Federal-State Health Reform Partnership
Section 1115 Quarterly Report
Demonstration Year: 8 (10/1/2013 – 9/30/2014)
Federal Fiscal Quarter: 2 (1/01/2014 – 3/31/2014)

I. Introduction

On September 29, 2006, New York State received approval from the Centers for Medicaid and Medicare Services (CMS) to join in a partnership to reform and restructure the state's health care delivery system. To accomplish the reform and restructuring, CMS approved a five-year 1115 demonstration entitled, Federal-State Health Reform Partnership (F-SHRP). The waiver was effective October 1, 2006 through September 30, 2011. On March 31, 2011, CMS approved a three year extension of the F-SHRP Demonstration for the period April 1, 2011 through March 31, 2014. An amendment to the F-SHRP waiver, approved on July 29, 2011 included authority to mandatorily enroll participants in the Recipient Restriction Program, one of the recommendations of the Governor's Medicaid Redesign Team (MRT). CMS approved subsequent waiver amendments on September 30, 2011, March 30, 2012, August 31, 2012 and November 19, 2012 incorporating additional changes resulting from recommendations of the MRT.

Under F-SHRP, the federal government invested up to $1.5 billion over the life of the Demonstration in agreed upon reform initiatives. The primary focus of these initiatives was to promote the efficient operation of the state's health care system; consolidate and right-size the state's health care system by reducing excess capacity in the acute care system; shift emphasis in long-term care from institutional-based to community-based settings; expand the use of e-prescribing; foster the implementation of electronic medical records and regional health information organizations; and expand ambulatory and primary care services.

F-SHRP expired on March 31, 2014. The current populations, which consist of Mainstream Medicaid Managed Care (MMMC) and Managed Long Term Care (MLTC), were transitioned into the Partnership Plan Medicaid Section 1115 Demonstration. The current Designated State Health Programs (DSHPs) under the F-SHRP Demonstration are under discussion with CMS. If extended, they will be modified to reflect agreements between CMS and the State, and incorporated into the Partnership Plan.

On November 27, 2013, a Phase-Out Plan focusing on transitioning remaining F-SHRP members into the Partnership Plan and addressing continuation or expiration of other F-SHRP components was submitted to CMS. The Phase-Out Plan has been implemented.

In accordance with Section VII, paragraph 49 and Attachment B of the Special Terms and Conditions (STCs), this annual/quarterly report outlines Demonstration activity for the second quarter (01/01/14 – 03/31/14) and Demonstration year eight (10/1/2013 – 9/30/2014).

II. Enrollment: Second Quarter

Population Groups	Current Enrollees	# Voluntary Disenrollments	# Involuntary Disenrollments
Population 1 – TANF Child under 1 through 20 ("new" MC enrollment)	**91,193**	**5,699**	**3,478**
Population 2 – TANF Adults aged 21 through 64 ("new" MC enrollment)	**32,286**	**2,481**	**1,518**
Population 3 – Disabled Adults and Children (SSI 0 through 64 Current MC)	**57,984**	**2,260**	**326**
Population 4 – Disabled Adults and Children (SSI 0 through 64 New MC)	**247,233**	**10,946**	**2,175**
Population 5 – Aged or Disabled Elderly (SSI 65+ Current MC)	**3,588**	**241**	**47**
Population 6 – Aged or Disabled Elderly (SSI 65+ New MC)	**47,537**	**2,054**	**475**

F-SHRP Waiver – Voluntary and Involuntary Disenrollment

Voluntary Disenrollments	
Total # Voluntary Disenrollments in current Demonstration Year	**23,681**

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 Departments of Social Services (LDSS) approval to disenroll based upon good cause**.**

Involuntary Disenrollments	
Total # Involuntary Disenrollments in current Demonstration Year	**8,019**

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

III. Outreach/Innovative Activities

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

A. <u>New York City (NYC) Outreach Activities</u>

The total Medicaid eligible population in NYC is approximately 3.1 million. Currently, 2.2 million are enrolled in a managed care plan, including eligible SSI recipients.
The Medicaid Redesign Team (MRT) changes implemented during the reporting period had a significant impact on the work of New York Medicaid Choice (NYMC).
NYMC Field Customer Services Representatives (FCSRs) were assigned to cover 6 HIV/AIDS Services Administration (HASA) sites, 13 Medicaid offices and 17 Job Centers.
The Education and Enrollment Driven Referral (EED) process was responsible for 84% of the total consumers engaged by NYMC in the last quarter.

The overall activities at Medicaid offices remained constant averaging 14 consumers per work session. A work session covers a half day of work activities.
A total of 2,649 presentations were scheduled by NYMC. Of these, 584 or 22% of the total scheduled presentations were observed by the Contract Monitoring Unit (CMU).

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

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

IV. F-SHRP Waiver

A. F-SHRP Waiver Amendments

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

CMS granted the Department authorization for MMMC enrollment of individuals in foster care who are placed in the community directly by LDSS. This does not extend to individuals in foster care in a waiver program, those placed through a contracted agency, or those housed in an institution. In addition, the Department received CMS authorization for managed care enrollment of individuals eligible through the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) program. There were no additional changes this past quarter.

B. Benefit Changes/Other Program Changes

Hospice services: The Department received CMS approval to include Hospice services to the Medicaid managed care benefit package. Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care.

Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC): The Department received authorization from CMS regarding the addition of ADHC and AIDS ADHC to the Medicaid managed care benefit package. These programs are designed to assist individuals to live more independently in the community or to eliminate the need for residential health care services. Individuals currently in receipt of these services will receive 90 days of transitional care with the current care plan, or until the MCO authorizes an alternate care plan, whichever is later. This addition to the benefit package will prevent the loss of access to this service for MMMC enrollees who transition from fee-for-service Medicaid and may reduce the risk of failure for these specific enrollees to remain in the community.

Directly Observed Therapy for Tuberculosis (TB/DOT): The Department received CMS approval to include TB/DOT in the Medicaid managed care benefit package. TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen, and to monitor effectiveness of the prescribed treatment. Previously MCOs included medications for the treatment of tuberculosis, and this initiative adds the direct observation to ensure medications are appropriately ingested.

C. 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 certain adults in the same way that it has for children on Medicaid. The adults covered under this proposal are those that are categorized under the Modified Adjusted Gross Income (MAGI) category, to potentially include pregnant women, parents/caretaker relatives, and other adults under age 65. Twelve months continuous coverage will be effective January 1, 2014 with the implementation of the New York Health Insurance Marketplace.

D. Managed Long Term Care Program

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

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

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

1. Accomplishments

- Mandatory enrollment process initiated and continuing in all five boroughs. Due to the length of the prior authorization and Medicaid eligibility periods, additional cohorts from all NYC counties will continue to be identified for the enrollment process; the anticipated

time frame to transition all personal care cases in the five boroughs is June 2013. The mandatory transition process for Personal Care Services in NYC counties was essentially completed as of September 2013.

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

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

- Expanded MLTCP availability by approving 13 service area expansions, 2 new lines of business for operational MLTCPs, and 12 new certificates of authority since September 2012. During the period October 2013 through December 2013, MLTCP availability was expanded by approving 2 service area expansions. During the period January through March 2014 MLTC availability was expanded by approving one new Certificate of Authority and four Service Area Expansions.

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

- Established a standardized process for MLTCPs to enter into agreements with entities for the provision of Care Management Services. The three documents developed and issued to plans, Care Management Administrative Services Contract Statement and Certification, Standard Clauses for Care Management Administrative Services Contract, and Care Management Administrative Services Contract Guidelines for MLTC Plans, allow MLTCPs to establish this relationship in an expedited manner. Care management is the foundation of the managed long term care process.

- New York's Enrollment Broker (NYMC) conducted the MLTC Post Enrollment Outreach Survey which contains specific questions specifically designed to measure the rate at which consumers are able to maintain their relationship with their personal care aide or home attendant. For the period ending December 2012, 957 surveys were completed and found that 86% of the respondents are receiving services from the same home attendant (personal care) agency. For the period from July 2013 to September 2013 post enrollment surveys were completed for 1,604 enrollees and 86% of the respondents are receiving services from the same home attendant. For the period from October 2013 to December 2013 post enrollment surveys were completed for 193 enrollees and 88% of the respondents are receiving services from the same home attendant. For the period from January 2014 to March 2014 post enrollment surveys were completed for 897 enrollees and 86% of respondents are receiving services from the same home attendant.

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

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

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

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

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

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

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

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

- Developed strategies to achieve the 2014 transition plan; expanding mandatory to additional counties incrementally each month. Preparation activities have commenced with April Districts (Columbia, Putnam, Sullivan, and Ulster). Initial outreach underway with the May Districts (Rensselaer, Cayuga, Herkimer, and Oneida).

2. Significant Program Developments

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

- Submitted preliminary proposal to develop independent clinical assessment process for MLTC enrollment. Formulating process guidelines to inform development of strategic goals and objectives.

- Conducted outreach and education in preparation to enroll permanent Nursing Home residents into MLTC plans in NYC, Westchester, Nassau, and Suffolk; pending CMS approval. Enhanced monitoring of MLTC NH networks to ensure increased capacity is established.

3. Issues and Problems

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

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

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

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

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

4. Summary of Self Directed Options

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

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

   - **Contracting During the Transition Period**: For the period October 1 2012- September 30, 2013 (Transition Period), Health Plans 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.

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

  If, at the time of transition, a FI serves less than five (5) members in a county, MLTC/MCOs may encourage the members to use an alternative FI to minimize the number of FIs an MLTC/ MCO must have under contract. However, during the transition period, the expectation is that a member is not required to transition to a different consumer directed personal assistant due to the lack of an MLTC/MCO/FI contract. MLTC/ MCOs are prohibited from coercing or threatening the member or the worker to change FIs.

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

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

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

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

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

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

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

5. Required Quarterly Reporting

   1. **Critical incidents:** The most significant critical incident that occurred during this demonstration was Hurricane Sandy which occurred during October 2012. In the aftermath, 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 developed the critical incident reporting structure.

There were 215 critical incidents reported to the Department for the first quarter utilizing the enhanced system.

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

Period: 1/01/14 - 3/31/14			
Grievances			
Total for this period:		**Resolved**	**Resolved %**
# Same Day	7714	7714	100%
# Standard/Expedited	1213	1074	89%
Total for this period:	8927	8788	98%

Period: 1/01/14 - 3/31/14	
Appeals	
Total appeals filed for this period:	
Total for this period:	14

Period: 1/01/14-3/31/14	
Grievances	
Reason for Grievances	**Total**
Dissatisfaction with quality of home care (other than lateness or absences)	**970**
# Same Day	700
# Standard	266
# Expedited	4
Home care aides late/absent on scheduled day of service	**849**
# Same Day	736
# Standard	113
# Expedited	0

Dissatisfaction with quality of day care	**12**
# Same Day	3
# Standard	9
# Expedited	0
Dissatisfaction with quality of other covered services	**340**
# Same Day	243
# Standard	95
# Expedited	2
Dissatisfaction with transportation	**5728**
# Same Day	5316
# Standard	408
# Expedited	4
Travel time to services too long	**14**
# Same Day	8
# Standard	6
# Expedited	0
Wait too long to get appointment or service	**74**
# Same Day	51
# Standard	23
# Expedited	0
Waiting time too long in provider's office	**2**
# Same Day	2
# Standard	0
# Expedited	0
Dissatisfaction with care management	**174**
# Same Day	126
# Standard	48
# Expedited	0
Dissatisfaction with member services and plan operations	**211**
# Same Day	168
# Standard	43
# Expedited	0
Dissatisfied with choice of providers in network	**26**
# Same Day	21
# Standard	5
# Expedited	0
Misinformed about plan benefits or rules by marketing or other plan staff	**9**
# Same Day	5
# Standard	4
# Expedited	0
Language translation services not available	**5**
# Same Day	1

# Standard	4
# Expedited	0
Hearing/vision needs not accommodated	**2**
# Same Day	0
# Standard	2
# Expedited	0
Disenrollment issues	**21**
# Same Day	8
# Standard	13
# Expedited	0
Enrollment issues	**9**
# Same Day	4
# Standard	5
# Expedited	0
Plan staff rude or abusive	**32**
# Same Day	11
# Standard	21
# Expedited	0
Provider staff rude or abusive	**87**
# Same Day	65
# Standard	22
# Expedited	0
Violation of other enrollee rights	**18**
# Same Day	16
# Standard	2
# Expedited	0
Denial of expedited appeal	**0**
# Same Day	0
# Standard	0
# Expedited	0
Other:	**344**
# Same Day	230
# Standard	113
# Expedited	1
Total for this period:	**8927**
# Same Day	**7714**
# Standard	**1202**
# Expedited	**11**

Period: 1/01/14 – 3/31/14	
Reason for Appeal	**Total**
Denial or limited authorization of service including	**277**

amount, type or level of service	
# of Standard Filed	263
# of Expedited Filed	14
Reduction, suspension or termination of previously authorized service	**163**
# of Standard Filed	157
# of Expedited Filed	6
Denial in whole or part of payment for service	**1174**
# of Standard Filed	1174
# of Expedited Filed	0
Failure to provide services in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon grievance or appeal of grievance in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Failure of plan to act upon appeal of plan action in a timely manner	**0**
# of Standard Filed	0
# of Expedited Filed	0
Other	**11**
# of Standard Filed	9
# of Expedited Filed	2
Total appeals filed for this period:	**1625**
# of Standard Filed	1603
# of Expedited Filed	22

Period: 1/01/14-3/31/14	
Fraud and Abuse Complaints Reported during Quarter	50

Period: 1/01/14 – 3/31/14	
Reason for Complaints	**Total**
Home Health Care- unspecified	86
Billing- provider questions on coverage/payer	27
Billing- claims denied in error	24

1. **Assessments for enrollment:** The total number of assessments for enrollment performed by the plans is 15,382, with 721 individuals who did not qualify to enroll in an MLTC plan. For the fourth quarter of 2013, the total number of assessments for the enrollment performed by the plans is 15,966, with 1,791 individuals who did not qualify to enroll in an MLTC plan. For the first quarter of 2014 the total number of assessments for enrollment performed by the plans is 19,128, with 2036 individuals who did not qualify to enroll in an MLTC plan.

2. **Referrals and 30 days assessment:** This was the first quarter for Plans to report to the enrollment broker (New York Medicaid Choice) the number of individuals they received referral on from outside NYMC and the time frame in which assessments were completed. The establishment of the reporting system and training of Plans to assure data completeness and quality is an ongoing effort. This quarter there were 1,604 reported referrals with 1,362 dates of assessment within the 30 day time frame. This represents an 85% rate of assessment completion based on data elements submitted. The remaining 242 reported referrals had errors in the data that resulted in an inability to calculate a date for assessment. NYMC is reaching out to plans to improve the data reporting. The State will review the finalized data to determine if actions need to be taken. For the quarter from July to September, the Department continues to track the data provided by NYMC and will continue to identify areas that need improvement. For the fourth quarter of 2013, total assessments conducted by MLTC plans during the period are 2579. 50% were conducted within the 30 day time frame. Noncompliance is specific to 5 plans. Quality of data will be verified then remedial action pursued. Data reporting has improved. For the first quarter of 2014, total assessments conducted by MLTC plans during the period is 5,995. 83% were conducted within the 30 day time frame.

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

4. **Referrals outside enrollment broker:** 6,580 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials. During the fourth quarter of 2013, 7,763 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials. During the first quarter of 2014, 9,594 people were not referred by the enrollment broker and contacted the plan directly and were provided MLTC materials.

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

for reporting, we have clarified instructions and improved data. No further reporting needed on this bullet.

6. **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. Percent admitted by reason:

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

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

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

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

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

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

Period: 1/1/14 – 3/31/14
Rebalancing Efforts

Number of Individuals enrolled in the plan from a nursing home	163
Number of Enrollees admitted to a nursing home but returned to the community	1971
Number of Enrollees permanently admitted to a nursing home	883

V. Operational/Policy Developments/Issues

A. Mandatory Enrollment of the SSI Population

The state expanded mandatory managed care enrollment under the F-SHRP demonstration to 14 counties with managed care capacity and to SSI and SSI-related Medicaid beneficiaries statewide. 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.

B. Health Plans

1. Changes to Certificates of Authority:

Excellus Health Plan, Inc.

- removal of MMC/FHP products from Chemung, Jefferson, Lewis, Oswego, Schuyler, Steuben and St. Lawrence Counties effective February 1, 2014
- removal of MMC/FHP products from Cayuga, Clinton, Essex, Franklin, Madison, Onondaga and Tompkins Counties effective April 1, 2014

MVP Health Plan, Inc.

- removal of MMC/FHP/CHP products from Dutchess and Ulster Counties effective January 1, 2014
- approval of CHP product in Genesee, Livingston, Monroe and Ontario Counties effective December 17, 2013
- approval of Medicare product in Westchester County effective February 3, 2014

United Healthcare of New York, Inc.

- approval of MMC/FHP products in Lewis, Ontario, Seneca and Wayne Counties effective January 1, 2014.

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

Surveillance/Monitoring activities - FFY 2nd quarter 2014 (1/1/14 to 3/31/14)

New York State Catholic Health Plan, Inc.:

- The survey was conducted January 13-16, 2014. No deficiencies were cited.

AMERIGROUP of New York, LLC:

- The survey was conducted February 24-27, 2014, and a Statement of Deficiency issued on March 28, 2014.

3. Routine provider directory surveys were conducted for 16 Medicaid Managed Care Plans (mainstream) and 3 HIV SNP plans with results issued in this quarter. Where deficiencies were found, plans are required to provide plans of corrections. The following plans received a Statement of Deficiency as a result of the Provider Directory Survey:

Capital District Physicians' Health Plan, Inc.
Excellus Health Plan, Inc.
HealthNow New York, Inc.
Independent Health Association, Inc.
MVP Health Plan, Inc.
Affinity Health Plan, Inc.
AMERIGROUP New York, LLC
Amida Care, Inc.
New York State Catholic Health Plan, Inc.
HealthFirst PHSP, Inc.
Health Insurance Plan of Greater New York
MetroPlus Health Plan, Inc.
MetroPlus Health Plan, Inc. Special Needs Plan
VNS Choice SNP
UnitedHealthcare of New York, Inc.

C. Health Participation

During FFY 2012/2013 there were several expansions, one health plan name change, one Certificate of Authority updated to reflect an address change, one correction to a Certificate of Authority and two Certificates of Authority were updated to reflect a line of business being taken off plans' 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.*
- Amerigroup New York, LLC. had an address change on February 19, 2013.
- Amida Care, Inc. was approved for a HIV Special Needs Plan in Queens County, effective February 19, 2013.
- Amerigroup New York, LLC. was approved for expansion for the Medicaid Advantage program in Suffolk, and Westchester counties, effective February 19, 2013.

- Amerigroup New York, Inc. Medicaid managed care was removed from Orange county effective July 1, 2013.
- HealthNow New York, Inc. Medicaid managed care and Family Health Plus was removed from Genesee and Niagara counties effective July 1, 2013.
- UnitedHealthcare of New York, Inc. was approved for expansion into Albany, Chautauqua, Chemung, Columbia, Essex, Genesee, Niagara, and St. Lawrence counties for Medicaid managed care and Family Health Plus effective September 1, 2013.
- Wellcare of New York, Inc. was previously approved for Medicaid Advantage Plus in Bronx, Kings, Queens and New York counties. However, this designation was omitted from the COA in a previous edit. The Medicaid Advantage Plus designation was put back on the COA effective May 1, 2013.

* Represents retroactive changes that were not reported on the fiscal year 2011/2012 annual report.

VI. Consumer Issues

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

The Medicaid Managed Care Advisory Review Panel (MMCARP) met on December 19, 2013. The meeting included presentations on: Statutory Language; Managed Long Term Care Update; Auto-Assignment Rates; Explanation of Spenddown Process and Technical Problems with Spenddown; and Mail Order Pharmacy Issues.

B. Managed Care Policy and Planning Meetings

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

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

Presentations at the September meeting included: Emergency Preparedness, Finance and Rate Development, FIDA Update, New York City Flu Immunization Program, Behavioral Health/HARP, Discussion of Basic Benefit Information, Encounter Data Monitoring, and an Update on New York State of Health Exchange for the Medicaid/Child Health Plus Programs.

C. Complaints

As SSI enrollees typically access long term services and supports, the Department monitors complaints and action appeals filed by this population with managed care plans. Of the 5,009 total reported complaints/action appeals, mainstream Medicaid managed care plans reported 490 complaints and action appeals from their SSI enrollees. This compares to 520 SSI complaints/action appeals from last quarter. The top 5 categories of SSI complaints/action appeals reported were:

Category	Percent of Total Complaints/Appeals Reported for SSI Enrollees
Reimbursement/ Billing Issues	24%
Balance Billing	20%
Quality of Care	10%
Provider or MCO Services (Non-medical)	7%
Emergency Services	7%

The total number of complaints/action appeals reported for SSI enrollees by category were:

Category	Number of Complaints/Action Appeals Reported For SSI Enrollees
Adult Day Care	0
Advertising/Education/Outreach/Enrollment	13
AIDS Adult Day Health Care	0
Appointment Availability - PCP	0
Appointment Availability - Specialist	3
Balance Billing	96
Communications/Physical Barrier	1
Consumer Directed Personal Assistant	0
Denial of Clinical Treatment	12
Dental or Orthodontia	21
Emergency Services	32
Eye Care	0
Family Planning	0
Home Health Care	1
Mental Health or Substance Abuse Services/ Treatment	0
Non-covered Services	9
Non-Permanent Residential Health Care Facility	2
Personal Care Services	8
Personal Emergency Response System	0
Pharmacy	27
Private Duty Nursing	0
Provider or MCO Services (Non-Medical)	33
Quality of Care	50
Recipient Restriction Program/Plan Initiated Disenrollment	1
Reimbursement/Billing Issues	120
Specialist or Hospital Services	4
Transportation	8
Waiting Time Too Long at Office	1
All Other Complaints	48
Total	**490**

Medicaid Advantage plans reported 12 complaints and action appeals.

VII. Health Care and Affordability Law for New Yorkers (HEAL NY) Capital Grant Program

Program Summary:

The HEAL NY legislation amended the Public Authorities Law (1680-J) and the Public Health Law (2818) to authorize the Dormitory Authority of the State of New York and the Department of Health to award up to $1.5 billion in capital grants for improvements in the operation and efficiency of the health care delivery system within the State. Through 24 separate phases, or rounds of grants, HEAL NY awarded $3 Billion in grant funds. The first awards were made in the spring of 2006, and the last awards made in spring of 2014. A table of the various phases is attached to this report.

The Centers for Medicare and Medicaid Services (CMS), under the 1115 Medicaid Waiver Program, Federal-State Health Reform Partnership (F-SHRP), agreed to furnish DOH with $1.5 billion over five years to support implementation of health system restructuring as supported by HEAL NY, and to assist in Medicaid fraud recovery. These F-SHRP funds have served as a Federal match for HEAL NY dollars, thus enabling the Department and DASNY to award some $3 billion for support of capital restructuring/rightsizing projects, regional planning, expansion of primary and community-based care, and promotion of health information technology (HIT).

Spending Summary:

Eighty percent of 505 contractors spent 100 percent of their funds. More than 95 percent of contractors spent between 75 and 100 percent of their grant funding, with fewer than 5 percent spending 74 percent or less. Throughout the HEAL NY program history, unclaimed funds were repurposed and used to make additional awards.

The following table summarizes life to date expenditures for the HEAL NY program:

Fund	Total Appropriations Available for the Program	Life to Date Expended	Percent Spent
HEAL Bond	656,000,000	655,402,823	**99.91%**
HEAL Hard Dollar	779,000,000	778,525,204	**99.94%**
F-SHRP	1,500,000,000	1,365,863,344	**91.06%**
Roswell	175,000,000	175,000,000	**100.00%**
Total	**3,110,000,000**	**2,974,791,370**	**95.65%**

Federal Funds were unable to be used to match state projects including Phase 1, Roswell Park Cancer Institute, Phase 9 and Phase 19 planning grants, NYS Division of Budget spending reductions in 2011-12, and interest charges on late payments.

HEAL NY Award Information:

Regional Allocation of funds. When appropriate, consideration of statewide geographic distribution of funds was included in awards determination. The following displays the total program amounts awarded in each of the ten NYS economic development regions.

Capital Region: $158.4million (Albany, Columbia, Greene, Saratoga, Schenectady, Rensselaer, Warren, Washington counties)

Central New York: $133.7million (Cayuga, Cortland, Madison, Onondaga, Oswego counties)

Finger Lakes: $115.2 million (Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates counties)

Long Island: $302.7 million (Nassau, Suffolk counties)

Mid-Hudson: $407 million (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester counties)

Mohawk Valley: $116.8 million (Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie counties)
New York City: $1.254 billion (Bronx, Kings, New York, Richmond, Queens counties)

North Country: $130.5 million (Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence counties)

Southern Tier: $96.2 million (Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins counties)

Western New York: $317.3 million (Allegany, Cattaraugus, Chautauqua, Erie, Niagara counties)

Project Objectives, Outcomes and Deliverables:

Program outcomes data is still being collected. While the project spending was completed by mid-March of 2014, there remained roughly 65 contracts that had a contract end date of March 30, 2014. These projects have an additional 60 days to submit final quarterly progress. An all-inclusive review of project objectives, deliverables and outcomes will be completed during the next quarter.

Summary Table:

A summary of the 24 rounds or phases of all awarded HEAL NY grants is presented in the attached table.

HEAL Awards All Phases - 2006-2014

HEAL Phase	Eligible Projects	Total Amount (in Millions)	Awards Announced	Number of Awards	Brief Description
1	**Health Information Technology**	**$53**	May-06	**26**	The first round of Health IT grant projects. Funded interconnectivity for multiple providers on a regional basis.
2	**Capital Restructuring**	**$268**	Nov-06	**53**	The first round of capital restructuring grants. These projects were reviewed, scored and announced before the commission mandates were published.
3	**Health Information Technology**	**$53**	Canceled 8/07	**0**	This was an extension of Phase 1 in concept. This round was canceled under The Health Department's Office of Health Information Technology and Transformation. Phase 3 funds were rolled into Phase 5.
4	**Implementation of Berger Commission Mandates**	**$550**	**Four Rounds** 1) 9/28/07 2) 1/1708 3) 3/27/2008 4) 9/30/08	**49**	This Phase limited the eligible applicant pool to the facilities which were identified in the Commission's Report which became mandated activities. Grants were negotiated with the help of the Berger team with an emphasis on financial need and compliance with the mandate.
5	**Health Information Technology**	**$105**	Apr-08	**21**	This phase launched of the new statewide Health IT initiative. Goals include the building of a statewide health information network (SHINY) using regional health information organizations (RHIOs) and local health collaborations (CHITAs). Contracts are managed directly by OHITT.
6	**Expanding Primary Care**	**$100**	Sep-08	**79**	This phase enhanced and expanded primary care services in the community. It included a range of eligible applicants and only allowed $20 million to directly be awarded to hospitals.
7	**Capital Restructuring (Round #2)**	**$149**	Sep-08	**26**	This funded Berger Coverage Partners and Berger "Look-alikes" and included primary support to closures and mergers which were not identified in the Berger Commission's final report.
8	**Residential Health Care Facility Rightsizing**	**$30**	Sep-08	**10**	Grants to Nursing Homes supported activities which resulted in the reduction of RHCF beds and expansion community based services. Complied with 2818 Section 3.
9	**Regional Health Planning**	**$8**	Feb-09	**19**	Local Healthcare Planning Grants, which included $1M for the Finger Lakes Health Systems Agency.
10	**Health Information Technology**	**$100**	Sep-09	**11**	The goal of this phase was to improve care coordination and management through a patient centered medical home model supported by an interoperable health information infrastructure. Included funding for the New York eHealth Collaborative.

11	**Capital Restructuring (Round #3)**	**$174**	Sep-09	**26**	This phase assisted hospitals to voluntarily downsize, consolidate services and initiate changes in governance or merge for operational efficiencies.
12	**Alternative Long Care Initiatives**	**$172**	Sep-09	**19**	The goal assisted communities in developing viable alternatives to RHCF care for long term care populations while downsizing RHCF beds.

HEAL Phase	Eligible Projects	Total Amount (in Millions)	Awards Announced	Number of Awards	Brief Description
14-Q1	**Expanding Access in Queens - Round #1**	**$16**	Feb-09	**9**	These were emergency grants awarded to increase access in Queens responding to the healthcare need due to the closure of St. John's Queens and Mary Immaculate Hospitals and St. Dominic's Health Center.
14-Q2	**Expanding Access in Queens - Round #2**	**$30**	Sep-09	**12**	This phase was for additional funds to hospitals and D&TCs for projects that meet distinct health care needs in the borough of Queens.
14, 14DL, 14DH	**Individual Facility Awards**	**$105**	Sep-09	**15**	This block of discretionary awards were made to help address specific problems and issues experienced by various facilities across NYS. Some funds were used to complete pending Berger mandated changes and in addition, five awards were made to LTC facilities.
15	**Medicaid Transition Funding –$50 million**	**$50**	Sep-10	**17**	This phase supported capital projects to aid hospitals to implement DOH approved transition plans intended to restructure and improve financial operations and provide for continued financial viability in response to changes in Medicaid payments.
16	**Ambulatory Care in Lower Manhattan**	**$13**	Apr-10	**5**	This phase addressed service needs arising from the reduction of outpatient and ambulatory services resulting from the closure of St. Vincent's Catholic Medical Center due to their financial situation and associated bankruptcy proceedings.
17	**Health IT in Expanded Care Coordination**	**$117**	Sep-10	**14**	This phase of Health IT grants built upon previous funding initiatives (HEAL 1, 5 and 10) by furthering the implementation and effective use of interoperable health information infrastructure and participation in the Statewide Collaborative Process.
18	**Mental Health Services**	**$38**	Sep-10	**19**	Capital grants targeted projects to improve inpatient metal health facilities and Article 31 mental health clinics, especially capital improvements and innovations to service delivery to address problems associated with multiple inpatient stays.
19	**Facility Specific Reconfiguration Non Competitive**	**$190**	Sep-10	**32**	This block of non-competitive awards addressed unmet needs and help address specific problems and issues experienced by various facilities across NYS.
20	**Long Term Care Initiatives #2**	**$151**	Sep-10	**9**	These grants assisted in developing viable alternatives to RHCFs while maintaining critical access based on community need, and/or promoting access to aging in place by supporting Adult Care Facilities in transitioning to Enhanced or Special Needs Assisted Living Residence Licensure.

21	**Restructuring Initiatives in Medicaid Redesign**	**$300**	Jun-12	**40**	These grants assisted hospitals and nursing homes implement improve primary and community based care, eliminate excess capacity and reduce over-reliance on in-patient care. These grants helped implement recommendations from the Medicaid Redesign Team.
22	**Electronic Health Record Adoption**	**$38**	Oct-12	**2**	These grants promoted Electronic health record adoption and implementation support services for behavioral health and mental health providers.
CD	**Commissioner's Discretionary Awards**	**$275**	Fall 2013-Spring2014	**24**	Commissioners' Discretionary awards addressed unmet needs and helped address specific problems and issues experienced by various facilities across NYS.
Total (Total dollars excludes Phase #3)		**$ 3,032**		**537**	**Total HEAL Projects**

VIII. Financial, Budget Neutrality Development Issues

Budget Neutrality (BN) is a requirement of Section 1115 waivers which limits federal funding to the amount that would have occurred absent of the waiver. The analysis compares *without waiver* expenditure limits to *with waiver* expenditures.

The *without waiver* amount is an estimated amount for persons eligible for the waiver using the initial per member per months (PMPMs) trended forward by trends included in the terms and conditions times the eligibles. The *with waiver* amount is equal to the actual expenditures for eligibles. The cost before the waiver (without waiver) must also be greater than the *with waiver* to have budget neutrality.

There is no allowance for Safety Net or Family Health Plus (members without children) expenditures; these must be funded with the savings.

All persons eligible for the waiver are included in the BN formula whether or not they are enrolled in managed care.

BN is calculated over the entire demonstration, not for each year of the demonstration. BN is a fluid calculation; many changes impact BN. Recipients transitioned from Fee for Service (FFS) to the Managed Care (MC) demographic mix of waiver eligibles changes over time, service utilization trends change, health plan capitation payments change, Medicaid fee schedules change, additional populations are made eligible through waiver amendments.

The current savings for the 1115 waiver is $46B (estimated through the proposed extension 12/31/14). However, this amount is overstated since CMS requires the amounts to match the CMS64, which has some time frames with little or no lag, therefore, understating the with waiver amounts. The actual savings amount is closer to $40B.

A. Quarterly Expenditure Report Using CMS-64 and Savings Estimate, Budget Neutrality and Savings Analysis **(See Attachment 1)**

B. Designated State Health Programs

The FSHRP information is not available at this time. It will be updated when available in March 2014. (**No Attachment 2 at this time)**

C. Reform Initiatives **(See Attachment 3)**

D. Hospital and Nursing Home Data **(See Attachment 4)**

IX. Other

A. FY2013 State Budget Changes to Medicaid:

Under the FY2013 New York state budget, all previously existing exclusions or, exemptions from mandatory enrollment into Medicaid managed care were eliminated. The commissioner of Health was given the discretion to mandate enrollment of new populations into managed care once rates and benefits are in place. Two additional capitated programs were created within the Medicaid program: Fully Integrated Duals Coordination Organizations and DISCOs. The budget also provides the Commissioner of Health with the authority to include additional services in the Medicaid managed care plan benefit package.

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

On June 21, 2013, the Department received CMS approval of the October 1, 2012 amendment to the Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract.

The Department is currently in the process of drafting additional contract language changes related to implementation of various Medicaid Redesign Team initiatives and other programmatic changes. Upon CMS approval, these revisions will be incorporated into the new Model Contract for the period March 1, 2014 through February 28, 2019.

X. Transition Plan Updates

Attachment 5 contains the Department's updated Transition Plan indicating how New York State will transition enrollees to a coverage option under the Affordable Care Act, as required by the Section 1115 Federal-State Health Reform Partnership demonstration. **(Will be submitted as soon as available)**

Attachments

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Date Submitted to CMS:

May 28, 2014

Federal - State Health Reform Partnership
Actual Costs Through March 31, 2011 - DY4 Actuals 21 Month Lag Final
Extension through 2014

Attachment 1

Groups to be Included in the Demonstration	DY 1 (10/01/06 - 09/30/07) Actual	DY 2 (10/01/07 - 09/30/08) Actual	DY 3 (10/01/08 - 09/30/09 Actual	DY 4 (10/1/09 - 9/30/10) Actual	DY 5 (10/1/10 - 3/31/11) Actual	DY 6 (4/1/11 - 3/31/12) Projected	DY 7 (4/1/12 - 3/31/13) Projected	DY 8 (4/1/13 - 3/31/14) Projected	Full Demonstration Period
Without Waiver									
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$74,205,296	$253,872,674	$334,430,349	$414,815,337	$239,802,796	$544,361,378	$594,330,588	$651,790,556	$3,107,608,974
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$35,180,438	$111,195,397	$160,979,221	$214,698,744	$126,787,422	$260,885,727	$305,826,321	$334,767,657	$1,550,320,927
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$6,813,524,052	$5,923,775,716	$5,605,439,540	$5,385,789,164	$2,841,157,566	$4,843,425,289	$5,040,917,954	$8,926,172,481	$45,380,201,762
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$830,759,022	$2,270,724,236	$3,398,057,992	$4,342,757,874	$2,585,985,210	$6,032,136,992	$6,908,041,018	$3,889,940,199	$30,258,402,543
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$222,205,966	$163,717,812	$160,076,250	$171,081,672	$91,494,819	$149,090,947	$142,357,617	$392,116,627	$1,492,141,710
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$60,600,194	$173,756,116	$236,925,000	$299,624,894	$177,917,010	$412,271,069	$468,565,821	$261,975,123	$2,091,635,227
Demonstration Group 7 – Non Duals 18-64						$0	$233,691,291	$85,737,316	$319,428,606
Demonstration Group 8 – Non Duals 65+						$0	$62,159,385	$22,310,307	$84,469,692
W/O Waiver Total	**$8,036,474,967**	**$8,897,041,951**	**$9,895,908,352**	**$10,828,767,686**	**$6,063,144,823**	**$12,242,171,402**	**$13,755,889,995**	**$14,564,810,265**	**$84,284,209,441**
With Waiver									
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$41,943,140	$130,509,759	$160,465,088	$177,404,747	$74,728,987	$241,641,042	$262,345,473	$286,061,767	$1,375,100,002
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$27,926,591	$84,400,273	$117,867,951	$146,624,422	$67,444,741	$177,494,934	$207,326,005	$226,068,147	$1,055,153,065
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$6,771,231,995	$6,352,131,819	$6,101,041,487	$5,609,323,113	$1,844,323,814	$4,961,633,040	$5,326,834,797	$8,004,190,653	$44,970,710,717
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$548,195,127	$1,700,934,347	$2,402,760,736	$2,770,899,040	$1,211,469,426	$3,935,772,899	$4,246,923,918	$2,253,175,067	$19,070,130,559
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$231,248,905	$194,954,514	$196,434,562	$193,467,456	$52,558,028	$222,038,396	$237,153,242	$437,889,104	$1,765,744,208
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$43,085,276	$133,556,332	$176,503,700	$204,091,650	$101,563,996	$289,116,793	$311,973,545	$165,515,330	$1,425,406,622
Demonstration Group 7 – Non Duals 18-64							$197,034,128	$73,039,262	$270,073,390
Demonstration Group 8 – Non Duals 65+							$52,628,303	$19,509,306	$72,137,610
Designated State Health Programs	$74,849,675	$317,971,598	$361,117,274	$361,369,720	$335,807,682	$430,069,725	$745,876,000	$372,938,000	$2,999,999,674
With Waiver Total	**$7,738,480,708**	**$8,914,458,642**	**$9,516,190,798**	**$9,463,180,147**	**$3,687,896,674**	**$10,257,766,829**	**$11,588,095,411**	**$11,838,386,636**	**$73,004,455,847**
Expenditures (Over)/Under Cap	**$297,994,259**	**($17,416,691)**	**$379,717,553**	**$1,365,587,539**	**$2,375,248,149**	**$1,984,404,573**	**$2,167,794,583**	**$2,726,423,629**	**$11,279,753,594**

Federal - State Health Reform Partnership
Budget Neutrality Analysis

Groups to be Included in the Demonstration	FFY 2007 DY1 PMPM	FFY 2008 DY2 PMPM	FFY 2009 DY3 PMPM	FFY 2010 DY4 PMPM	FFY 2011 DY5 PMPM	SFY 2012 DY6 PMPM	SFY 2013 DY7 PMPM	SFY 2014 DY8 PMPM
	WITHOUT WAIVER PMPMS							
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$482.15	$514.58	$549.19	$586.13	$625.56	$667.00	$711.00	$758.00
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$661.56	$705.21	$751.73	$801.33	$854.19	$909.00	$967.00	$1,029.00
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,746.00	$1,852.00	$1,966.00	$2,086.00	$2,214.00	$2,349.00	$2,493.00	$2,646.00
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,746.00	$1,852.00	$1,966.00	$2,086.00	$2,214.00	$2,349.00	$2,493.00	$2,646.00
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,126.00	$1,186.00	$1,250.00	$1,318.00	$1,389.00	$1,464.00	$1,542.00	$1,625.00
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,126.00	$1,186.00	$1,250.00	$1,318.00	$1,389.00	$1,464.00	$1,542.00	$1,625.00
Demonstration Group 7 – Non Duals 18-64							$8,873.37	$9,396.90
Demonstration Group 7 – Non Duals 65+							$8,111.89	$8,403.92

Groups to be Included in the Demonstration	DY 1 (10/1/06 - 9/30/07)	DY 2 (10/01/07 - 09/30/08) Actual	DY 3 (10/01/08 - 09/30/09) Actual	DY 4 (10/1/09 - 9/30/10)	DY 5 (10/1/10 - 3/31/11)	DY 6 (4/1/11 - 3/31/12)	DY 7 (4/1/12 - 3/31/13)	DY 8 (4/1/13 - 3/31/14)
	WITH WAIVER PMPMS							
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	$272.53	$264.53	$263.51	$250.67	$194.94	$296.08	$313.84	$332.68
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	$525.15	$535.27	$550.41	$547.25	$454.39	$618.44	$655.55	$694.88
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,735.16	$1,985.92	$2,139.82	$2,172.58	$1,437.21	$2,406.33	$2,634.40	$2,372.70
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,152.14	$1,387.28	$1,390.16	$1,330.97	$1,037.20	$1,532.65	$1,532.65	$1,532.65
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$1,171.82	$1,412.28	$1,533.91	$1,490.46	$797.89	$2,180.31	$2,568.81	$1,814.69
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	$800.56	$911.61	$931.22	$897.77	$792.91	$1,026.67	$1,026.67	$1,026.67
Demonstration Group 7 – Non Duals 18-64						#DIV/0!	$7,481.48	$8,005.18
Demonstration Group 7 – Non Duals 65+						#DIV/0!	$6,868.07	$7,348.83

Federal - State Health Reform Partnership
Budget Neutrality Analysis

	MEMBER MONTHS							
Groups to be Included in the Demonstration	**DY 1 (10/1/06 - 9/30/07)**	**DY 2 (10/01/07 - 09/30/08) Actual**	**DY 3 (10/01/08 - 09/30/09) Actual**	**DY 4 (10/1/09 - 9/30/10)**	**DY 5 (10/1/10 - 3/31/11)**	**DY 6 (4/1/11 - 3/31/12)**	**DY 7 (4/1/12 - 3/31/13)**	**DY 8 (4/1/13 - 3/31/14)**
Demonstration Group 1 – TANF Child under 1 through 20 required to enroll in managed care in the 14 counties	153,905	493,359	608,952	707,719	383,341	816,134	835,908	859,882
Demonstration Group 2 – TANF Adults under 21 through 64 required to enroll in managed care in the 14 counties	53,178	157,677	214,145	267,928	148,430	287,003	316,263	325,333
Demonstration Group 3 – Disabled Adults and Children 0-64 voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	3,902,362	3,198,583	2,851,190	2,581,874	1,283,269	2,061,909	2,022,029	3,373,459
Demonstration Group 4 – Disabled Adults and Children 0-64 required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	475,807	1,226,093	1,728,412	2,081,859	1,168,015	2,567,960	2,770,975	1,470,121
Demonstration Group 5 – Disabled Adults and Children 65+ voluntarily enrolled in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	197,341	138,042	128,061	129,804	65,871	101,838	92,320	241,303
Demonstration Group 6 – Disabled Adults and Children 65+ required to enroll in managed care in those counties participating in the Partnership Plan as of October 1, 2006.	53,819	146,506	189,540	227,333	128,090	281,606	303,869	161,215
Demonstration Group 7 – Non Duals 18-64						0	26,336	9,124
Demonstration Group 7 – Non Duals 65+						0	7,663	2,655

New York State Department of Health ***Attachment 3***

Federal-State Health Reform Partnership (F-SHRP)
Report of Reform Initiatives For the Period 01/01/14 - 03/31/14

Awards Under FFY 2007	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 2 Restructuring	$230,831,661		$230,831,661	$188,894,238		$188,894,238
Community Health Center Capital Program	$10,000,000		$10,000,000	$9,032,024	$479,918	$9,511,942
Displaced Worker Program	$12,614,885		$12,614,885	$11,618,214		$11,618,214
HEAL NY Phase 4: Implementation of Commission Mandates	$362,299,349		$362,299,349	$333,223,772	$957,707	$334,181,479
	$615,745,895	$0	$615,745,895	$542,768,248	$1,437,625	$544,205,873

Awards Under FFY 2008	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 4: Implementation of Commission Mandates	$187,700,651		$187,700,651	$179,443,997		$179,443,997
HEAL NY Phase 5: Health IT	$104,944,003		$104,944,003	$103,278,557	$367,729	$103,646,285
HEAL NY Phase 6: Primary Care Services	$99,885,522		$99,885,522	$90,801,736	$3,090,433	$93,892,169
HEAL NY Phase 7: Berger Lookalikes and coverage partners	$149,951,753		$149,951,753	$140,234,478	$661,647	$140,896,125
HEAL NY Phase 8: Nursing Home Rightsizing	$30,000,000		$30,000,000	$24,891,637	$1,380,670	$26,272,306
	$572.481.929	$0	$572.481.929	$538.650.404	$5.500.478	$544.150.882

Awards Under FFY 2009	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 10: Health IT	$99,914,713		$99,914,713	$87,319,451	$8,736,851	$96,056,302
HEAL NY Phase 11: Restructuring	$174,343,776		$174,343,776	$121,797,616	$6,935,912	$128,733,528
HEAL NY Phase 12: Long Term Care	$172,363,541		$172,363,541	$149,786,090	$9,224,694	$159,010,783
HEAL NY Phase 14(Q) - Targeted Hospitals, Queens	$15,950,000		$15,950,000	$15,011,782		$15,011,782
HEAL NY Phase 14(Q2) - Targeted Hospitals, Queens	$30,052,135		$30,052,135	$28,749,534	$873,249	$29,622,783
HEAL NY Phase 14(Os) - Targeted Hospitals, Oswego	$17,800,000		$17,800,000	$17,800,000		$17,800,000
HEAL NY Phase 14(D) - Targeted Hospitals, Discretionary	$87,183,798		$87,183,798	$60,037,888	$3,306,259	$63,344,147
	$597,607,963	$0	$597,607,963	$480,502,360	$29,076,965	$509,579,325

Awards Under FFY 2010	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase 15 - Medicaid Transition Funding	$49,927,203		$49,927,203	$35,777,318	$8,709,056	$44,486,374
HEAL NY Phase 16 - Ambulatory Care Lower Manhattan	$14,000,000		$14,000,000	$13,299,868		$13,299,868
HEAL NY Phase 17-Health IT in Expanded Care Coordination	$138,575,701		$138,575,701	$93,945,522	$21,213,208	$115,158,731
HEAL NY Phase 18- Mental Health Services	$38,501,949		$38,501,949	$27,372,811	$8,389,446	$35,762,257
HEAL NY Phase 19- Facility Specific Reconfiguration	$200,181,491		$200,181,491	$169,909,242	$11,181,855	$181,091,097
HEAL NY Phase 20 - Long Term Care Initiatives #2	$150,794,505		$150,794,505	$142,375,857	$8,225,797	$150,601,654
	$591,980,849	$0	$591,980,849	$482,680,619	$57,719,362	$540,399,981

Awards *After* FFY 2010	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
HEAL NY Phase CD - Commissioner's Discretion (PHL Section 2818(6))	$75,861,715	$247,032,857	$322,894,572	$54,152,716	$267,653,562	$321,806,279
HEAL NY Phase 21 - Restructuring Initiatives in Medicaid Redesign	$295,683,549		$295,683,549	$226,337,476	$46,834,259	$273,171,734
	$371,545,264	$247,032,857	$618,578,121	$280,490,192	$314,487,821	$594,978,013

	Awards Made Prior Periods	Awards This Period	Total Awards to Date	Expenditures Prior Periods	Expenditures this Period	Expenditures to Date
Total All Health Reform Programs	**$2,749,361,900**	**$247,032,857**	**$2,996,394,757**	**$2,325,091,823**	**$408,222,251**	**$2,733,314,074**

Signed: Date:

Name: Marybeth Hefner
Title: Deputy Director, Fiscal Management Group

New York State Medicaid
Inpatient and Nursing Home Information
FFS Expenditures, Eligible Months, Days and Discharges
January 1, 2014 through March 31, 2014

Q2: January 1, 2014-March 31, 2014*

Inpatient Hospital		Medicaid Expenditures	Medicaid Discharges		Medicaid Cost Per Discharge	Medicaid Member Months	Discharges PMPY
Medicaid FFS	$	2,017,536,585	157,868	$	12,780	11,330,887	0.17
Managed Care**	$	4,758,821,814	553,334	$	8,600	44,913,576	0.15
Total Medicaid	**$**	**6,776,358,399**	**711,202**	**$**	**9,528**	**56,244,463**	**0.15**

Nursing Home		Medicaid Expenditures	Medicaid Days		Medicaid Cost Per Day	Medicaid Member Months	Days PMPY
Medicaid FFS	$	6,253,007,687	28,369,611	$	220	11,330,887	30.04
Managed Care**	$	217,545,620	896,772	$	243	45,829,118	0.23
Total Medicaid	**$**	**6,470,553,308**	**29,266,383**	**$**	**221**	**57,160,005**	**6.14**

*For discharges paid through February 2014
**Managed care data includes an estimate for under-reporting of hospital encounter data
Managed care cost is a blended rate of plan paid claims and encounter proxy costs during the time period.
Managed care member months used for nursing home calculation include managed long-term care member months as the nursing home utilization for those members is in the managed care utilization.

Attachement IV