NEW YORK MEDICAID REDESIGN TEAM
SECTION 1115 DEMONSTRATION
FACT SHEET

Last Updated August 6, 2019

Name of Medicaid Section 1115 Demonstration: New York Medicaid Redesign Team (Formerly titled, "Partnership Plan")

Date Proposal Submitted:	March 20, 1995
Date Proposal Approved:	July 15, 1997
Date Implemented:	October 1, 1997
Date Expires:	March 31, 2021
Number of Amendments:	**16**

SUMMARY

The New York Medicaid Redesign Team (MRT) demonstration (formerly known as "Partnership Plan") allows New York to implement a managed care delivery system to provide benefits to its Medicaid recipients, create efficiencies in the Medicaid program and enable the extension of coverage to many individuals needing long term services and supports (LTSS). The demonstration was originally approved in 1997 to enroll most of the state's Medicaid recipients into managed care organizations (MCO) and it has been amended numerous times, including through the following notable amendments:

- In 2010, a Home and Community Based Services (HCBS) expansion program was added;
- In 2012, an improved care coordination model of managed LTSS was added;
- In 2013, modifications were approved to coordinate with the Medicaid expansion and other changes under the Affordable Care Act—including a) transitioning childless adults and parents and caretaker relatives with incomes up to, and including, 133 percent of the federal poverty limit (FPL) into state plan coverage; and b) mandating them into managed care arrangements;
- In 2014, a Delivery System Reform Incentive Payment (DSRIP) program was added;
- In 2015, Health and Recovery Plans (HARP) were approved to integrate physical, behavioral health (BH) and HCBS for beneficiaries diagnosed with severe mental illness and/or substance use disorder;
- In 2019, a waiver of comparability was added to exempt Medicaid Mainstream Managed Care (MMMC) enrollees from cost sharing-except for applicable pharmacy co-payments; and
- Also in 2019, authority was provided which enabled the state to create a streamlined children's model of care for children and youth under 21 years of age with BH and HCBS needs-including medically fragile children, children with a BH diagnosis, children with medical fragility and developmental disabilities, and children in foster care with developmental disabilities.

ELIGIBILITY AND ENROLLMENT

The following table lists the Medicaid state plan populations affected by the MRT demonstration (note: some populations may voluntarily enroll):

State Plan Mandatory and Optional Groups
Pregnant Women
Pregnant women (42 CFR §435.116) Income up to 218% of FPL Pregnant minors under age 21 (42 CFR §435.222) No income test
Children
Infants (218% FPL) and children under age 19 (149% FPL) (42 CFR §435.117 and §435.118)
Children age 19 and 20 (42 CFR §435.222) Income up to 133% of FPL if living alone and 150% if living with parents
Medically needy children age 19 and 20 (42 CFR §435.308) Income at or below the monthly income standard or with spenddown
Adults
Adult group (42 CFR §435.119) Over age 18, under age 65, non-disabled, non-pregnant with income up to 133% of FPL, not eligible for Medicare Part A or B benefits, not eligible under the parents and other caretaker relative group, the foster care child group, or the former foster care child group.
Parents and Caretakers
Parents and other caretaker relatives (42 CFR §435.110 and §435.220) Income up to 133% of FPL Includes low-income adults enrolled in TANF who are exempt from receiving a MAGI determination in accordance with §1902(e)(14)(D)(i)(I) of the Act. Includes Transitional Medical Assistance under sections 1902(a)(52) and (e)(1); 1925; and 1931(c)(2) of the Social Security Act
Medically needy parents and other caretaker relatives (42 CFR §435.310) Income at or below the monthly income standard or with spenddown
Disabled
Blind and disabled individuals age 64 and under receiving SSI (42 CFR §435.120)
Medically needy adults/children aged 18 through 64 blind and disabled (42 CFR §435.322 and §324) Income at or below the monthly income standard, or with spend down to monthly income standard
Aged 18 through 64 Medicaid Buy In for Working People with Disabilities Income up to 250% of FPL
Aged
Aged Individuals Age 65 and Over Receiving SSI (42 CFR §435.120) Optional Adults aged 65 or older (42 CFR §435.210)
Medically needy age 65 and over (42 CFR §435.320) Income at or below the monthly income standard, or with spend down to monthly income standard

State Plan Mandatory and Optional Groups
Foster Care
Children with adoption assistance, foster care or guardianship under title IV-E (42 CFR §435.145)
Children in state foster care Children receiving non IV-E guardianship assistance (42 CFR §435.222)
Former foster care children up to age 26 (42 CFR §435.150)
Independent Foster Care Adolescents 18 through 20 (In foster care on the date of 18th birthday) (42 CFR §435.226)
Children who qualify under 1902 (a)(10)(A)(ii)(VIII) State adoption assistance.

The following table lists the individuals excluded from MMMC (including HARP and HIV SNP):

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities and residents of Residential Treatment Facilities for Children and Youth
Individuals under age 21 who are permanent residents of Residential Health Care Facilities or temporary residents of Residential Health Care Facilities at time of enrollment
Medicaid eligible infants living with incarcerated mothers
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals with access to comprehensive private health insurance
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than 6 months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Individuals with a “county of fiscal responsibility” code of 97, except for individuals in the New York Office of Mental Health family care program who other than their residence in district 97 would be eligible to enroll in MMMC
Individuals with a “county of fiscal responsibility” code of 98 including Individuals in an Office for People with Developmental Disabilities/OPWDD facility or treatment center
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage (Individuals with a “county of responsibility” code of 99)
Individuals who are eligible for Emergency Medicaid
Aliessa Court Ordered Individuals*
Medicare recipients
Residents of Assisted Living Programs

* Aliessa Aliens are NOT excluded from Managed Care but are excluded from FFP.

The following table lists the individuals who may be exempted from MMMC (including HARP and HIV SNP):

Individuals with chronic medical conditions who have been under active treatment for at least 6 months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs. Exemption is limited to six months
Individuals designated as participating in OPWDD-sponsored programs
Child and Youth residents of Residential Rehabilitation Services for Youth (RRSY). Note: as the RRSY services are phased into managed care through contract amendments, the children in RRSYs will mandatorily phase into the demonstration.
Native Americans
Individuals in the following Section 1915(c) waiver programs: Traumatic Brain Injury (TBI) and Nursing Home Transition & Diversion (NHTD)
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) Section 1915 (c) waiver program

The following table lists the individuals excluded from MLTC (including HARP and HIV SNP):

Residents of psychiatric facilities (stays exceeding 30 days)
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals with a “county of fiscal responsibility” code 99 in MMIS (Individuals eligible only for breast and cervical cancer services)
Individuals receiving hospice services (at time of enrollment)
Individuals with a “county of fiscal responsibility “ code of 97 (Individuals residing in a state Office of Mental Health facility)
Individuals with a “county of fiscal responsibility” code of 98 including Individuals in an OPWDD facility or treatment center
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
Individuals who could otherwise reside in an ICF/IID, but choose not to
Residents of alcohol/substance abuse long term residential treatment programs
Individuals eligible for Emergency Medicaid
Individuals in the Office for People with Developmental Disabilities Home and Community Based Services (OPWDD HCBS) section 1915(c) waiver program
Individuals in the following section 1915(c) waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion (NHTD) (see Attachment G)
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration
Aliessa Court Ordered Individuals*

* Aliessa Aliens are NOT excluded from Managed Care but are excluded from FFP.

The following table lists the individuals who may be exempted from MLTC (including HARP and HIV SNP):

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid buy in for the working disabled and are nursing home certifiable

DELIVERY SYSTEM

The MRT demonstration includes two main components—Mainstream Medicaid Managed Care (MMMC) and Managed Long Term Care (MLTC)—each of which affects different populations, some of which are eligible under the state plan and some of which are eligible only as an expansion population under the demonstration. In addition, subsets of MMMC and MLTC are eligible for additional benefits. The MRT demonstration also includes HARPs which are managed care that provide the same services as MMMC *plus* an additional set of HCBS services for SMI and/or SUD.

BENEFITS

Mainstream Medicaid Managed Care – state plan and demonstration benefits are delivered through MCOs with the exception of certain services carved out of the MMMC contract and delivered directly by the state on a fee-for-service basis. All MMMC benefits (regardless of delivery method), as well as the co-payments charged to MMMC recipients, are listed in Attachment A of the STCs. In addition to state plan benefits, there are four demonstration services provided only to all enrollees in MMMC under the demonstration.

Managed Long Term Care – state plan benefits are delivered through MCOs or, in certain districts, prepaid inpatient health plans, with the exception of certain services carved out of the MLTC contract and delivered directly by the state on a fee-for-service basis. All MLTC benefits are listed in Attachment B.

Health and Recovery Plans (HARP) – state plan and demonstration benefits that are identical to MMMC with an additional component that provides BH HCBS for SMI and SUD needs will be provided by the HARPs. Long term care services (in excess of 120 days) or permanent placement in a Nursing facility, however, are not provided by HARPs. There are no co-payments for HARP services. All BH HCBS benefits are listed in Attachment D.

Alternative Benefit Plan – the Affordable Care Act Adult Group receives benefits provided through the state's approved Alternative Benefit Plan (ABP) SPA.

QUALITY AND EVALUATION PLAN

The state and the contracted health plans are required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys and focused studies on critical health issues. Key quality monitoring tools include, but are not limited to: Medicaid encounter data; HEDIS®/Quality Assurance Reporting Requirements (QARR); member satisfaction surveys (e.g., Perception of Care Survey for Medicaid Managed Care Members; Perception of Care Survey for HARP Members); and External Quality Reviews by IPRO. The state compiles data on demonstration performance after each milestone-reporting period, as applicable and summarizes performance of different program components to-date for CMS in its quarterly and annual monitoring reports.

In addition to quarterly and annual monitoring of the demonstration performance, the state is engaged in conducting rigorous evaluation of each of the programmatic components. The approved evaluation designs for the different demonstration components are publically available. The state is conducting the evaluation of DSRIP, HARP and the Self-Direction Pilot separately from the evaluation of the demonstrations other components The evaluation will consist of assessing whether relevant programmatic goals are attained through assessing the demonstration's impact on appropriate performance and outcomes measures (at the least to capture health outcomes, quality of care, cost of care and access to care for demonstration populations). Additionally, the evaluation supports that the demonstration is budget neutral by monitoring the state's submission of the budget neutrality information and review of CMS reports. Specifically, for the DSRIP program, the evaluation will assess if long-term savings achieved through the DSRIP investment would offset the amount of time-limited federal Designated State Health Programs (DSHP) funding.

The state is also required to report to CMS the activities, progress and performance of each DSRIP project on a rapid cycle basis.

AMENDMENTS

Amendment #1 Date Amendment Submitted:	The Family Health Plus ("FHPlus") program expands health insurance coverage to uninsured adults, whose income and/or assets exceed Medicaid eligibility requirements. June 30, 2000
Date Amendment Approved:	June 29, 2001
Date Amendment Effective:	October 1, 2001
Amendment #2	The family planning expansion program provides family planning services only to women of childbearing age and some men.
Date Amendment Submitted:	January 16, 2001
Date Amendment Approved:	September 27, 2002

Date Amendment Effective:	October 1, 2002
Amendment #3	Dual eligible beneficiaries in the MRT demonstration are permitted to enroll on a voluntary basis into one managed care plan for both Medicare and Medicaid services (a Medicaid MCO and a Medicare Advantage Plan).
Date Amendment Submitted:	April 20, 2004
Date Amendment Approved:	December 15, 2004
Date Amendment Effective:	January 1, 2005
Amendment #4	Revises conditions for federal financial participation for the family planning expansion program by adding new service codes and procedures for which the state may receive enhanced federal match. In addition, 45 new service codes and medications are approved at the state's regular FMAP rate.
Date Amendment Submitted:	June, 28, 2007
Date Amendment Approved:	November 16, 2007
Date Amendment Effective:	November 16, 2007
Amendment #5	Provides authority for the state to enroll FHPlus-eligible individuals into employer-sponsored insurance if that coverage is more cost-effective than providing direct coverage under FHPlus. The state will "wrap-around" the employer benefit package to ensure that individuals have full access to FHPlus-equivalent benefits.
Date Amendment Submitted:	July 13, 2007
Date Amendment Approved:	December 31, 2007
Date Amendment Effective:	December 31, 2007
Amendment #6	This amendment contains several requests submitted on November 3, 2008, and on March 31, 2009. The approved requests require individuals living with HIV/AIDS, who may elect to enroll in an MCO, to enroll in either a mainstream MCO or an HIV Special Needs Plan. In addition, the amendment provides for 12 months of continuous eligibility to be provided to all demonstration eligibles, remove asset test from FHPlus eligibility criteria, permit state and local government employees into FHP premium assistance and permit managed care to expand without STC changes.
Date Amendment Submitted:	November 3, 2008
Date Amendment Approved:	January 25, 2010

Date Amendment Effective:	January 25, 2010
Amendment #7	Provides authority for the state to add the Home and Community-Based Services Expansion Program to the demonstration.
Date Amendment Submitted:	March 31, 2009
Date Amendment Approved:	April 8, 2010
Date Amendment Effective:	April 8, 2010
Amendment #8	Provides authority to the state to require mandatory managed care enrollment of populations that were previously exempt, or excluded from mandatory managed care.
Date Amendment Submitted:	April 13, 2011
Date Amendment Approved:	September 30, 2011
Date Amendment Effective:	October 1, 2011
Amendment #9	Provides authority to the state to require mandatory managed care enrollment of additional populations that were previously exempt, or excluded from mandatory managed care.
Date Amendment Submitted:	April 13, 2011
Date Amendment Approved:	March 30, 2012
Date Amendment Effective:	April 1, 2012
Amendment #10	Provides authority to the state to require individuals who receive community-based long term care services in excess of 120 days enroll into managed care.
Date Amendment Submitted:	April 13, 2011
Date Amendment Approved:	August 31, 2012
Date Amendment Effective:	August 31, 2012
Amendment #11	Expands the MLTC program by authorizing mandatory Medicaid managed care enrollment for individuals who have been served in the state's Long-Term Home Health Care Program, or "Lombardi Program." Adds medical social services and home delivered meals to the managed care benefit to this population. Allows mandatory enrollment into mainstream MMMC for foster care children placed by the local Department of Social Services (DSS) and individuals who are eligible for Medicaid buy-in for the working disabled. Applies an enhanced income standard for individuals who need nursing

	home level of care to remain in the community and receive services through the MLTC Program. Also provides expenditure authority for certain designated state health programs (DSHP), which allows the state to receive federal matching dollars to support efforts to transform the state's developmental disability system.
Date Amendment Submitted:	April 13, 2011 (Lombardi Program)
Date Amendment Submitted:	February 1, 2013 (Foster Care and Medicaid Buy-In)
Date Amendment Submitted:	March 15, 2013 (Developmental Disability Transformation)
Date Amendment Approved:	April 1, 2013
Date Amendment Effective:	April 1, 2013
Amendment #12	Amended to comply with Medicaid requirements under the Affordable Care Act (ACA). The FHPlus program is phased out and parents and childless adults with incomes up to 133 percent of the FPL are transitioned into full Medicaid coverage. Safety Net Adults are also transitioned into full Medicaid coverage under the state plan. FHPlus parents with incomes between 134 percent and 150 percent of the FPL are sent to the health insurance marketplace and are enrolled into a premiums assistance program.
Date Amendment Submitted:	July 19, 2013 (FHPlus Program)
Date Amendment Submitted:	October 9, 2013 (Safety Net Adults)
Date Amendment Approved:	December 31, 2013
Date Amendment Effective:	January 2, 2014
Amendment #13	Allows the state to claim FFP for its delivery system reform efforts under its ongoing statewide MRT initiatives. The state will receive FFP to assist in funding an Interim Access Assurance Fund to provide temporary funding to at-risk facilities in order to allow them to participate in long term delivery system reform efforts. This also establishes a framework for a five year DSRIP program that will assist the state fund a series of various projects approved by the state and administered by participating safety net providers statewide in order to effectuate health system transformation and over time stabilize New York's health system.
Date Amendment Submitted:	August 6, 2012
Date Amendment Approved:	April 14, 2014
Date Amendment Effective:	April 14, 2014

Amendment #14	Effectuates several outstanding requests: Allows a new waiver authority to allow the state to furnish HCBS services outside of the state plan as part of a new coverage product called HARPs, Temporary expenditure authority to furnish members of the Adult Group who turn 65 during their continuous eligibility period a continuance of coverage for the remainder of their continuous eligibility period, Temporarily furnishes coverage for individuals who are determined ineligible for Medicaid and sent to the Marketplace but experience a one month coverage gap, Temporarily extends the designated state health program that provides premium assistance to former demonstration-eligible adults that are sent to the Marketplace, and adds new demonstration group for adults who receive Temporary Assistance for Needy Families (TANF) to seamlessly enroll into Medicaid.
Date Amendment Submitted:	December 30, 2013
Date Amendment Approved:	July 29, 2015
Date Amendment Effective:	July 29, 2015
Amendment #15	Exempts MMMC enrollees from cost sharing by waiving the comparability requirements. Aligns the cost-sharing obligations of MMMC enrollees with the longstanding managed care assumptions about cost-sharing built into the methodology for determining Medicaid Managed Care Organization (MMCO) capitation rates paid to the MMCOs in which MMMC beneficiaries are enrolled.
Date Amendment Submitted:	May 11, 2018
Date Amendment Approved:	April 19, 2019
Date Amendment Effective:	April 19, 2019
Amendment #16	Provides authority for children with HCBS under the State's 1915(c) Children's Waiver and children placed in foster care through a Voluntary Foster Care Agency (VFCA) to enroll in Mainstream Managed Care or an HIV SNP; continues Medicaid eligibility for Fo1 Non-1915 children who would have been eligible under the Children's Waiver had case management not been moved under the State Plan as a Health Home service or who were in a non-SSI category and receive HCBS or HH comprehensive case management; includes Children's Waiver HCBS and State Plan behavioral health services in the Medicaid managed care benefit; and includes children receiving HCBS under the Children's waiver in the Self Direction Pilot for Individual Directed Goods and Services.

Date Amendment Submitted:	May 18, 2017
Date Amendment Approved:	August 2, 2019
Date Amendment Effective:	August 2, 2019

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