expedited	2
Home care aides late/absent on scheduled day of service	
# Same Day	213
# Standard	34
# Expedited	1
Dissatisfaction with quality of day care	
# Same Day	2
# Standard	7
# Expedited	0
Reason for Grievance	**Total**

Reason for Grievance Dissatisfaction with quality of home care (other than lateness or absences)	Total
Dissatisfaction with quality of other covered services	
# Same Day	126
# Standard	49
# Expedited	1
Dissatisfaction with transportation	
# Same Day	1334
# Standard	176
# Expedited	0
Travel time to services too long	
# Same Day	2
# Standard	1
# Expedited	0
Wait too long to get appointment or service	
# Same Day	8
# Standard	11
# Expedited	1
Waiting time too long in provider's office	
# Same Day	0
# Standard	1
# Expedited	0
Dissatisfaction with care management	
# Same Day	25
# Standard	38
# Expedited	0
Dissatisfaction with member services and plan operations	
# Same Day	23
# Standard	13
# Expedited	0
Dissatisfied with choice of providers in network	
# Same Day	14
# Standard	7
# Expedited	0

Reason for Grievance Dissatisfaction with quality of home care (other than lateness or absences)	Total
Reason for Grievance	**Total**
Misinformed about plan benefits or rules by marketing or other plan staff	
# Same Day	1
# Standard	3
# Expedited	0
Language translation services not available	
# Same Day	1
# Standard	1
# Expedited	0
Hearing/vision needs not accommodated	
# Same Day	1
# Standard	0
# Expedited	0
Disenrollment issues	
# Same Day	0
# Standard	1
# Expedited	0
Enrollment issues	
# Same Day	0
# Standard	1
# Expedited	0
Plan staff rude or abusive	
# Same Day	4
# Standard	4
# Expedited	0
Provider staff rude or abusive	
# Same Day	32
# Standard	6
# Expedited	0
Violation of other enrollee rights	
# Same Day	1
# Standard	1
# Expedited	0
Other:	
# Same Day	135

Reason for Grievance **Dissatisfaction with quality of home care (other than lateness or absences)**	**Total**
# Standard	50
# Expedited	0
Total for this period:	
# Same Day	2294
# Standard	559
# Expedited	5

Reason for Appeal	
Denial or limited authorization of service including amount, type or level of service	**Total**
# 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**
Access to covered services (includes transportation)	54
Home Care Quality	48
Enrollment Issues	17
Case Management	15

V. Financial, Budget Neutrality Development/Issues

A. Quarterly Expenditure Report Using CMS-64

See **Attachment 2**: 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.

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

Hospital-Medical Home Demonstration

During the period ending December 31, 2012, the Department:

- Announced preliminary award amounts, pending CMS approval and later received CMS approval for the funding methodology;
- Developed and released an electronic work plan template and instructions;
- Conducted web conferences and a teleconference to educate participants in the completion of the electronic work plan;
- Assembled and conducted weekly meetings with an eight member Work Plan Review Team, as well as several ad hoc specialty advisors, consisting of clinical and administrative staff both from Island Peer Review Organization (IPRO) and within the Department;
- Received work plan submissions from the sixty-four (64) participating hospitals; and
- Began the work plan review process.

The due date for work plan submission was extended from November 15, 2012 to December 3 through 18, 2012 due to the effect of Super Storm Sandy. Disbursement of

twenty-five percent (25%) of the Year 1 funds to the hospitals through their regular Medicaid disbursement is planned for the first quarter of 2013.

The Department is completing the initial review process and providing feedback and a request for further detail to all hospitals. The Department is also developing an electronic data reporting tool for tracking and reporting milestones and measures data for the prospective demonstration period. The remaining work plan reviews will be completed by mid-February 2013. Hospitals have now begun implementing the project work.

Potentially Preventable Readmissions Demonstration

No change at this time.

VII. Consumer Issues

A. Complaints

Medicaid managed care plans reported **4012** complaints/action appeals this quarter, a decrease of **8%** from the previous quarter. Of these complaints/appeals, **579** were FHPlus complaints/appeals. The most frequent category of complaint/appeal was balance billing disputes, accounting for **31%** of the total. There were **170** complaints/appeals reported by the HIV special needs plans (SNPs). The majority of these complaints (**123**) were in the category of reimbursement/billing. The Department directly received **101** Medicaid managed care complaints and **1** FHPlus complaints this quarter.

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

31% Balance Billing
17% Reimbursement/Billing Issues
8% Dissatisfaction with Provider Services
7% Dissatisfaction with Quality of care
7% Difficulty Obtaining Emergency Services

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	5
Non-Permanent Residential Health Care Facility	0
Personal Care Services	8
Personal Emergency Response System	0
Private Duty Nursing	0
Total	13

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

The MMCARP met on December 19, 2012. The agenda included discussions on: exclusive pharmacy networks and prescriber prevails initiatives; Hurricane Sandy emergency preparedness and actions; the status of the transportation carve-out for New York City plans; the status of mandatory managed long term care enrollment; and, a regional analysis of Quality Assurance Reporting Requirements (QARR) results.

C. Managed Care Policy and Planning Meetings

The October 17, 2012 Managed Care Policy and Planning Meeting included: updates on pharmacy rate adjustments, rate adjustments for Mainstream and MLTC and stop loss; changes to Medicaid benefits; discussion of QARR; and an update on the draft Request for Applications (RFA) for the Office for People with Developmental Disabilities (OPWDD) waiver program.

The November 8 meeting was shortened and conducted by conference call to avoid disruptions to Hurricane Sandy responses by plans and state staff. Discussions focused on pharmacy initiatives (exclusive pharmacy networks and prescriber prevails) and Phase 2 rates.

Discussion topics at the December 12 meeting included: finance and rate development; Fully-Integrated Dual Advantage (FIDA) workgroup progress and recommendations; the transportation carve-out for NYC plans taking effect on January 1, 2013; managed care efficiency analysis; QARR analysis by region; disenrollment of individuals with comprehensive third party health insurance; and, the Office of Mental Health government rates initiative.

VIII. Quality Assurance/Monitoring

A. Quality Measurements

Program updates are highlighted below.

1 - Medicaid Quality Incentive

The 2012 Quality Incentive for Medicaid health plans was awarded in January 2013. There are four award tiers: 100 percent, 75 percent, 50 percent, and 25 percent. The Quality Incentive includes quality measures, consumer satisfaction, Preventive Quality Indicators (PQIs), and plan compliance with the Department reporting requirements in the overall score. For the 2012 Quality Incentive, two plans received the highest reward (first tier), three plans were in the second tier, three plans in the third tier and four plans in the fourth tier. Six plans did not qualify for the incentive.

Incentive Premium Award (%)	Plan Name	Quality Points	Satisfaction Points	PQI Points	Compliance Points	Total Points	Percent
		(100 points possible)	(30 points possible)	(20 points possible)	(20 points possibly subtracted)	(150 points possible)	(up to 100%)
100	HIP (EmblemHealth)	99.61	10	10	-4	115.6	77
100	MetroPlus Health Plan	100.00	10	2.5	-8	104.5	70

Incentive Premium Award (%)	Plan Name	Quality Points	Satisfaction Points	PQI Points	Compliance Points	Total Points	Percent
75	Neighborhood Health Providers	83.01	15	6.5	-4	100.5	67
75	Health Plus	75.35	15	13.5	-4	99.8	67
75	Healthfirst PHSP, Inc.	74.07	15	11	-8	92.1	61
50	Hudson Health Plan	54.92	25	10	-4	85.9	57
50	CDPHP	39.47	30	16	-4	81.5	54
50	Fidelis Care New York	49.81	15	14	-4	74.8	50
25	UnitedHealthcare Community Plan	44.70	15	12.5	-4	68.2	45
25	Amerigroup New York	48.53	15	10	-8	65.5	44
25	WellCare of New York	47.25	15	10	-8	64.3	43
25	Affinity Health Plan	48.53	15	8.5	-8	64	43
0	Univera Community Health	35.53	20	10	-8	57.5	38
0	Excellus BlueCross BlueShield	34.21	20	6.5	-4	56.7	38
0	Independent Health's MediSource	34.21	20	10	-8	56.2	37
0	MVP	34.48	10	10	-8	46.5	31
0	Total Care	28.95	5	12.5	-2	44.4	30
0	HealthNow New York Inc.	23.68	15	4	-8	34.7	23

2 - Care Management (CM) Evaluation

The second annual submission of the Care Management Annual Reporting Tool (CMART) containing plan care management data for 2011 was completed for 18 Medicaid managed care plans. Plans submitted information for over 111,000 members who were either identified as possibly benefiting from case management services or who were enrolled in case management programs. The evaluation includes process measures as well as utilization and cost information for members who enrolled in case management (illustrated in the logic model below). Figure 1 displays several process measures using the type of care management program to demonstrate differences between types of programs. Figure 2 displays use of inpatient services for those who enrolled in care management and for those who triggered for care management, but did not enroll. The inpatient utilization is presented as pre and post enrollment in care management with a second graph indicating the percent change in inpatient utilization post enrollment in care management. Plan specific utilization and cost data will be shared with plans in the first quarter of 2013.

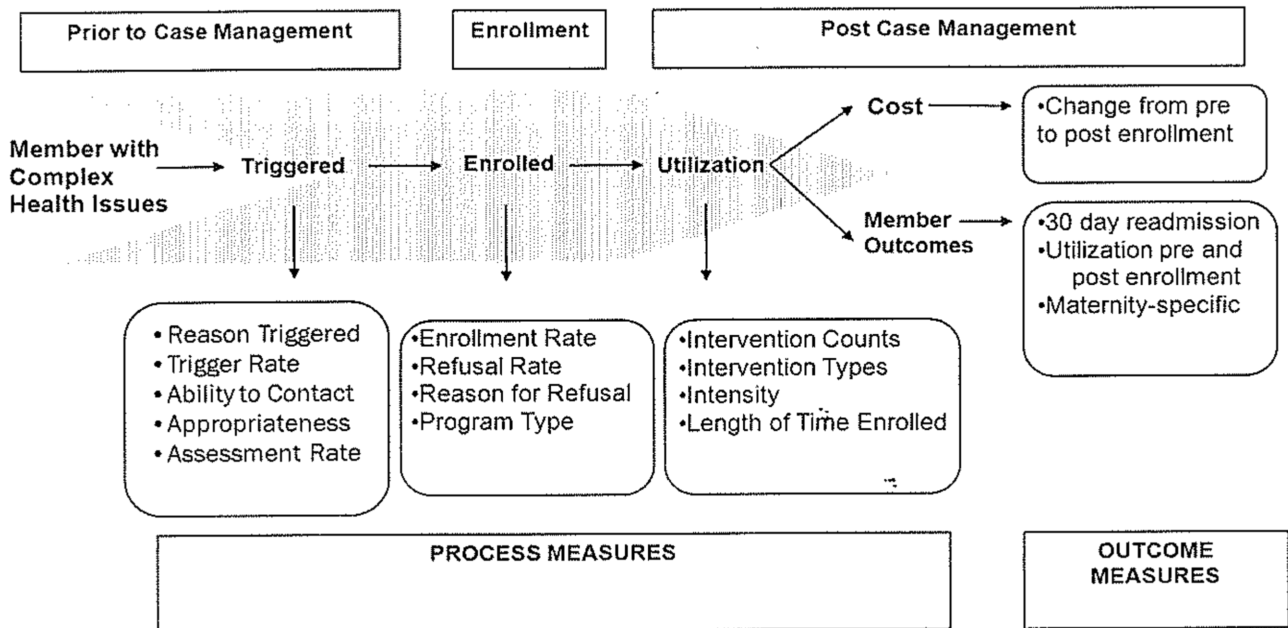
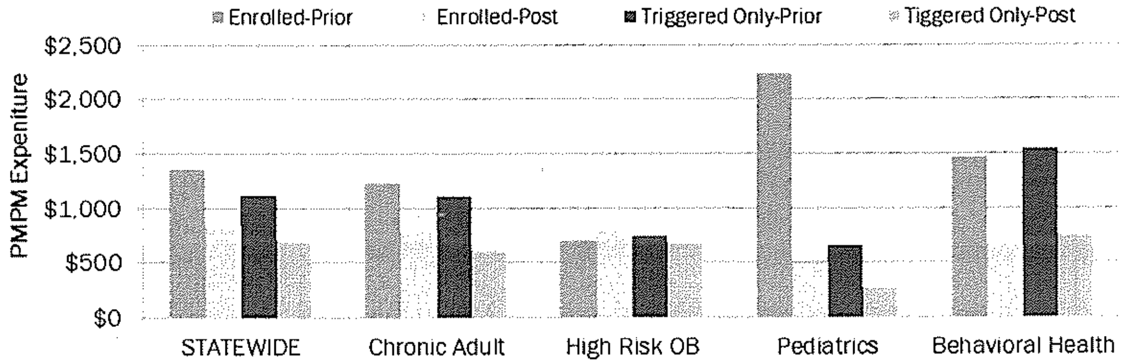


Figure 1: Example of 2011 Process measures by program type

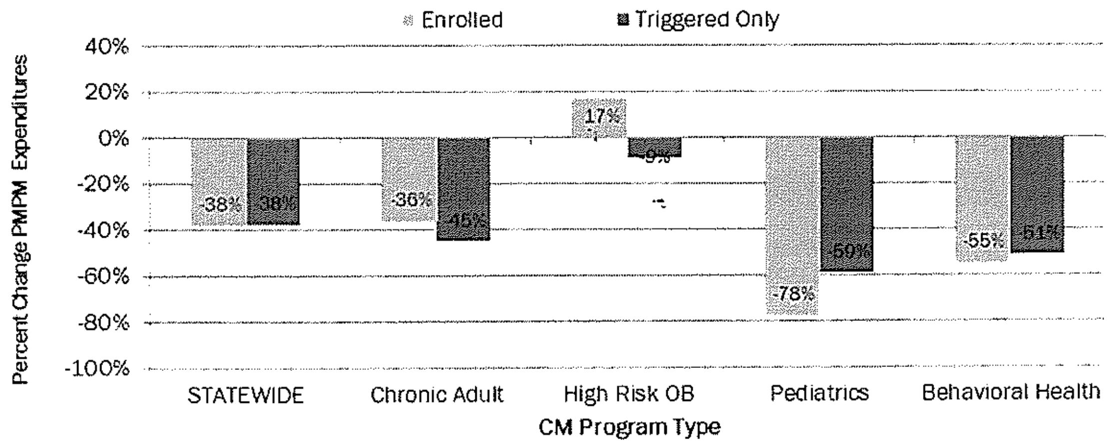
Process Measure	Chronic Adult	High Risk OB	Pediatrics	Behavioral Health
Percentage of members triggered (out of full cohort)	43.0%	26.4%	8.5%	8.5%
Percentage of members contacted (out of those who triggered)	49.7%	38.9%	50.9%	55.6%
Percentage of members who refused CM (out of those who triggered, were contacted and appropriate for CM)	13.3%	10.4%	5.8%	35.6%
Percentage of members newly enrolled in CM in 2011 (out of those who triggered)	40.3%	32.6%	43.1%	31.0%
Mean days from trigger to contact	10.5	24.9	8.5	7.0
Mean days from trigger to assessment	12.9	25.6	7.5	22.6
Mean days from trigger to enrollment	13.9	28.6	7.8	18.0

Figure 2: 2011 Cost Measures: Inpatient Per Member Per Month (PMPM) Expenditures

PMPM Prior to and Following Enrollment/ Trigger



Percent Change in PMPM



3 - Managed Long-term Care

<u>Managed Long-Term Care Regional Consumer Guides</u>

The MLTC New York City Regional Consumer guide was released. This guide will assist consumers in selecting a MLTC plan by providing information about the quality of care offered by the different plans and people's opinions about the care and the services the plans provide.

<u>Medicaid Advantage/Medicaid Advantage Plus Plans</u>

The model contract for Medicaid Advantage (MA) plans and MAP plans requires the annual submission of quality performance data to New York State. The Department released specifications for 2013 reporting of the 2012 measurement year. Twenty-one health plans are expected to report data.

B. Quality Improvement Activities

Health plans participated in a variety of quality improvement activities including Performance Improvement Projects (PIPs), and special studies.

1 - Performance Improvement Projects

The Department's external quality review organization, IPRO, assisted managed care plans with completing the PIPs. For the 2011 – 2012 study period, two collaborative PIP projects are in progress: 1) Eliminating Disparities in Asthma Care (EDAC) which involved six

Medicaid managed care plans in the Brooklyn, NY service area and 2) Reducing Potentially Preventable Readmissions (PPR) which has 10 health plans from across the state participating. Both PIP projects have concluded and final reports are being written by the plans. For the 2012 PPR PIP, a conference will be held on March 11, 2013 to share promising practices in the reduction of preventable hospital readmissions in the Medicaid managed care population. The audience for this conference will include health plan clinical and quality improvement staff, hospital and healthcare systems staff, home healthcare personnel, primary care providers and public officials.

A two-year collaborative PIP is in the planning stage which will have two parts: 1) implementing interventions to improve care in diabetes prevention and management, smoking cessation and hypertension management, and 2) testing the effectiveness of patient incentives on improving health behaviors and outcomes in the above-noted clinical areas. This PIP will support enrollment in the CMS funded Medicaid Incentives for the Prevention of Chronic Disease program the Office of Quality and Patient Safety is currently implementing.

2 - Focused Clinical Studies

Our external review organization, IPRO, is expanding its work on the Adherence to the Medicaid Prenatal Care Standards study. A group of large prenatal care centers will test a Prenatal Medical Record Review Tool to facilitate practice and provider self-evaluation. A reporting tool will be developed and decisions about the number and types of prenatal care centers to include are being made.

With the expansion of the MLTC program, the transition of individuals currently receiving community-based long-term care services from fee-for-service to managed care is of critical interest. Our external review organization, IPRO, is developing a validation study to determine MLTC plan compliance with two of the terms and conditions related to the MLTC program. Specifically, the terms state that 1) each MLTC plan must complete an initial clinical assessment of all new enrollees within 30 days, and 2) an individual receiving community based long term care services qualifying for MLTC must continue to receive services under the pre-existing service plan for at least 60 days. A study protocol has been developed and data collection will begin in the next quarter.

3 - External Quality Review

The Office of General Services has given the Department the approval to extend the external quality review organization contract. Approval from the State Comptroller is now necessary.

C. Quality Outcomes Evaluation

1 - Medicaid Encounter Data System (MEDS)

<u>Bariatric Surgery Selective Contracting</u>

Staff continues to work with hospital representatives concerning the Department's policy regarding Medicaid reimbursement for breast cancer surgery and hospital eligibility for the performance of such surgery. In addition, staff continues to maintain an updated database of CMS centers certified to perform bariatric surgery and field questions regarding the Department's policy that only CMS certified bariatric centers may be reimbursed for bariatric surgical services provided for Medicaid recipients.

Breast Cancer Selective Contracting

In an ongoing effort to ensure high quality care for breast cancer patients, since 2009 the Department has restricted Medicaid reimbursement for mastectomy or lumpectomy procedures to high volume hospital or ambulatory surgery centers – those where an average of 30 or more such surgeries were performed annually in the course of the three previous years. The Department has recently completed its fifth annual review of breast cancer surgical volumes. Low-volume facilities have been informed and will be allowed to appeal the decision prior to finalizing the list of restricted facilities.

2 - Quality Outcomes Evaluation

Potentially Preventable Hospitalizations

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

Prevention Quality Indicators for Managed Care Plans

Staff analyzed the 2011 managed care plan inpatient data and calculated risk-adjusted plan PQI rates to define plan performance in the annual Medicaid managed care plan Quality Incentive. These results have been shared with the plan representatives. Staff continues to work with the plans on a one-on-one basis to help them understand their data. In addition, a conference call is scheduled for March 2013 to provide a detailed description of the analytic process and provide a general question and answer (Q & A) session for the plan representatives.

Nursing Home Quality Improvement

As part of the Department's Nursing Home Quality Improvement Plan, staff will perform the analysis of potentially avoidable hospital admissions of nursing homes residents. Staff has completed the analyses of the Minimum Data Set (MDS) data to create risk-adjusted potentially avoidable hospitalization rates for each nursing home, using the methodology developed for the CMS sponsored Nursing Home Value Based Purchasing Demonstration.

Managed Long-Term Care Quality Incentive

As part of the Department's MLTC 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 MLTC 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.

Asthma Disparities Grant

EDAC Grant activities this quarter focused on the following: developing a close-out plan for each of the six participating plan/practice quality improvement teams; conducting a survey among stakeholders to receive feedback, comments and suggestions regarding their experience with EDAC; preparing an annual report for the Centers for Disease Control and Prevention (CDC); and overseeing monthly data collection.

The New York State EDAC Leadership Team began a series of internal discussions on how best to close-out the EDAC quality improvement work taking place at the six participating practices. Formal EDAC work ceased on December 31, 2012 for the majority of teams. Two plan/practice quality improvement teams, that expressed an interest in an additional visit from the EDAC quality improvement consultant, will continue work into early winter 2013. The following close-out plan was developed – formal, identical correspondences will be sent to both health plan and practice team members. Letters will use asthma quality of care data, partnership survey response data (discussed below) and qualitative data to identify team-specific areas of success and areas of opportunity moving forward. It is anticipated that letters will be drafted and sent in winter 2013.

The EDAC Partnership Evaluation Survey was distributed to 35 health plan and practice staff on December 3, 2012. Partners were given the option of completing the 17 question survey on-line or in hardcopy format. As of December 31, 2012, 18 completed surveys have been received for a preliminary response rate of 51 percent. An analysis of survey responses is ongoing. This survey is an integral component of the EDAC evaluation plan; the completion of the evaluation plan will dominate grant activities for the balance of the funding period.

IX. Family Planning Expansion Program

Family Planning Benefit Program Enrollment Summary
First Quarter FFY 2013 (October 1, 2012 – December 31, 2012)

	Female	Male	Total
New Enrollees This Quarter	4,497	1,645	6,142
Total Enrollees This Quarter	33,631	7,901	41,532
Enrollees Using Services This Quarter	11,421	127	11,548
Cumulative Enrollment Since 1/01/11	85,516	24,285	109,801
Enrollees Using Services Since 1/01/11	43,211	1,527	44,738
Continuous Enrollment Since 1/01/11	4,124	371	4,495

Source of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart, Report Date 01 Dec-2012

Family Planning Benefit Program Utilization by Category of Service
First Quarter FFY 2013 (October 1, 2012 – December 31, 2012)

TOTAL Medicaid Eligibles	**41,532**
TOTAL Medicaid Recipients	**11,548**
TOTAL Medicaid Expenditures	**2,017,269**
TOTAL Medicaid Eligible Months	**110,665**
AVERAGE Expenditures per Eligible	**49**
AVERAGE Months per Eligible	**2.7**
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	22,504	0.20	90	631	Claims	3	250
Nursing	483	0.00	37	15	Claims	1	13
OPD Clinic (hospital outpatient)	45,724	0.41	299	197	Claims	1	153
FS Clinic (D&T center)	768,155	6.94	213	4,219	Claims	1	3,601
Inpatient	5,780	0.05	1,156	0	Days	0	5
Pharmacy	1,090,422	9.85	119	18,819	Claims	2	9,161
Laboratory	32,660	0.30	45	1,467	Claims	2	731
Transportation	661	0.01	165	16	Claims	4	4
CTHP	815	0.01	54	16	Claims	1	15
Referred Ambulatory	48,020	0.43	98	786	Claims	2	490

Source Of Data: DOH/OHIP Audit, Fiscal and Program Planning Data Mart (Report Date: 01-Dec. - 2012)

X. Transition Plan Updates

There are no updates to the transition plan for this quarter. The Department continues to explore the necessary system and program changes needed to implement the Affordable Care Act.

Attachments

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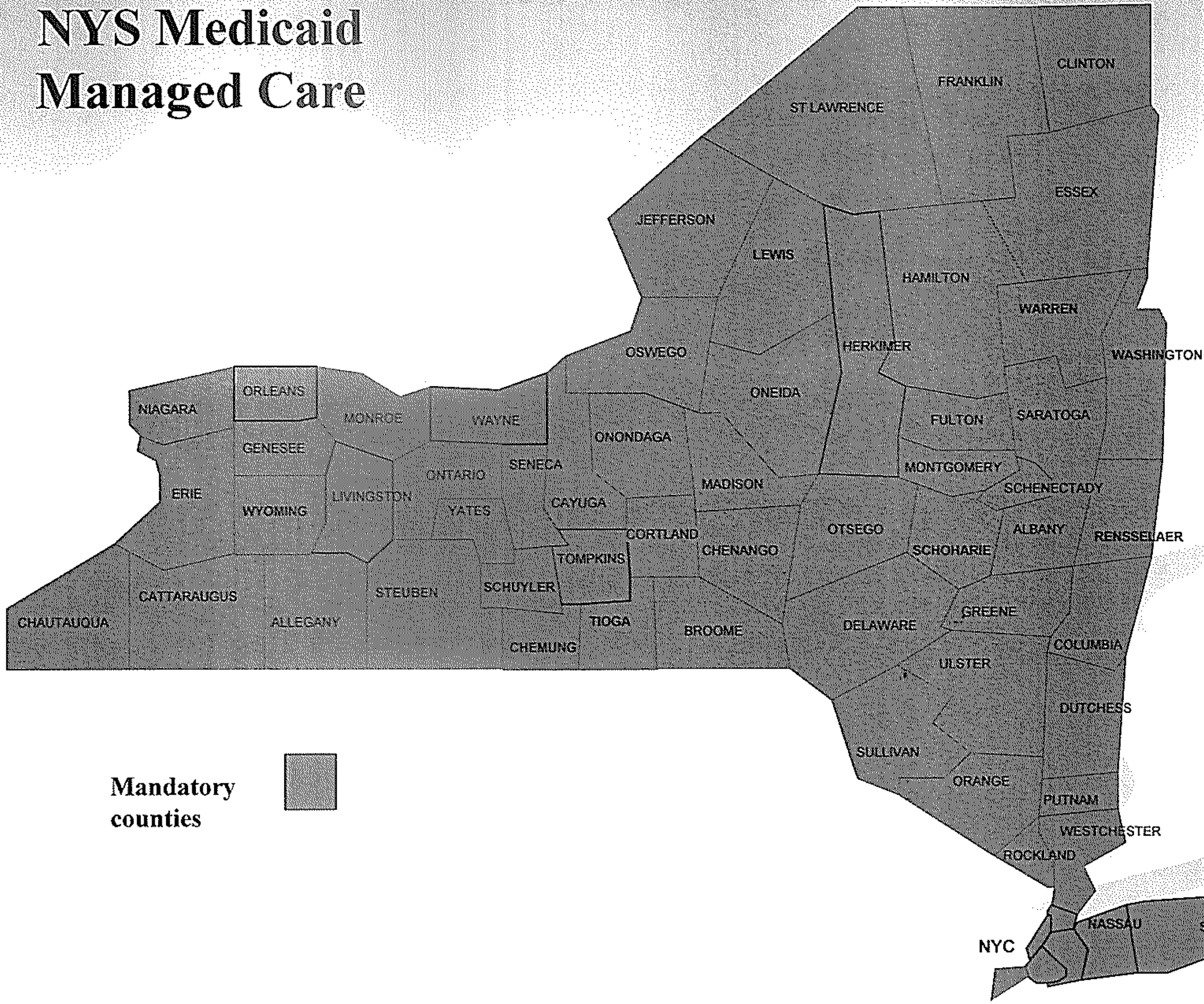
Submitted on: December 31, 2012

Attachment 1

NYS Medicaid Managed Care



ATTACHMENT 2

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