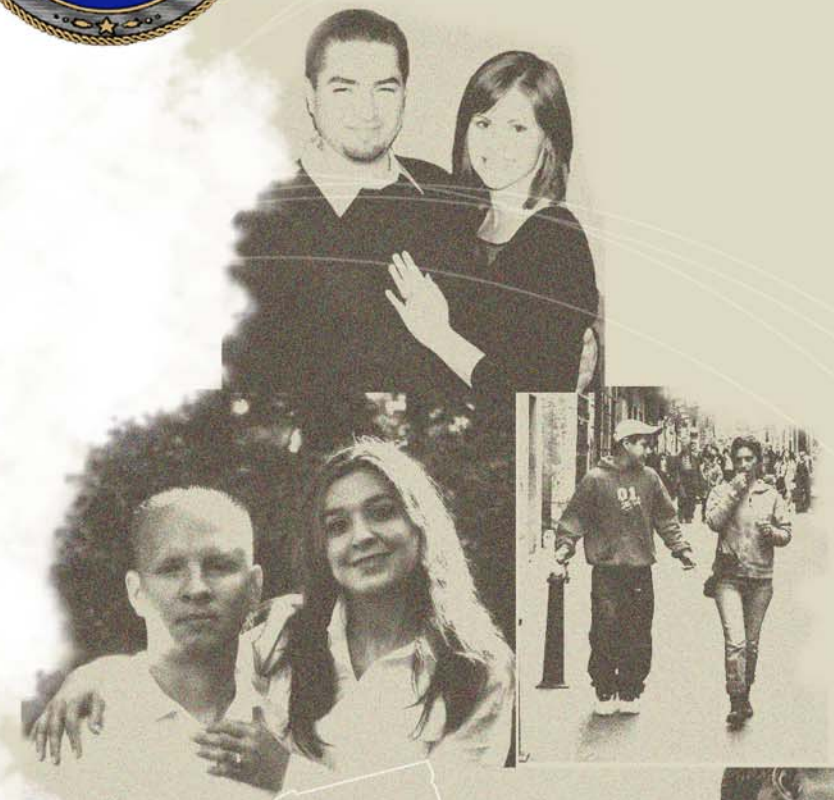
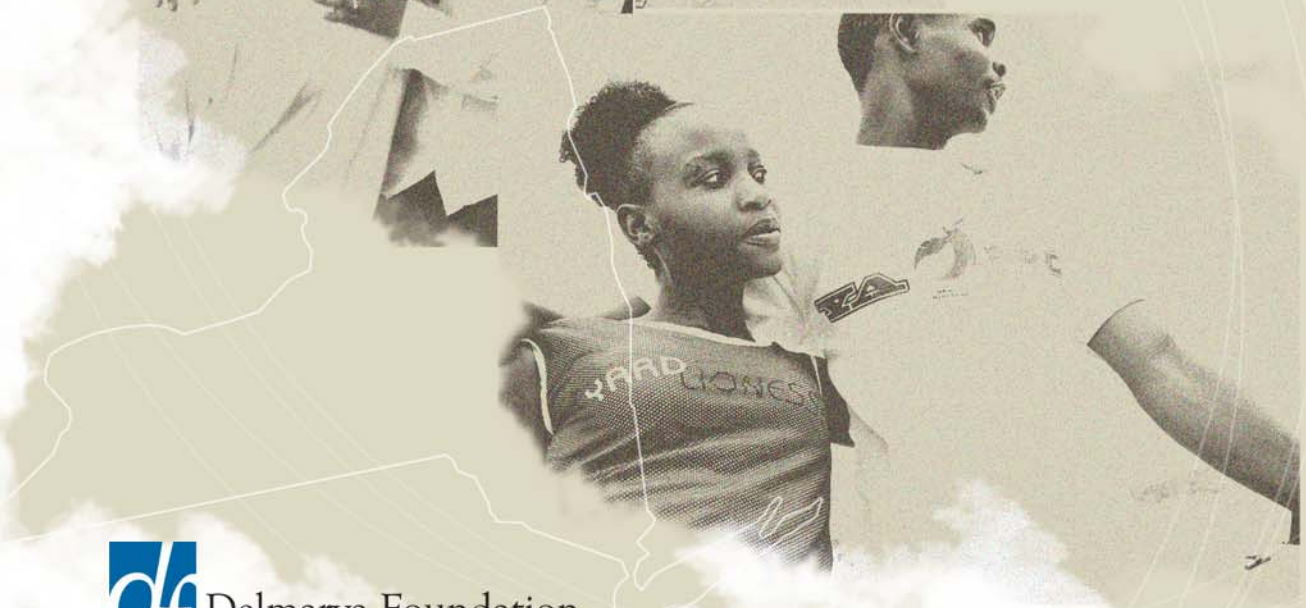
Partnership Plan Evaluation



New York Department of Health

Office of Health Insurance Programs

Interim Program Evaluation of Section 1115 Waiver Programs



Delmarva Foundation
Improving Health in the Communities We Serve

Submitted by
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9240 Centreville Road
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Interim Program Evaluation of Section 1115 Waiver Programs

New York Department of Health
Interim Evaluation Report
Section 1115 Waiver Programs

Introduction

Medicaid managed care has been viewed not only as an alternative health care delivery system through which costs can be controlled and contained, but also as a model for the provision of high quality services offering improved care coordination and increased access. With rapid growth in the 1990's, the proportion of Medicaid enrollees in managed care increased from nine percent in 1990 to approximately 64 percent in June 2007, of which almost 30 percent were in Medicaid-only managed care organizations.[1] All but three states (Alaska, New Hampshire, and Wyoming) have all or a portion of their Medicaid enrollment in managed care.[2]

In July 1997, New York State received approval for its Partnership Plan Section 1115 Demonstration. Similar to other states across the country, New York implemented its program with the goals of improving the health status of low income residents by improving access for a greater number of beneficiaries to high quality health care services. Initially, the Demonstration provided comprehensive benefits through managed care organizations to recipients who met the State plan eligibility requirements and to Home Relief recipients who were previously supported by State only dollars. The State created the Family Health Plus, a Medicaid expansion program, in 2001 to provide coverage for low-income uninsured adults whose income and/or assets exceeded the traditional income-eligibility standards. In 2002, the Demonstration was further expanded to provide family planning services to women who would lose their Medicaid coverage at their 60-day postpartum period, as well as for other low-income adults of childbearing age.

New York began implementation of the Partnership Plan with a geographic phase-in strategy starting with five upstate counties in October 1997. Mandatory Medicaid managed care began in New York City in August 1999. Today, New York has implemented the mandatory Medicaid managed care program in 37 counties and all areas of New York City. Voluntary Medicaid managed care programs operate in 13 additional counties. Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 2.3 million as of February 2009.

The mandatory managed care expansions include Medicaid beneficiaries who qualify for the federal Supplemental Security Income program (SSI) or who are certified as blind or disabled and 14 additional

[1] The Henry J. Kaiser Family Foundation, State Health Facts.Org. www.statehealthfacts.org.
[2] Centers for Medicare and Medicaid Services, Medicaid Managed Care Overview. www.cms.hhs.gov/MedicaidManagCare/.

counties throughout the State. These populations were moved from the Partnership Plan to the Federal-State Health Reform (F-SHRP) waiver effective October 1, 2006.

In accordance with the terms and conditions of the Demonstration extension approved by the Centers for Medicare and Medicaid Services (CMS) in October 2006, the New York State Department of Health (DOH) contracted with the Delmarva Foundation (Delmarva) to prepare an evaluation of the 1115 Demonstration program and its performance relative to the goals set forth at implementation. Specifically, Delmarva has been directed to assess the Partnership Plan Demonstration as specified in the Evaluation Plan approved by CMS:

- Goal 1: Managed Care Enrollment – evaluation of the Demonstration's ability to continue managed care enrollment in the Medicaid program;
- Goal 2: Improving Health Care Access – evaluation of the extent to which the Plan has improved health care access to primary care and specialty care services for Medicaid beneficiaries;
- Goal 3: Improving Quality of Care – evaluation of the Plan's ability to improve quality of care to Medicaid recipients, the extent to which financial mechanisms have evolved to support program goals, and the success of the HIV Special Needs Plan;
- Goal 4: Expanding Health Care Coverage – evaluation of the Plan's success in reducing the number of uninsured New York residents.
- Goal 5: evaluation of the effectiveness of the Family Planning Expansion Demonstration in reducing the number of unintended pregnancies by increasing access to family planning services.

To measure the performance of the 1115 Demonstration program, Delmarva has prepared quantitative and qualitative analyses of data and information made available by the DOH, including enrollment statistics, quality measurement data, and consumer assessment results. Where appropriate, New York data have been compared to national and/or state benchmarks; commercial insurance and/or Medicare plan performance rates, and trended over time. To provide historical perspective and context for the broader discussion of "performance", Delmarva has included brief literature reviews to identify trends, successes, and barriers in providing services to the Medicaid-eligible population.

While Delmarva has drawn some preliminary conclusions as to how well the program is doing in meeting the stated goals, the information assessed for this report reflects a baseline analysis and summaries. A more in-depth evaluation with conclusions and recommendations will be prepared and submitted to the state by December 28, 2009, that will include updated statistics that may more accurately reveal the program's strengths and challenges. Undoubtedly, the budgetary and political landscapes of the Medicaid program are under-going significant change, the impact of which may not be fully realized within the scope of this review. Inclusion of data from 2008 in the December 2009 report may expose some of the difficulties to be faced in planning for future years and facilitate a more informed discussion of recommendations for future action.

Medicaid Managed Care: The National Perspective

In the 2004 report "Moving to Medicaid Managed Care: Lessons from State Experiences under the Section 1115 Waiver Authority," Urban Institute researchers identified a series of issues that impacted the success of early demonstration projects.[3] Among their key findings, the authors noted the effects of managed care "are not homogeneous but rather, vary by subgroup (e.g. TANF, SSI), geographic area and type of managed care."[4] The authors observed that while managed care may not have significantly improved access for TANF beneficiaries in rural areas, the SSI population in rural areas did experience improved access under managed care. Individuals with a disability living in urban areas appear to have adequate access to specialists and do not seem to benefit appreciably by enrollment in a Medicaid managed care plan. However, they do appear to obtain better access in rural areas when enrolled in managed care. Accordingly, policymakers were cautioned to be cognizant of these variances before advancing with broad application and implementation of managed care.

The authors of the 2004 Urban Institute report also noted that strategic consideration of reimbursement requires analysis of market share – whether there are a sufficient number of enrollees to support a capitated program. Assumption of financial risk is only viable when the risk pool is large enough and the capitation rate is high enough to ensure that costs both direct medical and administrative, are sufficiently met. In their absence, plans were, and continue to be unwilling to partner with states in development of Medicaid managed care. By mandating enrollment throughout most of the state, New York ensured that participating health plans could achieve adequate market share and therefore reduce financial risk.

Flexibility with respect to provider networks has been required in order to attract specialists in rural and underserved areas. While some states have loosened their travel time requirements to broaden the specialist 'encatchment area,' others have relaxed credentialing standards at the risk of incurring increased quality issues. Regardless of the approach taken, states have had to implement strategic trade-offs in order to ensure adequate provider access. Preliminary analyses of access to services in New York suggest that challenges associated with provider availability have not been of particular concern. In fact, the findings indicate that enrollees in the Medicaid managed care plans are experiencing improved access in comparison to members of managed care plans across the country.

The authors also spoke to the need for states to be realistic in forecasting the potential cost savings in moving beneficiaries from fee-for-service to managed care. In analyses of states' experiences operationalizing their managed care programs, the authors found examples where demonstration programs were implemented

[3] This section provides background information on national studies and some reference to the New York program. The final report will include additional New York information on the Medicaid managed care program and relevant policies.
[4] The Urban Institute, September 2004. *Moving to Medicaid Managed Care: Lessons from State Experiences Under the Section 1115 Waiver Authority.*

despite evidence that fee-for-service was comparatively cost-effective. Where the needs of the Medicaid population were met without excessive hospital days or emergency room use, cost savings expected from the introduction of managed care were not significant or immediate. Comparable studies have shown that expanded use of managed care for low-income children and families has not resulted in significant savings as this segment of the Medicaid population has only accounted for 25 percent of total program costs.[5] It is possible, however, that long-term savings will be realized, if managed care administers services more effectively to produce improved health outcomes that reduce long-term expenditures associated with chronic care needs and system dependence. The terms and conditions of New York's waiver require budget neutrality; that is, the cost to the federal government under the waiver cannot be more than the cost that would have occurred without the waiver. The State projects the Partnership Plan waiver will result in significant savings from October 1997 through September 2009.

Prior to publication of the Urban Institute report, the Kaiser Commission on Medicaid and the Uninsured issued an update on Medicaid and managed care, providing an overview of national trends and issues.[6] The update showed that by 1991, analyses of Medicaid managed care had already identified a change in the number of commercial plans operating in this market. Specifically, the Kaiser Commission noted that between 1995 and 1999, the number of commercial plans exiting the Medicaid market exceeded the number entering. The inadequacy of capitation rates and instability of enrollment volume were documented as key determinants. Interestingly, the Balanced Budget Act of 1997 permitted the establishment of Medicaid-only plans by eliminating the "75/25 rule" which required that 25 percent of a plan's enrollment be privately insured. While this was seen as an opportunity for new managed care organizations to enter the marketplace, the Kaiser Commission pointed out these plans are most vulnerable to instability due to their dependence on historically low Medicaid capitation rates. Without other payors to offset losses, network stability and, consequently, accessibility are jeopardized. Studies of Medicaid managed care capitation rates have consistently revealed more than a two-fold variation in plan rates across states, with most paying less than the Medicare rate. While Medicare is providing services to a higher risk population (elderly people) and capitation rates may reasonably be expected to be somewhat higher, it is not clear to what extent low capitation will inhibit future growth and/or stability of Medicaid managed care programs. Once again, preliminary analyses suggest that New York has not been vulnerable to these issues. Although the scope of this study did not include evaluation of capitation rates or the impact of reimbursement policies, analysis of the health plan network and provider access reflect a stable, mature program.

With respect to the quality of care received by Medicaid managed care beneficiaries, the results of recent studies suggest that initial gains evidenced through HEDIS and CAHPS have tapered off. This is expected

[5] Kaiser Commission on Medicaid and the Uninsured, December 2001. *Medicaid and Managed Care.*

[6] Kaiser Commission on Medicaid and the Uninsured, December 2001. *Medicaid and Managed Care.*

where plans have improved data collection processes and stabilized encounter data reporting. Furthermore, as plans move closer to 100% on any measure, significant gains will be harder to achieve.

According to the National Committee for Quality Assurance (NCQA), among the 52 measures of clinical quality collected for Medicaid plans in 2008 (reflecting 2007 services), only 26 showed improvement, the majority of which was small.[7] NCQA noted a significant decline in the use of beta blocker drugs after a heart attack, with a rate of 62.0 percent versus 68.1 percent in 2006, compared to 69.8 percent in 2005. Admittedly, these findings are skewed by the fact that while 64 percent of Medicaid beneficiaries are enrolled in private health plans, only 1 in 4 are in a plan that routinely measures and reports performance. Stated otherwise, 75 percent of Medicaid managed care enrollees are receiving care for which there is no broad public accountability. While participation in the Medicaid program requires some performance reporting, requirements about public disclosure and the breadth of measurement have yet to be established by CMS. With increased enrollment of seniors and persons with disabilities into managed care, performance measurement and reporting are critical tasks to assess the quality of care provided to these most vulnerable populations.

In a recent study of Medicaid prepared by Health Management Associates, the authors noted that, in fiscal year 2008, nearly one-third of states extended their use of managed care by including persons with disabilities, expanding the managed care service areas, and/or mandating enrollment where it had previously been voluntary.[8] New York has employed these strategies, mandating enrollment in 37 counties and New York City, as well as for the SSI population. With 75 percent of states using, or planning to use pay-for-performance arrangements in 2009, there is evidence of increasing use of performance measurement and reporting at some level to support and reward quality improvement. There appears to be increased activity in the areas of disease management and chronic care management, driven by both cost concerns and the need to demonstrate effectiveness in serving seniors and the populations of people with a disability. More states are also reporting efforts to implement e-prescribing and electronic health records, investing in new technologies as a means to improve quality. As discussed later in this report, New York has implemented pay-for-performance mechanisms and disease management initiatives to facilitate health outcomes improvements.

Regardless of the focus of the documented research, all studies of Medicaid managed care point to the criticality of reimbursement. While evidence of the benefits of managed care may be limited to select sub-populations, geographic areas, and/or particular contractual configurations, there is ample proof that low reimbursement rates threaten access to services for all Medicaid beneficiaries. The financing of Medicaid is

[7] The National Committee for Quality Assurance. *The State of Health Care Quality 2008.*

[8] The Kaiser Commission on Medicaid and the Uninsured, September 2008. *Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009.*

an increasingly difficult issue for both federal and state governments that face not only increasing health care costs, but a growing number of uninsured who remain as such for longer periods of time. Used as a strategic approach to control costs, increase access, and improve the quality of care, managed care will only be a viable, sustainable model for Medicaid if planned and implemented judiciously, with assurances of adequate capitation to sustain health plan infrastructure.

Goal 1: Managed Care Enrollment

Goal 1 of the Demonstration is to continue managed care enrollment in New York's Medicaid program.

As part of the Evaluation Plan, the New York DOH must show the Demonstration Plan continues to enroll Medicaid recipients into the Medicaid managed care plans. Outcome measures specified in the Evaluation Plan include the number of beneficiaries enrolled in managed care organizations, analyzed across beneficiary types, age categories, and counties.[9] Data for the analysis of enrollment across these groups were taken from the Medicaid Management Information Systems, Enrollment Reports, 2006 and 2007.

Enrollment by Beneficiary Type

Data in Table 1-1 show enrollment and the number of people eligible for Medicaid managed care by beneficiary type and statewide. There are three major beneficiary types used for enrollment:

- TANF ADC & MA-ADC – Temporary Assistance to Needy Families (Aid to Dependent Children) and Medicaid Only ADC;
- SNA HR & MA HR – Safety Net Assistance (Home Relief) and Medicaid Only HR;
- SSI & MA SSI – Supplemental Security Income and Medicaid Only SSI. (included in Federal-State Health Reform waiver as of October 2006)

Table 1-1: Medicaid Managed Care by Beneficiary Type

Medicaid Managed Care by Beneficiary Type Enrollment and Eligibility for Enrollment - 2006 and 2007						
	Enrollment			Eligibility for Enrollment		
Beneficiary Type	2006	2007	Percent Change	2006	2007	Percent Change
TANF ADC & MA-ADC	1,555,789	1,572,060	1.1%	2,016,377	1,985,424	-1.5%
SNA HR & MA-HR	316,542	320,818	1.6%	478,974	460,832	-3.8%
SSI & MA-SSI	131,423	204,310	55.5%	416,383	420,326	0.95%
New York State Total	2,003,754	2,097,188	4.7%	2,911,734	2,866,582	-1.6%

[9] DOH is currently investigating some issues with birth date in the source data, which may be impacting the older age groups in particular. Age group analyses will be included in the final report if data are ready for use at that time.

Results presented in Table 1-1 include all Medicaid managed care plans in the State and are summarized as follows:

- Enrollment in New York increased 4.7 percent between 2006 and 2007, but at the same time eligibility for Medicaid managed care decreased by 1.6 percent.
- The overall increase in enrollment was driven by SSI & MA-SSI beneficiaries who no longer are exempted from managed care. With mandatory enrollment of this population beginning in 2005 in New York City, and expanding to other areas of the State in 2007 and 2008, SSI & MA-SSI beneficiaries increased by more than 55 percent between 2006 and 2007. Enrollment for the TANF and SNA populations increased by less than 2% each.

Enrollment as a percentage of eligibility, referred to as the "penetration rate", is shown in Table 1-2 for each beneficiary type and for New York State as a whole. Information from the analysis indicates:

- Medicaid managed care penetration rates (enrolled/eligible) for New York increased by over four percentage points from 2006 to 2007, from 68.8 percent to 73.2 percent. Analysis of penetration trends from 2000 through 2006 indicate that while enrollment in New York's Medicaid managed care program was below the national average, the penetration rate now exceeds the national rate of approximately 66 percent after expanding the mandatory program.[10]
- Penetration rates increased for each beneficiary type, but primarily for the SSI population which began implementation of mandatory managed care enrollment in New York City in 2005. Mandatory enrollment for SSI in Long Island and Westchester began in late 2007.
- Penetration rates for TANF ADC & MA-ADC enrollees were highest at 79 percent in 2007.

Table 1-2: Medicaid Managed Care by Beneficiary Type

Medicaid Managed Care by Beneficiary Type Penetration Rates (Enrolled/Eligible) 2006 and 2007			
Beneficiary Type	**2006**	**2007**	**Change**
TANF ADC & MA-ADC	77.2%	79.2%	2.0%
SNA HR & MA-HR	66.1%	69.6%	3.5%
SSI & MA-SSI	31.6%	48.6%	17.0%
New York State	68.8%	73.2%	4.3%

[10] Centers for Medicare and Medicaid Services, *Penetration Rate as of December 31, 2006*. www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr06.pdf

Enrollment by Borough and County

Enrollment in Medicaid managed care across various geographic areas is shown in Table 1-3. Enrollment and eligibility data are shown for New York State, Upstate, New York City, and each Borough within NYC. Findings indicate there was some variation in enrollment between 2006 and 2007 across the different areas.

- Upstate New York saw the greatest percent increase over the time period, an over eight percent gain in enrollment. Fourteen upstate counties switched to mandatory Medicaid managed care enrollment during this time period which accounts for the increases over this time period.
- Staten Island, with the smallest eligible population, showed the greatest increase among the NYC Boroughs, with a five percent gain from 2006 to 2007.
- The number of people eligible for the Demonstration Program has decreased in all areas with the exception of Staten Island and Queens, where eligibility appears to have remained fairly stable.

Table 1-3: Medicaid Managed Care Enrollment by Geographic Area

Medicaid Managed Care Enrollment by Geographic Area Upstate, Boroughs, NYC, and Statewide 2006 and 2007						
	Enrollment			Eligibility for Enrollment		
Area	2006	2007	Percent Change	2006	2007	Percent Change
Upstate	518,326	561,607	8.4%	931,929	913,427	-2.0%
New York City	1,485,428	1,535,581	3.4%	1,979,805	1,953,155	-1.3%
Bronx	355,391	368,797	3.8%	487,273	479,416	-1.6%
Brooklyn	542,836	556,629	2.5%	703,775	694,060	-1.4%
Manhattan	202,868	208,514	2.8%	295,836	287,240	-2.9%
Queens	339,253	354,305	4.4%	433,164	432,573	-0.1%
Staten Island	45,079	47,336	5.0%	59,757	59,866	0.2%
NY State	2,003,754	2,097,188	4.7%	2,911,734	2,866,582	-1.6%

Medicaid managed care penetration rates, enrollment per those eligible, by geographic area are displayed in Table 1-4, with the following findings:

- Among the NYC Boroughs in 2007, Brooklyn, Queens and Staten Island, have the highest Medicaid managed care penetration rates, close to or above 80 percent. This is expected as NYC has had a mandatory program for the TANF and SNA populations since 1999, and was the first region to implement mandatory SSI enrollment in November 2005.
- Upstate New York has the lowest penetration rates each year, but the greatest gain over the time period due to the continued rollout of mandatory managed care upstate.

Table 1-4: Penetration Rates by Geographic Area

Penetration Rates by Geographic Area Upstate, Boroughs, NYC, and Statewide 2006 and 2007			
Area	2006	2007	Change
Upstate	55.6%	61.5%	5.9%
New York City	75.0%	78.6%	3.6%
Bronx	72.9%	76.9%	4.0%
Brooklyn	77.1%	80.2%	3.1%
Manhattan	68.6%	72.6%	4.0%
Queens	78.3%	81.9%	3.6%
Staten Island	75.4%	79.1%	3.6%
NY State	68.8%	73.2%	4.3%

Enrollment, eligibility and Medicaid managed care penetration rates for each New York State county and for the NYC Boroughs are presented in Appendix 1, Exhibit 1-1. A summary of information from the Exhibit follows.

- In 2006, 14 upstate counties had penetration rates exceeding the national average of 66 percent. In 2007, 24 counties exceeded the national rate.
- One county and two NYC Boroughs had penetration rates greater than 80 percent in 2007: Rockland (88.9%), Queens (81.9%), and Brooklyn (80.2%).
- In 2007, an additional eight counties and NYC as a whole had penetration rates greater than the state rate of 73 percent.
- Nassau County was the only county that appears to have experienced a reduced penetration rate, with close to a 10.5 point decrease from 2006 to 2007, and enrollment rates down over 16 percent for the same time period. However, there was a significant change in the number of people eligible for managed care during this period that was not reflected in reports until January 2008. When the number of eligible residents was updated in January 2008, Nassau showed a three percent increase in penetration rate compared to December 2006.

Goal 1 Summary

One of the primary objectives of the 1115 Waiver Demonstration expansion program was to ensure continued enrollment in Medicaid managed care across the state of New York. The statistics indicate that implementation of mandatory enrollment has been a successful strategy for increasing managed care enrollment and penetration rates. Medicaid managed care enrollment has grown statewide from approximately 650,000 in July 1997 when the Partnership Plan was first launched to 2.1 million in 2007 and

2.3 million in 2009. New York's Medicaid managed care penetration rate is now 73 percent, which well exceeds the national rate of approximately 66 percent.

Enrollment and penetration rates in NYC have improved from 2006 to 2007, and penetration rates for the City in 2007 were over five percentage points higher than the state as a whole. Manhattan is the only borough with a penetration rate below the state average. Medicaid managed care penetration rates in Upstate New York were considerably lower than NYC; however, this likely reflects the more recent implementation of the mandatory program upstate. Increases in enrollment and penetration rates were greatest for residents upstate who were affected by mandatory managed care in the past two years. For example, three counties located centrally in the state, Fulton, Montgomery and Otsego, experienced high growth in enrollment rates and close to or more than a 40 point increase in penetration rates.

Only Nassau County showed a substantial decrease in enrollment (a 16% decline) and penetration rates (10.5 point decrease) from 2006 to 2007. This appeared to be due to the decrease in the number of individuals eligible for managed care which, when updated in January 2008, accounted for the decrease in enrollment. It is recommended the Department conduct further analysis as to the cause of eligibility decline in the area.

Goal 2: Improving Health Care Access

Goal 2 of the Demonstration is to improve health care access for Medicaid beneficiaries in New York.

New York DOH must show that Medicaid managed care plans continue to provide adequate primary and specialty networks for beneficiaries, and assure participants are able to access these services. Outcome measures to determine the extent the Demonstration Plan has improved access to care are specified in the Evaluation Plan:

1) Physician participation in Medicaid managed care organizations by specialty and county, for primary care and specialties;
2) The number of primary care visits per member per month (PMPM);
3) Appropriate HEDIS/QARR access measures for primary care and specialties;
4) Appropriate CAHPS measures for primary care and specialties.

Analysis for each measure compared the 2006 baseline rates with 2007 rates.[1] Data for physician participation by specialty and county analyses are from the Provider Network submissions and the visits Per Member Per Month (PMPM) were calculated from MEDS (Medicaid Encounter Data System). PMPM rates are compared to national rates for each year, and the difference between the two analyzed. National PMPM visit benchmarks were taken from the Ambulatory Care: Outpatient Visits/1000 measure in NCQA's Quality Compass, 2007 and 2008. In addition, the number of physicians participating in managed care and fee-for-service was provided by DOH and used to compare participation rates per 1,000 members.

Results for access to care measures from HEDIS and CAHPS for New York were taken from the New York Quality Assurance Reporting Requirements (QARR) system, and the CAHPS 2006 – 2008 data. QARR results are compared to national benchmarks for each measure. Comparisons are made between the 2006 baseline period and 2007, when available. Comparative analysis is not possible for CAHPS indicators because of the changes made to the survey instruments between versions 3.0 and 4.0. Some measures used in this portion of the evaluation analysis and reported by New York, including CAHPS, were rotated out by NCQA and are not included in QARR 2006. These are identified in the analysis section and for these measures results for 2005 are used, with 2005 national benchmarks for comparison to national level results. For measures rotated out in 2007, the 2006 results are shown and no analysis of changes over time or national comparisons can be completed until the 2008 data are available for the final report.

[1] Physician participation data were taken from the following files provided by DOH: "MDs by ctysum q406m" and "MDs by ctysum q407m". PMPM data were taken from "hmo-06 visits pmpm.pdf" and "hmo-07 visits pmpm.pdf".

Managed Care and Fee-For-Service Comparison

Table 2-1 provides a comparison of the Medicaid managed care and FFS physicians for New York State, to help determine if Medicaid managed care has improved the availability of primary care and specialist physicians. The table shows data for two sets of physicians: those who participate in the managed care program, which includes those who participate only in the managed care program as well as those who participate in both managed care and FFS and those who participate in the FFS program, which includes those who only participate in FFS and those who participate in both the FFS and managed care program. The eligible population for managed care is the Medicaid managed care enrolled population each year and the FFS population is the Medicaid population that is not enrolled in managed care. Findings from Table 2-1 indicate:

- The number of primary care and specialist physicians available to Medicaid beneficiaries is significantly greater in the managed care delivery system than in the State's current fee-for-service program.
- The managed care program has a considerably higher ratio of physicians to the eligible population than FFS has in both years.
- In both 2006 and 2007, the ratio of specialists to members is much higher for both managed care and FFS than the ratio of primary care physicians to members.
- There is little change in the managed care ratio between 2006 and 2007, while the FFS ratio increased somewhat over the same time period.

Table 2-1: Statewide Comparison Managed Care and Fee-For-Service

Number of Primary Care Physicians and Specialists with Claims Totaling Greater than $100				
	2006		2007	
	Managed Care	FFS	Managed Care	FFS
Primary Care	19,760	7,581	19,488	8,465
Specialty	31,985	14,033	32,407	16,550
Population	2,003,754	2,178,093	2,097,188	2,009,597
Physician Participation per 1,000%				
Primary Care	9.86	3.48	9.29	4.21
Specialty	15.96	6.44	15.45	8.24

Physician Participation by County and Specialty

The number of physicians participating in Medicaid managed care in 2006 and 2007, and participation rates are provided for 62 counties/boroughs, and by specialty in Exhibit 2-1 of Appendix 1. Categories for physician specialty include Primary Care (Pediatrics, Family Practice, General Practice, Internal Medicine and PCP Nurse Practitioner), OB/GYN (Ob/Gyn, Gynecology Only, and Nurse Midwife), Behavioral Health (Child Psychiatry, Psychiatry, Certified Social Worker, and Clinical Psychology), Non-PCP Nurse Practitioner, Dentistry (General Dentistry, Pedodontist, and Oral Surgery), and Other Specialty. Beneficiary participation rates per 1,000 members are calculated with enrollment data, as shown in Exhibit 1-1 of Appendix 1.

A summary of results for the counties/boroughs is provided below, with discussion of results in the Summary section for Goal 2. However, it is important to examine the counties individually as changes across the different categories vary considerably. It is also important to realize a number of counties have fewer than 1,000 enrollees in managed care, which may create unstable rates from year to year. Note also that summing the counties for a total number of providers statewide or regionally is not appropriate. Providers often work in several counties and the total count of providers would not be unique.

Findings from the Exhibit 2-1for providers participating in Medicaid managed care are summarized as follows:

- Nine counties did not have any managed care enrollment. Three counties began offering Medicaid managed care in 2007 (Clinton, Essex, and Hamilton). These are not included in analyses of participation rates.
- 16 of 50 counties/boroughs increased participation rates from 2006 to 2007 for the total number of practitioners working with a managed care plan within the county.
- Participation rates per 1,000 members for primary care physicians showed an increase from 2006 to 2007 in nine counties, from 0.1 percent to just over 23 percent. The remaining counties/boroughs displayed a decrease in primary care physician participation.
- 12 counties/boroughs showed an increase in OB/GYN physician participation rates, while 37 counties/boroughs displayed a decrease, from 2006 to 2007.
- 40 percent of the counties/boroughs (20) displayed an increase in the participation of behavioral health practitioners.
- Practitioners for other specialties increased participation rates in 15 counties/boroughs, and 34 counties/boroughs showed a decrease between 2006 and 2007.

Primary Care Visits Per Member Per Month

The number of visits (PMPM) is shown in Table 2-2, for 2006 and 2007. National and New York data are presented, and the difference between them for each year. The data indicate New York's managed care program provided somewhat fewer PMPM primary care visits than the national average in 2006, but in 2007

New York provided more primary care visits on a PMPM basis than the national average. From 2006 to 2007, the PMPM visit rate increased by 7.8 percent in New York compared to only 0.1 percent nationally, moving the New York rate more than 15 points above the national average.

Table 2-2: Primary Care Visits Per Member Per Month (per 1,000)

Primary Care Visits Per Member Per Month (per 1,000) New York and National Averages			
	2006	2007	% Change
New York	309.38	333.44	7.8%
National	317.97	318.29	0.1%
Difference	-8.6	15.5	7.7%

HEDIS/CAHPS Access to Care Measures

Access to primary care is measured with 13 HEDIS and two CAHPS indicators. Five were rotated out in 2006 and 2005 data are displayed with comparisons made to the 2005 national results. These include Well-Child Visits in the First 15 Months of Life (5 or more visits); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care and Preventive Visits; Getting Care Needed (CAHPS); and Getting Care Quickly (CAHPS). Two indicators, Timeliness of Pre-Natal Care and Post-Partum Care, were rotated out in 2007. Only one indicator was available to specifically measure Access to Specialty Care services – the CAHPS measure: "How much of a problem was it to get a referral to a specialist (Not a problem)." This question was asked differently in 2007—"How often was it easy to get appointments with specialists?"

Data for each measure for New York and national benchmarks are shown in Table 2-3 for 2006 and 2007. The percent of change from 2006 to 2007 is displayed as well as the difference between the percent of change for New York and the percent of change nationally (NY to Nat'l). Results for CAHPS indicators can not be compared from 2006 to 2007 due to changes in the survey used to collect the data. Therefore, comparisons can be made to the national benchmarks but not trended across the two time periods.

Table 2-3: Access to Care HEDIS/CAHPS Measures

New York and National Results by Year, 2006 and 2007							
	New York			National			
Primary Care	2006	2007	Percent Change	2006	2007	Percent Change	NY to Nat'l % point change
HEDIS Measures							
Well-Child Visits in the First 15 Months of Life (5 or more visits)*	69%	79%	14.5%	67%	70%	4.5%	10.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	76%	81%	6.6%	63%	65%	3.2%	3.4%
Adolescent Well-Care and Preventive Visits*	49%	58%	18.4%	41%	42%	2.4%	15.9%
Timeliness of Prenatal Care**	86%			81%			
Post-partum Care**	70%			59%			
CAP† 12-24 months	93%	95%	2.2%	94%	93%	-1.1%	3.2%
CAP 25-26 years	89%	90%	1.1%	85%	84%	-1.2%	2.3%
CAP 7-11y	91%	93%	2.2%	86%	86%	0.0%	2.2%
CAP 12-19y	87%	88%	1.1%	83%	83%	0.0%	1.1%
AAP† 20-44	79%	80%	1.3%	78%	77%	-1.3%	2.5%
AAP 45-64	86%	87%	1.2%	83%	82%	-1.2%	2.4%
AAP 65+	89%	88%	-1.1%	80%	79%	-1.3%	0.1%
CAHPS Measures							
Getting Needed Care*	70%	75%	N/A	74%	75%	N/A	
Getting Care Quickly*	74%	78%	N/A	72%	80%	N/A	
Specialty Care							
CAHPS Measures							
How much of a problem was it to get a referral to a specialist (Not a Problem)?*	70%	71%	N/A	65%	73%	N/A	

*Measure was rotated out in 2006, 2005 data displayed for 2006.
** Measure was rotated out in 2007.
†CAP=Children and Adolescents/ Access to Primary Care Practitioner; AAP = Adults' Access to Preventive/Ambulatory Services

Findings from Table 2-3 indicate the following:

- Ten measures presented in the table can be trended over time. Of these, all but one showed an increase from 2006 to 2007. However, the small decrease for "Adult access to preventive/ambulatory services" in New York was mirrored by a decrease nationally for this same time period, and the New York rates are above the national average for each year.

- The majority of access measures listed in Table 2-2 were above the national average for the years where comparable data were available.
- For nine of the ten measures that could be trended over the time period, New York rates improved more than the national average, from just over one percentage point to close to 16 points for Adolescent Well Care and Preventive Visits.
- Only one measure was available that specifically targets access to specialty care, indicating if it was a problem getting a referral to a specialist. The result in 2005 was five percentage points above the national benchmark but shifted to two points below the benchmark in 2007.

Goal 2 Summary

Improving access to health care for Medicaid beneficiaries is a primary objective of the Partnership Plan. Several measures were used to examine the extent to which access to care has improved from 2006 to 2007: a comparison of managed care and FFS physician participation rates, the number of primary care visits Per Member Per Month, physician participation in Medicaid managed care across counties and specialty, and access-related HEDIS and CAHPS indicators. Physician participation in managed care, as a rate per 1,000 enrollees, has remained about the same in 2007 as it was in 2006, but was substantially higher than FFS participation in both years.

The number of visits PMPM in New York was somewhat lower than the national average in 2006 but higher in 2007, an increase in New York of 7.8 percent. At the same time, the visits PMPM nationally remained about the same. There could be several possible explanations for an increase in primary care PMPM visits, including improved access, improved reporting, and/or changes in care delivery prompted by quality improvement initiatives and/or incentives. Additionally, increasing chronic care needs may necessitate increases in primary care visits. With the transition of SSI recipients to mandatory enrollment during the evaluation period and the ensuing enrollment increase for the disabled and recipients age 65 or over, the greater PMPM rate might reflect increased health care needs.

While data indicate the statewide physician participation rate in managed care has remained fairly consistent from 2006 to 2007, there is a tremendous degree of variation across counties and specialty categories. Many of these counties are quite small and may reflect fairly unstable rates from year to year. On the other hand, fewer than half the counties showed gains in the participation rates. For example, only nine counties increased primary care participation rates per 1,000 members from 2006 to 2007. The greatest gains were seen for behavioral health, with 20 counties increasing participation rates. It is important to note the Department has well-established standards for network adequacy that are articulated in Operational Protocol Chapter 26: MCO Network Requirements and Referral Authorization Policies. Plans are required to submit quarterly reports that address the adequacy of their network with respect to provider types, geographic coverage, and enrollee to primary care provider ratios. To a large extent, the stability of the provider

participation rate reflects the plans' ability to meet the Department's standards for network adequacy, as well as the maturity of the mandatory enrollment which maintains the enrollee population in managed care.

Analysis of the HEDIS and CAHPS indicators measuring access to primary care services lend support to the effectiveness of the Demonstration Program. Among the indicators used to examine access to primary care, the majority showed a higher performance rate for New York than the national benchmark in both years. For ten measures that could be trended, New York Medicaid managed care plans improved performance on all but one measure between 2006 and 2007. In addition, the rate of improvement over the two year time period was greater than the national average for nine of the measures. This provides some evidence the Demonstration has improved access to Medicaid managed care recipients at a level somewhat greater than for the average managed care plan across the nation.

Access to specialty care services can only be measured with one CAHPS indicator which reflects the degree of difficulty obtaining a referral to a specialist. The result for this measure was slightly lower than the national average in 2007. Because many counties in the state have seen a loss in the participation rates of specialists such as OB/GYNs and behavioral analysts, it is recommended that New York further explore whether access to specialists can be improved as has appeared to be the case for primary care providers.

Goal 3: Improving Quality of Care

Goal 3 of the Demonstration is to improve the quality of care for Medicaid beneficiaries in New York.

Six specific objectives were included in the Evaluation Plan approved by CMS to help determine the extent to which the New York Partnership Demonstration Plan has improved the quality of care for Medicaid beneficiaries. The objectives address not only performance indicators, but financial analysis, a review of the HIV Special Needs Plan, and a review of the Medicaid Advantage Program. Each section below describes the objective, data, and results from the analysis, with a brief summary of findings.

Objectives 1, 2 and 3: Quality of and Satisfaction with Care Comparisons

- How has quality of care for Medicaid managed care plans changed over the life of the Demonstration?
- How does quality of care for New York Medicaid managed care enrollees compare with national benchmarks?
- Has the gap in measures of quality of care and satisfaction narrowed between New York Medicaid managed care plans and commercial plans?

The first three objectives were analyzed together, using appropriate HEDIS and CAHPS indicators from New York's Quality Assurance Reporting Requirements (QARR) database: eQARR 2007 and 2008, QARR HEDIS CAHPS 2006 and QARR HEDIS CAHPS 2007. These databases house summary results for the HEDIS and CAHPS measures collected by New York DOH for Medicaid managed care plans and for commercial insurers operating in the State. National benchmarks for most of these indicators came from the NCQA Quality Compass for the specific years, or eQARR. Four specific outcome areas to be addressed were presented in the Evaluation Plan.

- Changes in managed care Quality measures for the plans that serve Medicaid managed care enrollees.
- Changes in member Satisfaction measures for the plans that serve Medicaid managed care enrollees.
- Comparison of New York Medicaid managed care quality and satisfaction results with national benchmarks.
- Narrowing of the gap in measures of quality and satisfaction between New York Medicaid managed care plans and commercial plans.

Performance rates addressing each of the four outcome areas are shown in Exhibit 3-1 of Appendix 1. Information is provided for 2006 and 2007 on New York's Medicaid managed care plans, New York's

commercial managed care organizations, the gap in performance rates between these two types of MCOs, and Medicaid managed care plan national benchmarks. Several measures were rotated out in 2006, and for these measures 2005 performance rates are used for New York and nationally. These are designated with a single star (*). Some indicators, noted with a double star (**), were rotated out in 2007, and therefore no performance results are listed in the 2007 column. Analysis of these indicators will not be completed until the 2008 data are available for the final report.

In addition, the CAHPS survey was modified in 2007, with substantial changes compared to 2005 (3.0 and 4.0 versions). Therefore, where CAHPS indicators are shown, the managed care rates can be compared to the commercial rates and/or the national rates for each year. However, the rates can not be trended over the time period. Childhood Immunization Status Combination 2, used in 2005, was replaced with Combination 3 in 2007. Because Combination 3 was a first time measure in 2005 the rates are not reported.

Managed care quality indicators are grouped into several broad categories:

- Child Preventive Care
- Adolescent Preventive Care
- Caring for Children and Adolescents with Illness
- Women's Health
- Adults Living with Illness
  - Managing Acute Illness
  - Managing Cardiovascular and Respiratory Conditions
  - Comprehensive Diabetes Care
  - Annual Monitoring for Patients on Persistent Medications
  - Antidepressant Medication Management
  - Follow-up After Hospitalization for Mental Illness
- Access and Service
- Member Satisfaction

Changes in Quality Measures for MCOs Serving Medicaid Managed Care Enrollees

Quality performance measures for Medicaid managed care plans are shown in the first three columns of results in Exhibit 3-1. Performance rates for 2006 (or 2005 if the measure was rotated out in 2006) and 2007, and the percent change in the rates over the time period are displayed. Fifty quality indicators (excluding Member Satisfaction) show results for both years, and can be trended over time. Commercial managed care rates and national benchmarks are also displayed, and discussed in the following sections. A summary of findings in the change of Medicaid managed care rates over the two-year time period (Exhibit 3-1) includes the following:

- For the Medicaid managed care plans, performance rates for 20 (40%) indicators increased by five percent or more over the time period, fairly significant given a one year time period. Only nine commercial rates displayed a five percent or greater improvement. On average, 40 of the 50 Medicaid managed care measures showed some improvement from 2006 to 2007, and only three showed small decreases in the performance rate (4% or less).
- Adolescent preventive care measures each showed fairly significant gains from 2006 to 2007. In particular, *BMI Screening* improved by 56 percent, compared to only a 15 percent improvement among commercial plans.
- *Follow-up care for children prescribed medication for ADHD*, and c*ontinuation and maintenance for children on medication* displayed substantial improvement from 2006 to 2007, 36 percent and 51 percent respectively.
- Three of five indicators of Child Preventive Care that can be trended over time, improved by seven percent or more.
- Three of five indicators that comprise Caring for Children and Adolescents with Illness improved by 14 percent or more.
- Only three measures for Women's Health were available for both years. For these, performance on *Breast cancer screening* improved by three percent, *Chlamydia screening in women (16-20 years)* by 10 percent, and the same screening for women age 21-25 showed a 13 percent increase.
- Two of three measures for Managing Acute Illness showed some reduction in the performance rate, *avoidance of antibiotics for adults with bronchitis* declined by four percent and *use of imaging studies for low back pain* by one percent.
- Two of three indicators for Antidepressant Medication Management were trended over time. E*ffective acute phase treatment* and *effective continuation phase treatment* showed improvement of 10 percent and seven percent respectively.

Changes in Member Satisfaction Measures for the MCOs that Serve Medicaid Managed Care Enrollees

Eight CAHPS indicators are used to help determine the level of satisfaction participants have with their health care plans. Because CAHPS indicators can not be trended over the time period (2005 to 2007), the change in member satisfaction for Medicaid managed care plans can not be analyzed at this time. However, in the following sections New York's managed care rates will be compared to New York's commercial rates and national benchmarks.

Comparison of New York Medicaid Managed Care Quality and Satisfaction Results with National Benchmarks

National Medicaid managed care benchmarks were available for 47 measures of quality in 2006 and 45 measures in 2007. Eight CAHPS indicators that measure member satisfaction were available both years. In

general, New York's Medicaid managed care plan performance on the Quality measures was higher or similar to the national standards each year. Some highlights from the results include the following:

- In 2006, New York Medicaid managed care plans performed the same or better than the national average on 41 of 47 indicators of quality (87%). This increased to 43 out of 45 in 2007 (96%).
- For 16 of 40 (40%) quality measures with national benchmarks both years, New York managed care rates were five percentage points or more higher than the national performance rate.
- New York's Medicaid managed care plans showed the best performance, relative to national benchmarks, on the two indicators that measure follow-up after hospitalization for mental illness, 16 or more percentage points higher on each measure both years.
- In 2006, NY plans performed higher than the national average on six of the eight indicators that measure satisfaction. NY performed better on three of the eight satisfaction measures in 2007.
- In 2007, NY Medicaid managed care rates for member satisfaction with a specialist and the overall rating of the health plan were lower than any other indicator of quality or satisfaction in either year, five percentage points lower than the national average.

Narrowing of the Gap in Measures of Quality and Satisfaction between New York Medicaid Managed Care Plans and Commercial Plans

Performance rates for commercial MCOs are listed in Exhibit 3-1. The difference between the Medicaid managed care and commercial rates (gap) is calculated for each year, as is the change in the gap between them. Medicaid managed care plans generally do not perform as well as commercial MCOs on performance and satisfaction measures. However, results in this analysis indicate that in New York there are some services in which Medicaid managed care plans have out-performed commercial plans, and on most quality indicators the gap between them has decreased.

- Of the 50 quality indicators that have reported rates for managed care and commercial plans, 38 performed the same or better in relation to commercial plans in 2007 than in 2006.
- For the 30 measures that remained at or below the commercial rate in 2007, the gap between them was reduced on 21 measures.
- For Adolescent Preventive Care, in 2007 Medicaid managed care plan performance rates were equal to or better than commercial plans on all but one of the seven indicators. This represented a fairly substantial improvement from 2006, when the commercial MCO performance was better than the Medicaid performance for all measures in this category. Medicaid managed care plans gained 11points or more relative to commercial plans for each measure in this category.
- Medicaid performance on both ADHD measures (*Caring for Children* and *Adolescents with Illness*) was better than commercial plans in both 2006 and 2007. However, Medicaid plans improved their performance

substantially in 2007, while commercial plans did not, resulting in relative gains over 10 percentage points for these measures.

- Eight indicators used to measure Annual Monitoring for Patients on Persistent Medications had both Medicaid and commercial rates available for analysis in 2007. Of these, Medicaid plans showed a higher rate on all but one indicator. *Therapy for rheumatoid arthritis* was seven percentage points lower for Medicaid plans, but the difference had been reduced by four points since 2006.
- Medicaid managed care rates for *Effective acute phase treatment* and *Effective continuation phase treatment* were 16 and 17 percentage points lower than commercial rates respectively in 2007. However, performance on these measures improved somewhat since 2006 and the gap between the Medicaid and commercial rates has been reduced.
- In 2007, Medicaid managed care rates for seven of the eight indicators that measure member satisfaction were below the commercial rates.
- There was little change in the gap between Medicaid and commercial plan performance on Access and Service measures.

Goal 3: Objectives 1, 2, and 3 Summary

Findings from examination of Medicaid and commercial MCO performance appear to indicate that gains have been made on many performance indicators by the Medicaid managed care plans in New York, moving them closer to and even beyond performance of commercial plans. Medicaid managed care plans in New York outperformed national benchmarks on a majority of indicators examined in this report, and on almost every indicator examined that could be trended, the plans showed improvement in 2007 compared to 2006. However, improvements are not consistent across all measures and results in the final report, that will include 2008 performance year measures, may help establish more meaningful trends on all the measures.

While member satisfaction measures can not be trended over the time period, the NY Medicaid managed care plans did not appear to perform as well as commercial plans in 2007, nor did they compare as well nationally on satisfaction measures as on quality of care measures. Because no further CAHPS data will be available for the final report, a comparison of the 2007 performance rates for member satisfaction to future performance will not be possible. However, the DOH should monitor member satisfaction when the 2009 CAHPS data results are available to determine if performance rates improve relative to commercial and national benchmarks.

Objective 4: Medicaid Financial Mechanisms

How have Medicaid financial mechanism/payment methods evolved to support program goals to achieve a higher quality health care system?

The overall goal of the NYS Department of Health's 1115 Waiver Program has been "to improve the health status of low-income New Yorkers by: increasing access to health care for the Medicaid population; improving the quality of health care services delivered; and expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies."[1] To demonstrate the successes or challenges that the Medicaid Managed Care Program has encountered in meeting this overall goal, the 2007 Quality Strategy defined six quantifiable, performance-driven objectives. These six objectives are:

- To increase preventive care for children in Medicaid managed care as measured by increases in the statewide rate for childhood immunizations, lead screening, well child care visits (3 – 6 year olds) and adolescent well-care and preventive visits.
- To increase services for the treatment and management of chronic diseases for adults and children in Medicaid managed care as measured by increases in the statewide rate for controlling high blood pressure, diabetes HbA1c good control and diabetes lipid control.
- To decrease the detrimental effects of smoking on the health of Medicaid managed care enrollees and their families as measured by the statewide rate of smokers who are advised to quit in each CAHPS survey.
- To increase the frequency of on-going prenatal care for Medicaid managed care enrollees as measured by the statewide rate of ongoing prenatal care.
- To improve access to available primary care services as measured by the Access and Availability Survey conducted annually by IPRO.
- To continue to review data on racial and ethnic disparities in order to develop meaningful objectives for improvement in preventive and chronic care.

Medicaid payment mechanisms are linked to these objectives in several ways, most notably by the performance measures that are included in the overall quality scores used to determine the size of the incentive bonus managed care plans earn and whether plans can be assigned enrollees under the performance-based auto-assignment. Fifteen measures are selected each year for the quality score algorithm – 10 from the QARR, three from CAHPS, and two related to regulatory compliance. The QARR measures vary each year, while the CAHPS measures generally remain the same. CAHPS measures included in the algorithm take into account patient reports of problems in getting needed care and receiving services quickly and patient ratings of their personal doctors, nurses, and health plans. QARR measures have focused on such items as well-child and preventive health visits for children and adolescents, childhood immunizations, lead testing, breast cancer screening, Chlamydia screening, postpartum care, prenatal care, controlling high blood pressure, asthma care, diabetes care, hospital follow-up for mental health care, medication management for mental health care, advising smokers to quit (from CAHPS), and cholesterol screening for cardiac

[1] NYSDOH. Quality Strategy for the New York State Medicaid Managed Care Program 2007, page 3.

patients. Use of these measures to determine quality incentive payments directly addresses objectives (1) through (4) above. While these measures may not directly focus on issues of the availability of primary care services (particularly for adults) or racial and ethnic disparities in health care, they may favorably impact access and lessen disparities as enrollees receive more and better care with health plan efforts to improve performance.

Payment System Quality Improvement Incentives

An important approach to improving quality of care is to incorporate into the payment system financial incentives that tie payment directly to quality. Linking payment to quality holds providers accountable for the care they provide and rewards providers who invest in processes that improve care. State Medicaid programs have steadily increased the use of financial incentives or pay-for-performance (P4P) mechanisms in their payment systems. According to a report published by the Commonwealth Fund in April 2007, more than half of state Medicaid programs were operating one or more P4P programs by mid-year 2006, with more than 50 percent in existence for more than five years.[2] Seventy percent of the existing P4P programs were operating in managed care or primary care case management systems and focused on children, adolescent, and women's health services. Among the programs in place, the authors identified six types of incentive: bonuses; differential reimbursement for rates or fees; penalties; auto-assignment of beneficiaries to a plan or provider; withholds; and grants.

The evolution of New York's Medicaid managed care Quality Incentive Program has followed a path similar to many states' experiences reported in the Commonwealth study. Beginning with public reporting of performance measure rates in the mid-1990's, New York moved toward a reward system in early 2001 with implementation of an auto-assignment algorithm. Based upon scores achieved on select NCQA HEDIS and state-specific performance measures, NY's Quality Assurance Reporting Requirements (QARR) system has been used to differentially assign enrollees, driving market-share to higher performing health plans.

In 2002, the program was expanded to provide increased incentives for improvement. Plans became eligible to receive bonuses of up to one percent of the premium based upon composite scores from the QARR measures and the CAHPS survey. The bonus was later increased to a maximum of three percent in 2005. While payout was initially computed on each plan's ability to exceed specific benchmarks and/or improve performance, the methodology for calculating bonuses was later refined to focus solely on achievement of targeted rates. In doing so, the State eliminated the possibility of paying for sub-par, albeit improved performance.

[2] The Commonwealth Fund, April 2007. *Pay for Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs.*

In February 2007, The Urban Institute published a comprehensive analysis of the New York Medicaid Managed Care Quality Incentive Program, examining the period of pre-implementation through 2004.[3] Funded by the Commonwealth Fund, the study focused on two areas: (1) how health plan management perceived and responded to the Quality Improvement (QI) initiatives; and (2) the impact of the QI program on health plan performance. Comparisons over time and with commercial plans were made to evaluate the impact of the program.

The qualitative analysis found that a majority of health plans identified the QI program as an important priority that led to positive organizational and/or operational changes. Despite initial concerns that financial incentives might drive plans to focus a disproportionate share of resources on select services (and therefore divert resources from other needed areas), health plan management indicated that efforts were in fact geared toward improvement of measures where performance was poorest. The desire to avoid "outlier" status appeared to be a strong incentive to improve services, regardless of the financial payout.

Additionally, the majority of plans spoke of a positive "spillover effect" in which the use of validated performance measures also used for assessment of commercial lines of business (i.e., HEDIS and CAHPS) supported evaluation of the plans' overall quality. Consequently, incentives provided for improvement of the Medicaid line of business facilitated systemic health plan changes such as enhancements of data collection and reporting systems. While the study noted some criticisms of the QI program, particularly with respect to the timing of selection and communication of performance measures, the authors reported that management of participating health plans viewed the Quality Incentive Program favorably and supported continuation of the program as a component of the State's payment methodology.

Results from the quantitative analysis revealed the QI program improved plan performance in some areas, but not across all twelve QARR measures examined in New York. Specifically, the authors noted the QI program significantly increased the probability that women enrolled in Medicaid managed care plans would receive timely postpartum care and breast cancer screenings. Access to primary care for adolescents also improved, but only for plans with a high Medicaid enrollment share. Despite these observed gains, the authors found that Medicaid managed care plans had still not reached the level of performance associated with commercially insured populations.

The authors acknowledged that study limitations presented some challenges. Changes in QARR measures, small sample size, and potentially confounding policies limited the authors' ability to establish any causal relationship. Conversely, the research may have had inherent "positive bias" as many plans had been

[3] The Urban Institute, February 2007. *Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program.*

achieving improved performance prior to the implementation of the QI program. The degree to which Medicaid incentives prompted improvement could not be determined.

Since the publication of the Urban Institute report, additional studies have been published that speak to the impact of P4P programs among Medicaid health plans in other states. In the June 2007 issue of Health Affairs, authors affiliated with Mathematica Policy Research presented their findings of the evaluation of a collaborative P4P effort among seven Medicaid-focused health plans in California.[4] Known as the Local Initiative Rewarding Results (LIRR) collaborative demonstration, the major goal of this California endeavor was to improve the quality of and access to preventive care services for children in Medi-Cal.[5] By assessing the features of incentive programs that contributed to improvements in children's preventive care, the authors were able to more closely identify the characteristics of successful P4P programs.

Sponsored by the California Health Care Foundation and the Robert Wood Johnson Foundation, the LIRR Collaborative involved seven Medicaid-focused health plans, five which implemented provider incentives designed to improve the HEDIS measure scores for well-baby visits. While four of the plans paid incentives to their contracted entities (i.e., individual physicians; small practices; larger medical groups), one plan paid the individual physicians directly. The parameters for provider incentive payouts varied among the five plans, as did the use of member incentives.

During the period of evaluation (2002 – 2005), the trend in the participating plans' HEDIS rates was positive. Plans and providers eligible for incentives appeared to out-perform the two plans that did not implement P4P. Upon closer examination, however, the authors found the incentives did not produce significant effects in four of the five plans. For example, in one case it was determined the incentive was not effective, as the HEDIS score dropped after implementation of the P4P program. Although the score rebounded during the following year, the authors discovered the changes were due to increased on-site technical assistance to participating providers and increased outreach to members. In a second plan, the rise in HEDIS scores were attributed to improved collection of data from medical records. As incentive payout was dependent upon encounter reporting and that had not improved, the authors ascertained that practice-level changes were unrelated to the prospect of financial gain.

After thorough analysis, several characteristics associated with successful P4P provider programs were identified in the study. Most notably:

- Successful programs offered sufficient financial gain to offset any effort required by the provider.

[4] S. Felt-Lisk, G. Gimm, S. Peterson, "*Making Pay-for-Performance Work in Medicaid,"* Health Affairs, June 2007.

[5] In California, the Medicaid program is called "Medi-Cal."

- When plans offered incentive pay only when the ultimate goal was reached, providers were less apt to change practice patterns to obtain the incentive.
- Plans that paid incentives on a "stair-step approach", enabling providers to earn a larger amount as they approached the goal, achieved higher performance scores because the program rewarded change on an incrementally increasing basis. Providers perceived this approach as having greater pay-out relative to the costs of the required actions.

Some barriers specific to the provision of services for Medicaid beneficiaries were also identified in the California study.

- Difficulties associated with members' non-adherence to preventive visit recommendations; lack of resources for member outreach; and lack of adequate technology for scheduling, tracking, and/or reporting services.
- To the extent that plans supported improvement by providing outreach services, member recall lists, and/or updated contact information, providers indicated that such activities contributed to change.

In applying these findings to the development and refinement of state-supported initiatives, one lesson of critical importance is the necessity to combine incentives with other complementary approaches. While financial and/or non-financial rewards may be essential to prompt change, incentives alone may not be sufficient to bring about, or sustain system-wide improvements.

Pay for Performance New York Initiative

In May 2006, New York released a Request for Application to solicit proposals for regional demonstration projects to develop physician incentive programs that promote patient safety and quality of care. Four two-year Pay-for-Performance Demonstration Projects were initiated in mid-2007, focusing on areas of care important to the Quality Strategy objectives. Four grants projects were awarded in 2007. The grantees and their projects are:

- **Montefiore Medical Center (Bronx)** – This major provider of health services in the Bronx is partnering with health plans (Aetna, Affinity, Empire Blue Cross and Blue Sheild, HealthFirst, HealthNet, 1199 SEIU Benefit and Pension Funds, Oxford Health Plans) and a network of community-based providers to improve inpatient and outpatient care for residents with heart disease and associated risk factors, including smoking and obesity. The project will also implement new evidence-based approaches to reducing hospital-acquired infections. Montefiore was awarded $2,382,925 for their demonstration project.

- **New York Quality Alliance (Statewide)** – This project is a statewide collaboration involving 12 health plans (Aetna, Affinity, CDPHP, Elderplan, GHI HMO, HealthNet, HealthNow, HIP, Hudson Health Plan, Independent Health Association, MVP, and Oxford). NYQA will partner with physician, business, and consumer groups, Capital District hospitals and RHIOs to improve performance on ambulatory care measures statewide, including cardiac care measures in the Albany area and diabetes measures in the Hudson Valley. The NYQA award was for $3,208,658.

- **Taconic Health Information Network and Community Regional Health Information Organization (THINC RHIO) (Hudson Valley Region)** – THINC RHIO explores improving the portability of patient records by combining health data from health plans, hospitals, pharmacies, and laboratories with information gathered from electronic health records to create a complete and easily accessible picture of a patient's medical history. The project will initially target performance in antibiotic use, diabetes management and cardiac care and infection control in inpatient settings. This Hudson Valley-based project involves regional health plans (Aetna, CDPHP, CIGNA, Empire Blue Cross and Blue Shield, Hudson Health Plan, and MVP) and area hospitals. THINC was awarded $1,900,000 for their demonstration project.

- **Western New York Quality Collaborative (Buffalo)** – This project partners Independent Health Association with regional plans HealthNow and Univera to implement a P4P program targeting improved provider performance in cardiac care, diabetes management, antibiotic use, and infection control. The project will also look at performance on preventive health measures, including treatment for asthmatics, the use of anti-depressants, and post-partum visits. Grant funding will support the development of a program model and provide physicians a nominal fee for the initial participation in the project. The WNYQC award was for $2,008,317.

While the mechanisms that will link payment to quality in these demonstrations are still currently being discussed, the projects are focusing on measures related to some of the Quality Strategy objectives including screening and preventive care for children and adults and care for chronic conditions such as heart disease, diabetes, and asthma. P4P projects are also focusing on some issues beyond the Quality Strategy objectives such as mental health care, appropriate antibiotic use, and postpartum care. Demonstrations focusing on inpatient measures related to AMI, heart failure, pneumonia, surgical infection prevention, diabetes, and surgical care may provide data to inform future payment initiatives that reduce payments to hospitals with high potentially preventable complication rates and high potentially preventable readmission rates.

Additionally, New York has launched a risk-adjusted capitated payment system to more closely align reimbursement with the cost of care associated with Medicaid managed care enrollees. With the use of Clinical Risk Groups (CRGs) to classify patient populations by risk category, the State is now better

positioned to monitor utilization and cost, thereby tying payment and quality. The use of CRGs in risk-adjusting health plan capitation payments may also help to achieve Quality Strategy objectives. The previous payment system for Medicaid managed care was based initially on FFS costs and then trended forward or negotiated in different years. But NYS wanted managed care premiums to reflect the service mix being delivered under the managed care program, not that of the FFS program. Risk adjusted capitation allows NYS to pay more to plans with a higher risk case mix (for example, a plan which has more enrollees with chronic conditions than its peers) so that payments follow need more closely. Clinical risk groups are also used to monitor quality and efficiency. New York is currently working on two efficiency measures that will encourage CRG-level reductions in preventable hospital admissions and disease progression. Preventable quality indicator (PQI) hospitalizations should not occur if good primary and preventive care are being delivered, such as a diabetes hospitalization. Plans that prevent enrollees from progressing to a more severe form of diabetes or prevent co-morbid conditions (such as hypertension or CHF) could be rewarded as part of the quality incentive.

Evolution of the New York State Medicaid program's approach to quality improvement and payment system quality incentives is summarized in Table 3-1.

Table 3-1: Evolution of NYS Medicaid Quality Improvement and Payment Systems

Evolution of NYS Medicaid Quality Improvement and Payment Systems		
Timeline from 1995 through Future Initiatives		
Initiative	**Date Introduced**	**Notes**
Public reporting of performance measures	1995	The NYS DOH has annually collected HEDIS and other performance measure data and published health plan performance rates in the Quality Assurance Reporting Requirements (QARR) report.
QI Matrix targeting measures most in need of improvement	1998	The QI Matrix targets measures based on two dimensions: plan performance compared to statewide averages and plan performance over time.
Performance-based auto-assignment	2000	Plans with higher quality receive more enrollees through auto-assignment, and 75% of all assignments are based on quality. The program uses the same algorithm as the quality incentive program.
1% quality incentive payments	2002	Plans can earn an additional premium incentive of up to 1% depending on their overall quality score. The overall quality score combines results of approximately 10 HEDIS measures and 5 CAHPS measures.
3% quality incentive payments	2005	Additional premium incentive increased to up to 3%.
Pay-for-performance grant initiatives	2007	Four grants have been awarded through the P4P Demonstration Project to study and test payment incentive programs. The demonstrations will run for two years.
Risk-adjusted capitation	2008	The system uses Clinical Risk Groups (CRGs) to assign

payments		each enrollee to a clinically meaningful risk category. Risk-adjusted capitation will result in greater payments for enrollees in higher risk categories.
Future initiatives		Begun process of measuring quality in the FFS sector. Considering tying FFS payments to quality through selective contracting and ending payments for "never events." Investigating new primary care and prenatal care standards for managed care and FFS, as well as reducing payments to hospital with high potentially preventable complication rates and high potentially preventable readmission rates.

NYS has taken a performance measurement/quality reporting initiative and used its results to create increasingly sophisticated and targeted payment mechanisms in support of continued quality improvement.

Plan Performance under the Quality Incentive Program

A 2007 study conducted by the Urban Institute examined plan performance under the quality incentive program[6]. Aspects of the program that were examined included the number of plans receiving incentives under the program over time and the impact of the quality incentive program on selected performance measures in the areas of women's health care, mental health care, preventative care and chronic disease. We have extended these analyses with additional years of data.

Figure 3-1 (presented in the appendix) shows the percentage of New York Medicaid managed care plans eligible to receive a quality incentive in each year from 2001 through 2007.[7] Plans are divided into three groups –those that received no incentive, received a partial incentive (from 25 to 75 percent of the full incentive), and received the full incentive. In 2007, 23 health plans were evaluated and 87 percent received some incentive (74 percent partial incentive and 13 percent full incentive). A smaller proportion of health plans received no incentive in 2007 than in any previous year, a decrease of 29 percentage points compared to 2006. In addition, the proportion of plans receiving a full incentive, while not as great as in earlier years (2001 – 2004), increased from 7.7 percent in 2006 to 13 percent in 2007. Plans that received any incentive payment also qualified for preferential auto-assignment. The incentive increased from 1 percent to 3 percent in 2005. While it appears from the figure that this may not have had an immediate impact, by 2007 87 percent of plans received some incentive – a substantially higher proportion than in any of the previous years.

A second analysis conducted by the Urban Institute examined selected performance measures and found the Quality Incentive Program improved health plan performance for Medicaid enrollees in some areas but not all. The analysis examined 11 performance measures, comparing the statewide average rates across commercial and Medicaid managed care plans, as well as across a pre-QI period (1996 -1999) and a post-QI

[6] The Urban Institute, February 2007. *Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program*

[7] Source, New York State Department of Health. Data years in the Figure are years on which the incentive is based.

period (2000 - 2004). Regression analysis was used to hold other factors constant while examining the impact of the QI program. Results showed a significant increase in the probability of receiving timely postpartum care and breast cancer screening for women enrolled in a Medicaid managed care plan. When compared to levels of plan performance for commercial plans, results indicated that for most indicators, while Medicaid managed care plans may have improved performance between the two time periods they still had not reached the level of performance observed in the commercial insurance plans.

We have extended the Urban Institutes analysis of descriptive trends for their selected measures in Exhibit 3-2 of Appendix 1. Our analysis adds a second post-QI time period (years 2006 and 2007) in which the additional quality incentive that could be earned by Medicaid managed care plans had risen to up to three percent and includes all the selected measures except two, postpartum care and lead testing, which were not included in the QARR database for both 2006 and 2007.
Analysis of the information in the Exhibit shows the performance of Medicaid managed care plans has generally remained below that of commercial plan performance over the QI period. With the exception of one mental health measure -- "Follow-up After Hospitalization for Mental Illness, 30 Days," Medicaid managed care plan performance rates were significantly lower ($p=.05$) than commercial plan performance in the post-QI (3%) period. Importantly, however, the gap in performance between Medicaid managed care plans and commercial plans narrowed in 2006-2007 post-QI (3%) period for several indicators. For five of the six indicators that showed significant improvement for both Medicaid and commercial plans over the entire QI period, the degree of improvement was better for the Medicaid plans. For example, the percentage of 12 to 24 month old children who had access to primary care rose 13.3 percentage points for Medicaid enrollees compared to 10.4 percentage points for commercial enrollees. For four of these measures – three access to primary care and the mental health hospitalization follow-up measure – Medicaid managed care plans gained on commercial plans in both post-QI periods.

Additionally, between the two post-QI periods, significant improvement occurred in five of nine measures for Medicaid enrollees. For the measures breast cancer screening, diabetes HbA1c testing, and the two antidepressant medication management measures, no significant improvement occurred in the post-QI (3%) period. The statewide average rates actually fell in the post-QI (3%) period for these indicators, with the exception of diabetes testing. Commercial plans did better with seven of nine measures improving significantly between the post-QI periods. Between the pre-QI period and the post-QI (3%) period, significant improvement occurred in six of nine measures for Medicaid plan enrollees; the exceptions were breast cancer screening and the two mental health medication management measures. For commercial plans, all nine measures improved over the entire period and although Medicaid plans have made gains and continued to close the gap relative to commercial plans for some measures, Medicaid plans still performed less favorably than commercial plans at the end of the post-QI period on almost all quality measures studied.

Goal 3: Objective 4 Summary

From our review and analysis of payment incentives in the NYS Medicaid managed care program, we conclude the following:

- Program payment mechanisms have evolved substantially since implementation of public reporting of performance measures in 1995. NYS has taken a performance measurement/quality reporting initiative and used its results to create increasingly sophisticated and targeted payment mechanisms in support of continued quality improvement

- Delmarva's analysis of NY incentive program data parallels the Urban Institute's study findings. In 2007 more health plans earned quality incentive payments than in any previous year, suggesting that increasing the maximum incentive payment from 1 to 3 percent in 2005 may have incentivized plans as intended.
- Our extension to the Urban Institute's analysis of selected performance measure shows continued performance improvement for the majority of indicators included in the analysis in the post-QI (3%) period (i.e., the years 2006 - 2007). While the performance of Medicaid managed care plans has generally remained below that of commercial plan performance over the QI period, the gap in performance between Medicaid managed care plans and commercial plans narrowed in 2006-2007 post-QI (3%) period for several indicators.

Objective 5: HIV Special Needs Plan

Has the HIV Special Needs Plan (SNP) been a successful model for delivery of care to persons living with HIV/AIDS and their eligible dependents?

New York State has been a pioneer in the provision of services to persons living with HIV/AIDS through Medicaid Special Needs Plans (SNPs). New York's 1996 Medicaid Managed Care Act authorized the creation of these specialized managed care plans as an alternative to mainstream managed care for persons with HIV/AIDS and their dependents. HIV SNPs are designed to offer coordinated care through a network of primary care physicians who meet defined criteria as HIV/AIDS-experienced providers and a network of specialty and HIV support service providers. Additionally, the HIV SNPs are designed to provide a host of coordinated services including case management, treatment adherence supports, and HIV/AIDS prevention and risk-reduction education. Enrollment in Medicaid managed care including SNPs is voluntary for HIV+ beneficiaries. During the evaluation period the plans were reimbursed under a risk-adjusted capitation strategy. In 2006, the HIV SNP payment methodology including a risk-sharing provision that allowed each plan to share excess medical surpluses or losses with the State. This provision was terminated January 1, 2007.

HIV SNPs were developed jointly by the NYS DOH AIDS Institute and the Office of Managed Care, largely in response to advocates' concerns that mainstream managed care was poorly suited to address the needs of Medicaid clients with chronic and severe illnesses and disabilities. Many issues were raised including concerns that placing HIV/AIDS clients in mainstream managed care plans would not only disrupt existing relationships patients had with specialists and caregivers, but that plans would try to meet client's specialized needs through reliance on primary care doctors, would fail to include sufficient numbers of specialized physicians in their networks, would unduly restrict access to needed care and not make the latest treatments available, and would push enrollees to accept less expensive treatment options.[8] Further, service providers worried that placing HIV/AIDS clients in mainstream managed care plans would direct public resources away from existing dedicated HIV/AIDS service providers, undermining their ability to continue operations. During development of HIV SNPs in NYS, information and data were gathered to help inform program design and reimbursement mechanisms.[9] The work began with the use of planning grants to solicit recommendations from HIV service providers, and a workgroup was convened to facilitate discussion between the program stakeholders. The State also conducted a client survey to assess patient satisfaction with the FFS system, identify the barriers patients encountered in accessing care, and assess the impact of managed care on persons with HIV. Finally, the State created a longitudinal database of the clinical and service use history of approximately 100,000 Medicaid HIV clients that was used to address issues of capitation and risk adjustment.

Developing an appropriate reimbursement mechanism was an important part of the design process. It was recognized that HIV SNPs would require higher capitation rates than mainstream managed care plans since the SNPs would be enrolling a sicker population and would be required to offer a broader array of services. It was also expected that enrollees would have easier access to specialists, which would also result in higher plan costs. A 1997 study of capitated rates in the first nine states to implement statewide Medicaid managed care programs found that capitated rates for every enrollment category in these programs were substantially below the costs of HIV/AIDS care, raising concerns about the impact on access to care for persons living with HIV/AIDS.[10] States have developed and implemented various strategies to reduce the financial risk of managed care plans that enroll persons living with HIV/AIDS. These include the use of risk-adjusted payment systems (as in New York), the use of AIDS-specific reimbursement rates, the use of carve-outs from the capitation rates to cover medications and other services, and several methods of sharing the financial risk with plans such as risk pools for high cost enrollees, risk corridors, and stop-loss insurance policies.[11]

[8] Swidler, RN. Special needs plans: adapting Medicaid managed care for persons with serious mental illness or HIV/AIDS. *Albany Law Review*. March 1998.
[9] Feldman, I. et al. Developing a managed care delivery system in New York State for Medicaid recipients with HIV. *American Journal of Managed Care*,5:1457-1465, 1999.
[10] Conviser R, Kerrigan D, Thompson S. The adequacy of reimbursement for HIV under section 1115 Medicaid waivers. *AIDS & Public Policy Journal*. 12:112-127, 1997.
[11] Conviser R, Murray, M, Lau D. Medicaid managed care reimbursement for HIV and its implications for access to care. *American Journal of Managed Care*, 6:990-999, 2000.

State Medicaid programs have taken a variety of approaches to managed care for beneficiaries living with HIV/AIDS. Several states have included persons living with HIV/AIDS in their mainstream managed care programs with rate-setting strategies that result in higher payment for these enrollees. TennCare pays a capitated rate by eligibility category with most HIV enrollees included in eligibility categories for individual who are uninsurable or have a disability. Maryland has developed a separate capitated rate for HealthChoice (the State Medicaid managed care program) enrollees with HIV/AIDS. Other states have created programs for HIV beneficiaries that do not include enrollment into managed care plans. In Florida, the State Medicaid program provides disease management services to persons living with HIV/AIDS who are enrolled in a primary care case management program. There appears to be no literature comparing the various approaches taken by states. New York provides individuals with HIV/AIDS who are eligible for Medicaid the choice of three alternative service delivery systems – FFS, mainstream managed care plans or HIV SNPs.
It is likely the role of Medicaid programs in the delivery of healthcare to persons with HIV/AIDS will continue to grow for several reasons: today more people are living with HIV/AIDS than ever before; those who are newly infected are increasingly likely to be low income; and Medicaid programs provide prescription drug coverage, which is the most important element of HIV/AIDS care.[12] New York has developed an innovative way to provide services to this population through HIV SNPs. In this section of the report, we look at the success of the HIV SNP model in terms of enrollment, service quality, and plan financial viability.

New York HIV SNP Enrollment

In the spring of 2003, five HIV SNPs began operating in New York City, with 41 enrollees. As of June 2008, enrollment reached 3,255.[13] The tables below show HIV SNP enrollment by beneficiary type, age category, and borough for 2006 and 2007. HIV SNP enrollment is a very small part (about one-tenth of one percent) of the overall Medicaid managed care enrollment, which was over two million in December 2006. An analysis of Medicaid and managed care eligible data for CY 2007 estimated that the number of beneficiaries with HIV/AIDS in New York City who are eligible to enroll in managed care is about 36,000. HIV SNP enrollment less uninfected children of HIV+ parents (about 8.35 percent of SNP members) was 2,417 in 2007, suggesting that about 6.7 percent of eligible HIV+ beneficiaries in NYC enrolled in an HIV SNP. This penetration rate reflects the voluntary nature of the program and the non-participation of several large HIV care providers. Beneficiaries who have established relationships with non-participating HIV care providers may have chosen to remain in FFS with these providers.

Table 3-2 displays enrollment by beneficiary type. Data indicate the following:

[12] Kaiser Family Foundation. Medicaid and HIV/AIDS. HIV/AIDS Policy Fact Sheet (#7172-03). October 2006. Accessed at: http://www.kff.org/hivaids/7172.cfm.
[13] In 2005, two SNPs, Fidelis Healthier Life and Health First, withdrew from the program, primarily due to low enrollment and a third SNP that was pending certification, also decided to withdraw.

- Total enrollment in HIV SNPs increased close to 21 percent between 2006 and 2007.
- Almost all enrollment is across 4 beneficiary types -- "Safety Net Adult" (adults who receive benefits under New York's Safety Net Assistance program), "SSI" (recipients of supplemental security income), and TANF adults and children.

Table 3-2. HIV/SNP Enrollment by Beneficiary Type

HIV/SNP Enrollment by Beneficiary Type, 2006 and 2007			
	Number Enrolled		
Beneficiary Type	2006	2007	Percent Change
TANF ADULT	188	230	22.3%
TANF CHILD	181	216	19.3%
SAFETY NET ADULT	712	899	26.3%
SSI	935	1,128	20.6%
Other	165	164	0%
Total Enrolled	2,181	2,637	20.9%

IV SNP enrollment by age category in 2006 and 2007 is shown in Table 3-3. Results indicate the following;

- People age 45 to 64 represented the largest age category each year, which grew by 28 percent over the two year time period.
- No age groups showed a loss in enrollment numbers.

Table 3-3: HIV/SNP Enrollment by Age Group

HIV/SNP Enrollment by Age Group, 2006 and 2007			
	Number Enrolled		
Age Group	2006	2007	Percent Change
< 20	275	295	7.3%
20-24	50	59	18.0%
25-29	93	112	20.4%
30-34	141	155	9.9%
35-39	227	273	20.3%
40-44	429	496	15.6%
45-64	960	1,233	28.4%
65+	6	14	133.3%
Total Enrolled	2181	2637	20.9%

Enrollment in the HIV/SNP program within each New York City borough is displayed in Table 3-4 for 2006 and 2007. All three SNPs operate in the boroughs Manhattan, Bronx, and Brooklyn. Through 2007 only one SNP had an approved service area in Queens and no SNP is certified for Staten Island. SNP members who enroll and move to Staten Island are not required to leave the plan but must use plan providers in other boroughs. The SNP model has adopted a "live and work" option, which is unique to SNPs, for NYC residents to extend enrollment eligibility to HIV+ beneficiaries who receive care in a SNPs service area. Table 3-4 shows that:[14]

- The boroughs with the largest enrollment were the Bronx, followed by Brooklyn.
- Enrollment in Brooklyn showed a substantial increase (39%) between 2006 and 2007.

[14] Please note the totals in this table do not match earlier tables. The data reflect a separate data run; enrollment numbers are expected to vary slightly based upon the data source and the length of the enrollment run-out in the database at the time of the data run. The enrollment run-out refers to the updating of databases with retroactive enrollment information.

Table 3-4: HIV/SNP Enrollment

HIV/SNP Enrollment by Borough, 2006 and 2007			
	Number Enrolled		
Borough	2006	2007	Percent Change
Bronx	1017	1202	18.2%
Brooklyn	585	813	39.0%
Manhattan	466	515	10.5%
Queens	121	150	24.0%
Staten Island	5	9	80.0%
Unassigned	2	4	100.0%
Grand Total	2196	2693	22.6%

Enrollment in the HIV SNP in New York City is increasing, up approximately 21 percent from 2006 to 2007, but remains relatively low due to the voluntary nature of the program. Eligible beneficiaries with established relationships among HIV care providers who are not participating in the HIV SNP program appear to have stayed with these providers in the FFS system. The FFS program in New York has a well-established integrated case management infrastructure and it is likely that because of this, beneficiaries do not easily see the benefits of choosing a HIV SNP over FFS.

Because there are no regional or national comparison data available for this analysis, it is difficult to determine how the trend in New York HIV SNP enrollment compares to similar programs in other states. If national data are available for the final report, the information will be included, with relevant analysis and recommendations made at that time. However, the extent to which people with HIV/AIDS qualify for Medicaid varies by states so the size of enrollment might be difficult to compare even if available.

HIV SNP Quality

HIV SNPs were developed to meet the unique health and medical needs of Medicaid recipients with HIV/AIDS. The extent to which the HIV SNPs have met expectations has been under study since the development of the SNP program. Beginning in 2003, the DOH AIDS Institute, in conjunction with researchers from the Memorial Sloan-Kettering Cancer Center, embarked on a longitudinal study of Medicaid enrollees and their dependents receiving services from the five original HIV SNPs.[15] The purpose of the study, known as "Choices in Care," was to evaluate the effectiveness of the SNP compared to fee-for-service by examining self-reported perceptions of care. By conducting a series of interviews with study participants

[15] New York State Department of Health AIDS Institute, July 2008. *Choices in Care Study.*

over the course of a year, the researchers were able to gather information about the individuals' experiences with care, not just at a single point in time, but as problems were identified and/or concerns expressed, as well as when issues were expected to be addressed.

Presented in mid-2008, the findings of the study indicate the SNP model has in fact offered Medicaid enrollees living with HIV/AIDS an alternative model of care that provides more favorable care. Not only did SNP enrollees report fewer interruptions in their relationships with providers than those in fee-for-service, but they indicated there were fewer barriers to receiving care, including referrals to specialists. Similarly, communication with providers was perceived to be better among SNP enrollees than those receiving care in fee-for-service. While satisfaction with the care received was very high for both populations studied, SNP enrollees reported greater satisfaction with obtaining specialty or inpatient care. They also indicated better outcomes with respect to problem resolution.

Among study participants who were experiencing medical symptoms, SNP enrollees reported fewer problems at the time of subsequent surveys. This finding suggests that SNP care is being delivered in a timely, appropriate manner, thereby reducing the risk of increased morbidity. With respect to preventive care and education services, results indicated that SNP enrollees reported a decrease in unprotected sex with HIV/AIDS-negative partners, as well as a decrease in smoking, as compared to the fee-for-service cohort. The researchers acknowledged that SNP enrollees with the highest level of need appear to self-select this model of care. Nonetheless, findings clearly support the notion that a focused program, designed to meet the needs of individuals with complex physical needs and environmental challenges such as housing and financial problems, offers significant advantages in the delivery of coordinated, integrated health care services.

Results from this study reinforce findings of the Department's HIV SNP IPRO reviews conducted in 2006 and 2007. The AIDS Institute contracts with an Evaluation and Quality Review Organization (Island Peer Review Organization) to conduct on-site reviews at each SNP to assess SNP program-specific requirements and aspects of coordination of care. Coordination of care includes assessment of needs in the areas of mental health, chemical dependence, treatment adherence, and family planning. In an examination of the plans' post-enrollment activities and coordination of care reviews, statistics collected indicated that upwards of 90 percent of plan members were receiving orientations and were assigned to PCPs and case managers within the required timeframes.[16] Eighty-four percent of all assessments examined in the review process (for mental health, chemical dependency, treatment adherence, and family planning) were conducted.

Data in Table 3-5 provide baseline (2006) results for the HIV SNP quality review performed by the IPRO and the HIVQUAL quality review of HIV/AIDS clinics performed by participating clinic providers. Both

[16] New York State Department of Health, October 2008. *Summary Statistics: Initial SNP Activities Review and Coordination of Care Reviews.*

sets of data were provided to us by DOH. The two sets of data have some differences. Data for these indicators were obtained through record reviews, and while the HIVQUAL-participating clinics had access to their complete records, the IPRO may not have had access to all components of the patient record at all sites. This may have impacted the plan scores for the HIV SNPs. Also, there may be differences based upon participating payors. SNPs serve Medicaid beneficiaries only; HIVQUAL assesses all payors. Indicators that were not measured or reported comparably for the two reviews are not reported under the HIVQUAL results in the table.[17]

Table 3-5: Summary HIV SNP and HIVQUAL

Summary HIV SNP and HIVQUAL Quality Review Results – 2006 All Plans/All Sites		
	Average Score	
Performance Measure	SNP HQ	HIVQUAL
ARV Appropriate Mgt-Stable, Patients	74	n/a
ARV Appropriate Mgt-Unstable, Patients	40	n/a
Adherence	67	80
CD4 Count every 4 months	82	66
VL every 4 months	87	66
Pelvic Exam	76	72
PPD (TB Testing)	55	n/a
Hepatitis C Screening	84	93
Substance Use Screening	94	87
Tobacco Use Screening	92	87
Mental Health – All Components	59	56

Results from the comparison of the two reviews indicate:

- HIV SNP participants scored best (over 90) on substance use screening and tobacco screening.
- HIV SNP participants scored higher on six of the eight measures reported for the two quality reviews.

HIV SNP Financial Viability

A third measure of program success is the financial viability of participating health plans. The HIV SNP program began with five participating health plans in 2003, but in 2005 two plans withdrew from the program due to low enrollment. No new health plans have entered the program, while the three remaining original

[17] Adherence indicator measured by periods (3 periods per year). All other indicators measured by patients.

plans have steadily increased enrollment over time. Table 3-6 reports HIV SNP financial summary data for the three plans based on data reported in each plan's 2006 - 2007 HIV SNP Operating Report (SNPOR). The data contained in the SNPOR reflect the plan's HIV SNP line of business only. Data are not audited and are reported on an accrual basis, thus total expenses are impacted by a plan's estimate of services that have been incurred, but have not been billed to the plan. The last data column in Table 3-6 provides a point of comparison – the statewide averages for the mainstream Medicaid managed care plans for selected financial ratios in 2005[18].

Table 3-6: HIV SNPs Financial Summary Data

HIV SNPs Financial Summary Data, 2006 and 2007 And Mainstream Managed Care Financial Summary Data, 2005							
	Plan A		Plan B		Plan C		Mainstream MC Statewide Average
Financial Indicator	2006*	2007	2006*	2007	2006*	2007	2005
ENROLLMENT							
% Change in Enrollment Since January 1	50.3%	26.3%	10.8%	11.6%	88.5%	29.4%	–
Enrollment at Year End	1,081	1,365	726	810	411	532	
ASSETS							
% Change Total Assets Since January 1	23.5%	31.4%	18.7%	8.8%	31.1%	64.4%	–
PROFITABILITY							
Assets To Net Worth	2.6	2.8	3.7	3.0	-6.3	—	2.1
Premium Surplus Ratio	38.5%	32.4%	-3.5%	-4.6%	-11.6%	-4.8%	-1.6%
Medical Loss Ratio	46.8%	57.7%	83.2%	84.6%	72.1%	69.8%	87.0%
Administrative Loss Ratio	14.7%	9.9%	20.3%	19.9%	39.5%	35.0%	14.6%
LIQUIDITY							
Current Ratio = Current Assets/Current Liabilities	1.5	1.4	1.2	1.3	1.1	1.3	1.2

*HIV SNP 2006 results do not reflect the application of aggregate risk-sharing provisions that were not part of the 2007 results or the 2005 results for mainstream Medicaid managed care plans.

[18] Data for 2005 were used because that was the latest year of data available.

Financial data for 2006 and 2007 show that only one of the three SNP plans is profitable. The premium surplus ratio for this plan was over 30 percent in both 2006 and 2007, but this was before application of the risk corridor in 2006[19]. All three plans have increasing enrollments and assets.

The financial ratios shown in the table are defined as follows:

- Assets to Net Worth: Reflects the relationship of assets to net worth. Assets and net worth are net of intangible assets. Assets to net worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles).
- Premium Surplus Ratio: Indicates what percentage of premium dollars goes toward surplus. It indicates whether a plan is generating sufficient revenue from its premiums to cover medical and administrative expenses.
- Medical Loss Ratio: Indicates what percentage of premium dollars is spent on medical costs.
- Administrative Loss Ratio: Indicates what percentage of premium dollars is spent on administrative costs.
- Current Ratio: Reflects to what degree current assets cover current liabilities.

The premium surplus ratio (an indicator of profitability) shows that the largest HIV SNP, Plan A, is the only profitable HIV SNP among the three in operation. The plan has substantially lower medical loss and administrative ratios than the other HIV SNPs. One reason for the lower administrative costs for this plan is that Plan A is one part of a larger managed care plan with the ability to allocate administrative costs in a manner that minimizes the HIV SNP administrative costs it incurs. The high administrative cost ratio for both Plan B and Plan C is a direct result of their small enrollment, suggesting that their administrative loss ratio will likely fall as enrollment grows.

Goal 3: Objective 5 Summary

From our review of HIV SNP enrollment, quality, and financial data, we conclude the following:

- Enrollment in the HIV SNP in New York City is increasing, up approximately 21 percent from 2006 to 2007, but remains relatively low apparently due to the voluntary nature of the program and the non-participation of several large HIV care providers. Eligible beneficiaries with established relationships among HIV care providers who are not participating in the HIV SNP program appear to have stayed with these providers in the FFS system.

[19] The 2006 HIV SNP provider contract established a medical loss ratio (MLR) target of 85 percent of the SNP's capitation revenue, with a 2 percent risk corridor. If the plan experienced a MLR below 83 percent, the plan is obligated to pay the State 50 percent of the difference between actual medical costs and the amount of medical expense that would have occurred at an 83 percent MLR. If the plan experienced a MLR above 87 percent, the State is obligated to pay the plan 50 percent of the difference between actual medical costs and the amount of medical expense that would have occurred at an 87 percent MLR.

- Current studies and quality reviews point to the success of the NY SNP model in delivering care to persons with HIV/AIDS. Yet, large numbers of HIV+ beneficiaries are not choosing to join HIV SNPs, which suggests that eligible beneficiaries may not know (or understand) the benefits of choosing to enroll in an HIV SNPs.

- Review of financial data shows that the program is facing financial challenges in two of three participating plans. The two plans in financial difficulties have significantly lower enrollments than the largest (and most financially viable) plan. High administrative loss ratios for the two plans will likely fall as enrollment grows.

Objective 6: Medicaid Advantage Program

Has the Medicaid Advantage Program been successful in integrating Medicare and Medicaid covered services for dually eligible beneficiaries?

Beginning in April 2005, New York's residents with both Medicare and Medicaid eligibility could voluntarily enroll in the same health plan (a Medicaid Advantage Plan) to receive most of their Medicare and Medicaid benefits. Health plans participating in this program must: 1) be approved by CMS as a Medicare Advantage Plan; 2) participate in the Medicaid managed care program or be qualified as a Medicaid Advantage Plan by the State DOH, and 3) offer the standardized Medicare Advantage benefit package to individuals with dual eligibility enrolled in the program. Medicaid covered services in the Medicaid Advantage benefit package include: inpatient mental health in excess of Medicare's 190 day lifetime limit; non-Medicare covered home care; and private duty nursing services. Non-emergency transportation and dental services are required Medicaid Advantage benefits in New York City, but optional in other areas of the State where they are made available either through the health plan or Medicaid fee-for-service.[20]

The development of the Medicaid Advantage program began in 2003. The initial focus was on existing enrollees who were aging into Medicare. These enrollees who had joined a health plan prior to becoming eligible for Medicare had to disenroll when they became Medicare eligible, since dually eligible individuals were excluded from participation in Medicaid managed care at that time. While this situation provided the initial motivation for the development of Medicaid Advantage plans, the scope quickly broadened. In New York, spending on individuals with dual eligibility accounts for a significant portion of Medicaid spending. Individuals with dual eligibility tend to have more serious and complex medical and long-term care needs and

[20] New York State's Operational Protocol for the Partnership Plan. Chapter 29: Medicaid Advantage-Dual Eligible-Managed Care Program, page 29-5. Accessed at: http://www.health.state.ny.us/health_care/managed_care/partner/operatio/index.htm.

having coverage divided between two payers can be confusing to beneficiaries and result in fragmentation and misaligned incentives. The Medicaid Advantage program was designed to address all these issues.

New York State has coordinated with CMS in the development, implementation, and administration of the Medicaid Advantage program. The State has been a leader in identifying the various regulatory, administrative, and other financial issues that served as barriers to integrating Medicaid and Medicare benefits for dual eligibles. In particular, there have been several issues related to enrollment, marketing, and the grievance and appeals process. The grievance and appeals process has been difficult as the different program requirements remain in effect. New York's proposal was to have Medicare rules apply except for those benefits solely covered by Medicaid. CMS determined, however, that for services which are covered benefits under both programs, enrollees can chose which process to follow. While both the State and CMS would like to merge these processes into one, neither has the ability to waive specific requirements. The State was also unable to develop a single enrollment process or use a single enrollment form, and so the State developed an abbreviated supplemental enrollment form for enrollment in Medicaid Advantage, which collects only the essential additional information needed to process a Medicaid enrollment, and the required written consents. Coordination has been easier for other issues such as review of marketing materials (which is done together) and quality reporting (NYS accepts CMS reporting requirements).

In December 2004, CMS approved an amendment to the 1115 waiver that paved the way for the first enrollment of dually-eligible recipients under the Partnership Plan. In 2007, eleven health plans were contracted to participate in this initiative and slightly more than 4,100 individuals with dual eligibility were enrolled in the Medicaid Advantage program.

The Literature on Integrated Care for individuals with Dual Eligibility

In 2005, the Center for Health Care Strategies, Inc. (CHCS) launched the Integrated Care Program (ICP) to support state efforts in integration of services for dually eligible persons.[21] Five states, including New York, were selected to receive grants and technical assistance in the areas of performance measurement, rate setting and risk adjustment, and administrative improvements. Over the course of the project, CHCS assessed every state's progress in development and implementation of their model in an effort to identify best practices, challenges, and opportunities for future improvements.

Among the five states studied, three offered voluntary enrollment in a single managed care organization (Minnesota, New York, Washington) providing both Medicare and Medicaid covered services; one permitted persons with dual eligibility to use either their required Medicaid managed care plan for Medicare covered services or select Medicare fee-for-service, or a Medicare Advantage plan (New Mexico); one allowed the

[21] Center for Health Care Strategies, Inc., October 2008. *Integrated Care Program: Final Evaluation.*

target population to select between a voluntarily chosen Medicaid managed care plan, Medicare fee-for-service or a Medicare Advantage plan for the Medicare covered services (Florida).

CHCS prepared a comprehensive analysis of each state's experiences, with particular attention paid to the plans' success at implementation and enrollment. Three key factors were found to impact enrollment rates:

- CHCS noted that involvement of stakeholder groups, early and routinely in the planning process, significantly impacted the states' ability to promote the model, conceptually and operationally.
- Mandatory versus voluntary enrollment was found to be a second contributory factor to enrollment success. While stakeholders and advocates have raised objections to mandatory enrollment, market penetration in states with voluntary enrollment models has remained below 10 percent.
- CHCS recommended that states find entities that are able to provide Medicaid and Medicare services from the same managed care plan (as is done in New York). By having one plan assume full financial responsibility for enrollees, the plan has incentive to provide high-quality, cost-effective care including preventive care services. Single-plan coverage also enables the streamlining of enrollment processes, member communications, and care coordination services to reduce administrative costs, barriers to access, and inefficiencies in the delivery of health care.

Complementary to the CHCS analysis, the Commonwealth Fund published an evaluation of Medicare Advantage SNPs in February 2008.[22] The report speaks to the slow growth of integrated programs as an outcome of SNP design flaws. The Medicare Prescription Drug and Modernization Act (MMA) of 2003, which introduced Medicare Advantage plans including the Special Needs Plan (SNP) model, does not require SNPs to form relationships with state Medicaid programs, nor does it mandate state Medicaid agencies coordinate with SNPs operating within the state. Consequently, SNPs are not required to share encounter data, nor is the state obligated to share data with SNPs on Medicaid-financed services. Effective care coordination, utilization monitoring, quality improvement and cost management require the exchange of data. Without this transparency, the model of integrated care cannot be operationalized in the manner intended by the passage of the MMA.

In a recent analysis of cost savings associated with capitated models for integrated health care, The Lewin Group echoed conclusions of prior studies, noting that existing policies inhibit enrollment of persons with dual eligibility.[23] In the fee-for-service environment, enrollees receive comprehensive benefits at no cost. While a capitated model provides case management and outreach services which enrollees reportedly value, these benefits are not necessarily evident prior to enrollment. There is no financial incentive to selecting the managed care model, but rather, a disincentive to accept a restricted provider network. While some states

[22] The Commonwealth Fund, February 2008. *Medicare Advantage Special Needs Plans for Dual Eligibles: A Primer.*
[23] The Lewin Group, November 2008. *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities.*

have mandated managed care enrollment for Medicaid, current policy prohibits mandated MCO enrollment for Medicare coverage. Without a mandate or significant, apparent benefits, enrollees have no explicit reason to select managed care over fee-for-service. The Lewin Group also points to the financial disincentive experienced by the states as cause for low enrollment in integrated plans of individuals with dual eligibility. Analyses of costs indicate that early savings are accrued to the Medicare program, while the net costs initially occur under Medicaid.

Two key policy changes were identified by The Lewin Group as necessary to address growth barriers: (1) broader use of the mandatory enrollment model or an "opt-out" model and (2) a 50/50 split of net savings between Medicare and Medicaid programs. Given the estimates of annual spending for services for dually eligible beneficiaries, significant savings are expected in transitioning this population from the largely fee-for-service based care delivery system to an integrated, capitated model. Without the ability to direct enrollment and capture savings resulting from improved coordination and administration, it is unlikely that states or plans will dedicate additional resources to expand their integrated care programs.

On July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) to introduce a number of changes related to the Medicare program including several modifications specific to Medicare SNPs.[24] While extending SNP authority through 2010, MIPPA requires that new SNPs for individuals with dual eligibility are required to contract with the State for the provision of Medicaid benefits and provide all prospective enrollees with a comprehensive, written statement of benefits and cost-sharing protections under Medicaid and the plan. Additionally, MIPPA limits the out-of-pocket costs for full dual beneficiaries while requiring all SNPs to provide a range of care management activities for all members. Performance measurement data used to assess the plans' provision of services and quality of care must now be reported at the plan level. These requirements were instituted, in part, as the result of concerns raised by health experts and advocates in response to the proliferation of SNP programs despite the lack of evidence of added-value to the managed care system.

The findings of the Center for Health Care Strategies, the Commonwealth Fund, and the Lewin Group undoubtedly contributed to the formation of MIPPA requirements. Whether their recommended policy changes and the revisions required under MIPPA lead to growth of the integrated care system for dually eligible beneficiaries remains to be seen. What is known is that with increased accountability, states and plans must brace for increased costs. Some health care experts predict the stronger provisions will induce some plans to terminate their programs or revert to Medicare Advantage-Prescription Drug plans. Others argue

[24] CMS Interim Final Rule: Changes to the Medicare Advantage and Prescription Drug Benefit Programs (CMS 4138-IFC), August, 2008.

that states will gain information with which to monitor utilization and plan performance, thereby facilitating the demonstration of effectiveness while enabling plans to build the case for return on investment. If viewed as viable business conditions, these new requirements may well assist the states in expanding integrated care and meeting their enrollment goals.

In this following discussion, we examine New York's Medicaid Advantage program in terms of the number of participating plans and beneficiaries, quality and member satisfaction measures, cost efficiencies, and the ability to replicate integrated programs statewide

The Number of Participating Health Plans and Beneficiaries

Information in Table3-7 presents the number of MCOs and beneficiaries participating in the Medicaid Advantage program in 2006 and 2007.

Table 3-7: Number of MCOs and Beneficiaries

Number of MCOs and Beneficiaries Medicare/Medicaid Integrated Plans		
Year/Location	**MCOs**	**Beneficiaries**
2006		
Upstate	**4**	**297**
NYC	**6**	**3,894**
Total	**7**	**4,191**
2007		
Upstate	**6**	**559**
NYC	**9**	**3,571**
Total	**11**	**4,130**
2006-2007 % Change		
Upstate	**50%**	**88%**
NYC	**50%**	**-8%**
Total	**57%**	**-2%**

The program has been successful in increasing plan participation and the geographic reach of the program, but plan enrollment remains relatively low. Between 2006 and 2007, the number of participating health plan increased from 7 to 11 plans[25]. These plans enrolled beneficiaries from 6 upstate counties in 2006, but from 24 upstate counties in 2007, suggesting the service area has expanded substantially. However, the total number of beneficiaries enrolled in Medicaid Advantage plans actually decreased between the two years by

[25] Some plans operate in Upstate and NYC.

about two percent, from 4,191 enrollees to 4,130. Enrollment increased in Upstate New York, but fell in New York City.

Quality Measures and Member Satisfaction with Integrated Models

While participating Medicaid Advantage plans are required to submit Medicare HEDIS and Medicare CAHPS results to the State DOH, as specified by CMS for the Medicare Advantage Program,[26] separate reports for the dual eligible population are currently not required. This makes analysis of quality and member satisfaction for integrated models impossible at this time. HEDIS and CAHPS data are reported to CMS for the overall Medicare Advantage organization, not at the individual plan level. As Medicaid Advantage enrollees are such a small fraction of the health plans' overall Medicare enrollment in New York, the CMS quality reports cannot speak specifically to the quality and/or consumer satisfaction associated with Medicaid Advantage plans. [27]

Cost Efficiencies

Medicaid Advantage plans receive two monthly premiums – a Medicare Advantage program premium from CMS and a Medicaid Advantage premium from New York State that covers any Medicare supplemental premium and the cost of the Medicaid Advantage product. The State is required to demonstrate the Medicaid Advantage premiums paid by DOH are cost-effective as compared to the fee-for-service equivalent cost of care to persons who have dual eligibility. A cost effectiveness analysis would compare the cost of services provided under the Medicaid Advantage program (the Medicaid Advantage premium) to the cost of the same services provided to an actuarially equivalent population not enrolled in the program. The analysis could be performed with a quasi-experimental control group design that compares the total cost of services to Medicaid Advantage enrollees (the study group) to the total cost of services for Medicaid beneficiaries who meet the Medicaid Advantage enrollment requirements, but who have chosen to remain in the FFS system (the control group).

Such an analysis was not possible for this interim report, but we should be able to obtain data on the cost-effectiveness of Medicaid Advantage plans for the final report.

Ability to Replicate Integrated Programs Statewide

[26] New York State's Operational Protocol for the Partnership Plan. Chapter 29: Medicaid Advantage-Dual Eligible-Managed Care Program, page 29-26. Accessed at: http://www.health.state.ny.us/health_care/managed_care/partner/operatio/index.htm.

[27] As an example, the Health Insurance Plan (HIP) of Greater New York operates 15 Medicare Advantage plans in New York. Of these 15 plans, just 3 are plans for dual eligibles and only 2 of the 3 are Medicaid Advantage plans. On the 127,000 HIP Medicare Advantage enrollees (in July 2007) just 1,723 were in Medicaid Advantage plans (as of December 2007).

The Medicaid Advantage program operated in New York City and 24 upstate counties in 2007. While the program already operates in much of the State, DOH is committed to expanding to all counties and would also like to continue to expand in the long-term care area. (NYS has just implemented a program called Medicaid Advantage Plus that adds a long-term care benefit to the Medicaid Advantage product.) An important benefit of Medicaid Advantage is that it allows beneficiaries who are enrolled in a Medicaid managed care plan to remain with their plan once they become dually eligible for both Medicare and Medicaid. The State supports the creation of a managed care continuum in which beneficiaries can remain with their health plan when they become Medicare eligible.

One important issue for the Medicaid Advantage program has been the expectation that Medicaid managed care can ensure savings through better coordination of services for persons with dual eligibility, but that with this dual population such savings would accrue to the Medicare program, not to Medicaid. In creating the Medicaid Advantage program in NY, the State developed a benefit package designed to allow the State to realize a share of those savings. Insurers were asked to build into their Medicare bid the cost of hospital deductibles and co-payments (usually paid for by Medicaid). Without having to cover these expenses, the State would achieve savings. However, this arrangement appears to have put Medicaid Advantage plans at something of a disadvantage when competing for enrollees.

Beneficiaries with dual eligibility who want to enroll in a managed care program have multiple products from which to choose. They can choose to enroll in Medicare dual SNPs as well as Medicaid Advantage plans. (If they enroll in a Medicare dual SNP, their Medicaid benefits are covered in the FFS system.) By having insurers build the cost of hospital deductibles and co-payments into their Medicare benefit package, the State has eliminated any dollars that might have been available for additional benefits. Therefore, the Medicaid Advantage plans cannot offer the same "extras" that a Medicare dual SNP plan can. For example, dual SNPs offer a drug card that allows beneficiaries to buy health related items at the drug store at no cost. This might be worth $400 to the beneficiary; Medicaid Advantage plans cannot afford to provide this benefit.

To encourage participation of more dual plans, the State is considering changing the benefit package[28]. The State is currently preparing a benefit package analysis to see what changes can be made to the required Medicaid benefits to make the package more attractive to enrollees. The State has been meeting with insurers, who have expressed support for the program, and believes that additional plans are ready to enter the market once the benefit package issue is decided. Also important to plans decisions to participate has been the reauthorization of Medicare dual eligible SNPs in the 2008 MIPPA legislation. During the time period of this analysis, 2006-2007, Medicare Advantage SNPs were getting mixed messages from CMS about whether SNPs

[28]Interview with Linda Gowdy, Director, DOH Bureau of Continuing Care Initiatives.

would be reauthorized, which may have caused some plans to delay participation decisions or expand enrollment efforts.

At baseline, we are unable to evaluate the success of the Medicaid Advantage program in terms of either quality or cost-effectiveness. Enrollment has been a challenge for the program, but the State understands the problem and is currently seeking solutions. Additional analysis may be possible in the final report.

Goal 3: Objective 6 Summary

The Medicaid Advantage program is a relatively new managed care program for New York State. Data on quality measures and customer satisfaction, as well as cost effectiveness data, were not available for this interim report. From the available data and information, we have found that:

- The program has been successful in increasing plan participation and the geographic reach of the program, but plan enrollment remains low. Plan participation and coverage increased substantially between 2006 and 2007, yet the number of beneficiaries enrolled actually fell between the two years by about two percent.

- The time period covered by this analysis (2006-2007) was one of uncertainty for Medicare Advantage SNPs concerning SNP reauthorization. This may have delayed decision making for some Medicare SNPs regarding plans to participate in Medicaid Advantage or to expand enrollment efforts in existing plans.

- Expanding enrollment may require changes to the Medicaid Advantage benefit package so that Medicaid Advantage plans are better able to compete for enrollees with Medicare Advantage SNPs.

Goal 4: Expanding Health Care Coverage

Goal 4 of the Demonstration is to reduce the number of uninsured New Yorkers.

In May 2001, CMS approved an amendment to the 1115 waiver to provide for implementation of Family Health Plus (FHPlus), a Medicaid expansion that provides comprehensive health coverage to low-income uninsured adults, with and without children, who have income and/or assets greater than the Medicaid eligibility standards. Providing that the applicable resource test is met, parent(s) living with a child under the age of 21 are eligible if gross family income is up to 150% of the federal poverty level (FPL). For adults without dependent children in their households, gross income can be up to 100% of the FPL.

Enrollment into FHPlus began in September 2001 for all areas other than New York City, which delayed program implementation until February 2002 because of system problems due to the World Trade Center disaster. Instead potential FHPlus eligibles were enrolled in the temporary Disaster Relief Medicaid program in New York City through January 31, 2002 and transitioned to FHPlus or regular Medicaid over the next year. Today, FHPlus makes coverage available to almost 440,000 previously uninsured New Yorkers.

As part of the evaluation plan, the New York DOH must 1) show that the 1115 Demonstration will expand coverage in the FHPlus program for low-income uninsured adults and 2) implement a premium assistance program for individuals eligible for FHPlus who have access to cost-effective Employer Sponsored Health Insurance (ESHI), the FHPlus Premium Assistance Program (PAP). Outcome measures specified in the evaluation plan to measure expanded coverage through FHPlus include the number of beneficiaries enrolled in the program by beneficiary type, age group, and county. To determine the extent of enrollment in PAP, outcome measures were specified as beneficiaries enrolled in PAP through the FHPlus program by beneficiary type, age group, and county.

Data for the analysis of enrollment in FHPlus across these different categories were provided by New York DOH.[1] Comparisons are made between the 2006 and 2007 time periods to help determine if the FHPlus program continues to reduce the number of uninsured New Yorkers through increased enrollment in the program. The PAP program was enacted in July 2007 and went into effect in January 2008. Therefore, data for this program were relatively limited and comparisons over time are not yet possible. The DOH provided enrollment information, with numbers for total enrollment and new enrollment during the July – September 2008 and October - December 2008 quarters, presented for two different beneficiary types.

[1] Data provided in two separate files from the Medicaid Management Information System Enrollment Reports: "Copy of EN06" and "Copy of EN07" – Family Health Plus tab.

Family Health Plus (FHPlus) Enrollment by Beneficiary Type

There are two enrollment categories for individuals enrolling in the FHPlus program: Adults with Children and Adults without Children. Data in Table 4-1 indicate:

- At the end of 2007, 519,000 previously uninsured adults with and without children were enrolled in FHPlus.
- Statewide, the number of individuals enrolled in FHPlus has increased by over two percent from 2006 to 2007, indicating the program continues to increase enrollment.
- Adults without Children were more likely to enroll over the time period than were Adults with Children, 3.7 percent and 1.3 percent increase respectively.

Table 4-1: Family Health Plus Program

Family Health Plus Program Enrollment by Beneficiary Type, 2006 and 2007			
	Enrolled		
Type	2006	2007	Percent Change
Adults with Children	313,572	317,591	1.3%
Adults without Children	194,119	201,288	3.7%
NY Total	507,691	518,879	2.2%

FHPlus Enrollment by Age Group

Results for the FHPlus enrollment analysis by age are presented in Table 4-2. Only individuals between the ages of 19 and 64 are eligible to enroll in FHPlus. Table 4-2 shows enrollment of individuals by age groupings and includes 15 to 19 year olds and 65+ years of age. The 65+ age category includes individuals in the month in which they turn 65, individuals in their guarantee period as of their 65th birthday and individuals who turned 65 while awaiting a redetermination of Medicaid eligibility by the local district. The 15-19 age band likely reflects individuals who turned 19 years of age during the year. Therefore, tentative results indicate enrollment among the younger participants dropped off between 2006 and 2007, but enrollment among eligible residents age 45 and over has increased, particularly among individuals age 65 and over. Further investigation of the age groupings is warranted and will be conducted prior to the final evaluation report. However, it is clear that the FHPlus expansion has provided access to health insurance for a significant number of adults between 19 and 64 who would otherwise be uninsured. In general, many uninsured are low-income adults who struggle with finding affordable health care – they work in low paying jobs where benefits are often not offered or are beyond their ability to purchase.

Table 4-2: Family Health Plus Program

Family Health Plus Program Enrollment by Age Group, 2006 and 2007			
	Number Enrolled		
Age Group	2006	2007	Percent Change
15-19	6,249	5,937	-5.0%
20-44	317,481	315,328	-0.7%
45-64	178,512	188,193	5.4%
65+	472	608	28.8%

FHPlus Enrollment by County

FHPlus enrollment for each New York County for 2006 and 2007 is presented in Appendix 1, Exhibit 4-1, including the percent enrollment change over the time period. Information is displayed for each county, for New York City, for each Borough within the City, and statewide. A summary of findings from the Exhibit includes the following:

- While there is evidence of improvement in enrollment in the FHPlus program, a statewide increase of over two percent, there is a great deal of variance across the counties, which may in part be a function of where those eligible for the program reside.
- Only 18 of the 57 counties (31.6%), and NYC, showed a consistent or increased enrollment rate from 2006 to 2007.
- Three counties reflected greater than a 10 percent increase in enrollment: Columbia (22%), Fulton (15%), and Orange (11%).
- Three counties reflected greater than a 10 percent decrease in enrollment: Nassau (24%), Steuben (12%), and Greene (11%).
- Enrollment information was available in the NYC Boroughs only for 2007.

Family Health Plus Premium Assistance Program (FHPlus PAP)

Under the FHPlus PAP, individuals eligible for FHPlus with access to employer sponsored health insurance that is deemed qualified and cost effective by the Commissioner of Health are required to enroll in the employer sponsored health insurance to be eligible to receive FHPlus benefits. The state subsidizes the premiums for this coverage and reimburses any deductibles and co-payments to the extent that these co-payments exceed the amount of the enrollee's copayment obligations under FHPlus. FHPlus wrap-around benefits are also provided to the extent that such benefits are not covered by the individual's employer sponsored health plan.

The FHPlus PAP helps individuals eligible for FHPlus move to more cost effective insurance programs through their employers, if available. Because this is a relatively new program, enacted in July 2007 and implemented in January 2008, information on enrollment is limited. Information provided by DOH indicates there were 411 new enrollees during the July – December 2008 time period. As of December 2008, there were 902 individuals enrolled in the FHPlus PAP program, a majority were adults without children (66.4%).

Table 4-3: Family Health Plus Premium Assistance Program

Family Health Plus Premium Assistance Program Enrollment by Beneficiary Type, 2008		
	Enrollment	
Beneficiary Type	Number	Percent
Adults with Children	303	33.6%
Adults without Children	599	66.4%
Total Enrolled	902	100.0%

FHPlus Conclusions

Since its implementation in 2001, FHPlus has been successful in increasing the rate of coverage for previously uninsured adults. At the end of 2007, more than 518,000 adults who were uninsured but not eligible for Medicaid were enrolled in the program. In addition, the FHPlus PAP has made comprehensive cost efficient health coverage available to more than 902 employers, and employees and their families. Therefore, continuation of the program is appropriate and beneficial to New York.

An enrollment increase of just over two percent is evidenced in the FHPlus program between 2006 and 2007, providing support that FHPlus continues to help enroll low-income residents in the program. This enrollment growth may have been slowed by a change in FHPlus eligibility policy as implemented late in 2005 that imposed a resource test for the FHPlus program. The implementation was rolled out as current eligibles were recertified for their continued FHPlus during 2006. Thus, much of the enrollment growth could have been hampered by persons losing eligibility for FHP due to their having resources in excess of the new applicable standard.

Enrollment in the FHPlus program across age groups indicates older individuals were more likely to have been enrolled over the 2006 to 2007 time period than were individuals under age 45. Additionally, adults without children were somewhat more likely to enroll than adults with children. However, the increase is not consistent across beneficiary types or counties and a few counties appear to have captured a majority of the increase in enrollment statewide. Eligibility data were not available for this analysis and it is therefore not possible to say if certain counties may have neared saturation points for enrollment.

Several counties showed declines in enrollment in the FHPlus program, including Nassau, with a 24 percent decrease from 2006 to 2007. As described in Goal 1 on Medicaid managed care penetration rates, there were issues with the processing of eligibility renewals at the Nassau County local social services district which affected reporting of the number of eligibles, as well as penetration rates, for FHPlus and Medicaid.

The FHPlus PAP program is a relatively new initiative within the New York DOH. Information provided to date indicates that 902 adults were enrolled in FHPlus through the PAP program at the end of 2008. A majority who successfully used the program to move to more cost effective insurance programs were adults without children; only about one third of participants were adults with children. This could reflect varying eligibility across the two groups, which was not available for this analysis.

Goal 5: Avert Unintended Pregnancies
Family Planning Expansion Program Evaluation

The goal of the Family Planning Expansion Demonstration is to avert unintended pregnancies by increasing access to publicly funded family planning services.

To achieve the Family Planning Expansion Program evaluation goal, the Demonstration must expand eligibility for services, including but not limited to services related to contraception or sterilization. Seven evaluation questions, and related outcome measures, were specified in the Evaluation Plan approved by CMS. In this section of the report, a brief outline of the background and recent research on Family Planning Expansion Programs is provided, and each research question is addressed.

Background and Recent Research

Since the early 1970's, Congress has recognized the importance of family planning services in meeting the needs of Medicaid beneficiaries.[1] With the mandated inclusion of "family planning services and supplies" in the 1972 State plan amendments, Congress ensured that Medicaid beneficiaries of child-bearing age could obtain access to a broad range of services, including contraceptive education and counseling, testing and treatment for sexually transmitted infections, cervical cancer screening, and contraceptive drugs and devices. The amendments provided a financial incentive for states by establishing a special matching rate of 90 percent for family planning services. Moreover, Congress improved access by exempting family planning services from beneficiary cost-sharing provisions and requiring states to permit managed care enrollees to obtain family planning services outside their managed care network.

In the early 1990's, CMS enabled states to expand family planning services coverage under the 1115 waiver. Since that time, more than half of the states (including New York) have received CMS approval to extend Medicaid eligibility for family planning services to individuals who might not otherwise qualify for Medicaid enrollment. Family Planning Expansion Programs (FPEP) have been implemented under one of three approaches: (1) by expanding the period of coverage for enrollees for a specified period of time as part of a post-partum care program; (2) by allowing access to family planning services for individuals leaving Medicaid for any reason; or (3) by extending coverage based upon income rather than previous participation in or eligibility for traditional Medicaid services. Today, 26 states offer FPEPs, with most covering individuals for the full span of child-bearing years. Seventy-five percent of women estimated to be in need of publicly-funded family planning services reside in one of these 26 states.[2]

[1] This section provides historic and current research on national Family Planning Expansion Programs. The final report will include additional information specific to the New York experience.
[2] The Henry J. Kaiser Family Foundation, October 2007. *Medicaid's Role in Family Planning.*

Given the number of publicly funded family planning programs and the length of time they have been in operation, there is considerable evidence of their success in meeting goals for improved access to care, realization of cost savings, and reduction in unintended pregnancies. In a seminal study published by the Guttmacher Institute in 2008, health care economists estimated that for each dollar invested in family planning services, Medicaid realizes a four-fold savings.[3] By comparing the costs of providing contraceptive care services ($1.4 billion in 2004) with anticipated costs for maternity and infant care among women eligible for Medicaid whose births were averted ($5.7 billion), the authors calculated an annual net public-funds savings of approximately $4.3 billion.

In a complementary analysis on reducing unintended pregnancies through Medicaid family planning services, expanded eligibility policies were found to have had a significant impact in decreasing unplanned pregnancies, particularly among women ages 18-24.[4] Approximately 50 percent of pregnancies in the United States are reported to be unintended, with one-third of these among unmarried women in their twenties. Since the introduction of family planning waivers which enabled increased access to contraceptive drugs and devices, birth rates for women ages 18-19 enrolled in income-based FPEPs have fallen by 6.8 percent; for women ages 20-24, by 5.1 percent. The authors also noted a 15 percent decline in births among women ages 20-24 who were newly eligible for family planning coverage. This study corroborated the findings of a previous evaluation of six state expansion programs, conducted by the CNA Corporation. Their analysis not only demonstrated cost savings and increased access, but also produced evidence in two states of a measurable reduction in unintended pregnancies among women eligible for the program.[5]

Comparison of family planning service models suggests that states with income-based expansion programs have been more successful in increasing access, serving half of the women in need versus only 40 percent in states without FPEPs.[6] Additionally, researchers at the Medical University of South Carolina identified lower birthrates in states with Medicaid FPEPs, in comparison to those without.[7] Most recently, the Guttmacher Institute released a report indicating that "without publicly funded family planning, the U.S. abortion rate would be nearly two-thirds higher, and nearly twice as high for poor women." Based upon data from fiscal year 2006, the researchers determined the national family planning program prevented 1.94 million unintended pregnancies, including almost 400,000 teen pregnancies.[8]

[3] Guttmacher Institute, 2008. *The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings.*
[4] Brookings Center on Children and Family, July 2008. *Reducing Unplanned Pregnancies through Medicaid Family Planning Services.*
[5] Guttmacher Institute, 2004. *Doing More for Less: Study Says State Medicaid Family Planning Expansions are Cost Effective.*
[6] Guttmacher Institute, 2006. *Estimating the Impact of Expanding Medicaid Eligibility for Family Planning Services.*
[7] Women's Health Issues, March/April 2007. *The Effect of Medicaid Family Planning Expansions on Unplanned Births.*
[8] Associated Press, February 24, 2009. *Report: Family Planning Services Cost Effective.*

Central to the success of these programs has been the aggressive outreach efforts undertaken in each state, not only with potential enrollees, but providers as well. In many states, Medicaid providers are automatically eligible to serve FPEP enrollees and billing and enrollment procedures have been streamlined to achieve maximum efficiency. In a recent policy review of Medicaid FPEPs, one author noted that development of universal applications for a range of government programs created an "express lane enrollment."[9] To further expedite enrollment processes, some states have introduced presumptive eligibility, while others have developed "one-stop" same-day, point-of-service enrollment. Some critics have argued these approaches have placed a burden on provider offices, increasing financial risk and demand on resources. In response, states have initiated reimbursement for provider assistance with application processes.

Despite this unequivocal evidence that family planning services and FPEPs in particular improve access, reduce health care costs, and reduce the number of unintended pregnancies, Congress has passed legislation that could adversely affect family planning care. While family planning services remain exempt from cost-sharing, the Deficit Reduction Act of 2005 (DRA) excluded drugs from this exemption. In the October 2007 update on women's health policy, the Henry J. Kaiser Family Foundation reported this provision had affected the price of prescription contraceptives for some low-cost family planning providers.[10] Medicaid law had previously allowed manufacturers to offer prescription drugs to family planning centers and college health clinics at a low price without impacting the discount required to Medicaid. Under the DRA, some types of family planning providers are now excluded from the category of entities that qualify for low-cost pricing. The authors warned that such a policy might reduce access to contraceptives as low-cost clinics, met with increasing drug costs, decline to offer contraceptive services.

Current federal guidelines also pose potential problems due to the broad parameters by which states can define covered services. As previously noted, states receive a 90 percent match for services "when performed routinely as part of an initial, regular or follow-up visit/examination for family planning." If the patient has a medical problem that requires treatment, those services would not qualify for 90 percent federal match. The categorization of services, and how those services are delivered, are pivotal issues for states and providers in determining funding and reimbursement. Moreover, the criterion upon which family planning services are defined may introduce unintended access barriers for beneficiaries who may be subject to in-network restrictions or cost-sharing requirements, or be altogether ineligible for services deemed outside family planning coverage.

In 2007, the Unintended Pregnancy Reduction Act (H.R. 2523) was introduced as an amendment to title XIX of the Social Security Act to expand access to contraceptive services for women and men under the Medicaid Program and help low income women and couples prevent unintended pregnancies and reduce abortion

[9] Guttmacher Policy Review, Spring 2008. *Breaking New Ground: Ingenuity and Innovation in Medicaid Family Planning Expansions.*
[10] The Henry J. Kaiser Family Foundation, Women's Issue Brief, October 2007. *Medicaid's Role in Family Planning.*

rates. Building upon the demonstrated success of the 26 states with waiver programs, the amendment was intended to eliminate unnecessary expenses and delays associated with applying for, or renegotiating, family planning waivers. The amendment was not approved.

In a recent publication of Women's Health Issues, investigators examining preconception care suggest that additional improvements to the FPEP model are necessary to yield greater cost savings for publicly-funded programs.[11] The authors speak to the need for preventive services such as genetic counseling and prenatal depression screening programs which could increase the likelihood that pregnancies are intended while decreasing complications associated with high-risk pregnancies and post-partum issues. In light of the current requirement that FPEP waivers demonstrate budget neutrality, the authors acknowledge that inclusion of such services would be challenging and might jeopardize approval of a waiver.

With the recent change in administration and increased support for health care reform, evidence of success, as measured by improved access, reductions in unplanned pregnancies, and demonstrable cost savings, will likely lead to broader adoption of the FPEP model. Refinements to the waiver application process, scope of services covered, provider qualification, and beneficiary enrollment processes can facilitate the spread of well documented best practices for the provision of family planning care.

In New York, the Partnership Plan Medicaid Section 1115 Demonstration expanded in 2002 to include a Family Planning Expansion Program, referred to as the Family Planning Benefits Program (FPBP). The FPBP was designed to provide family planning services to men and women of childbearing age, with net incomes at or below 200 percent of the federal poverty level, who are not otherwise eligible for Medicaid or other public or private health insurance coverage that provides family planning. Also eligible are women who lose Medicaid eligibility under the Partnership Plan at the conclusion of their 60-day postpartum period.

Family Planning Participation

How many individuals received Medicaid family planning services as a result of the Family Planning expansion Demonstration?[

There were 38,139 participants enrolled in FPBP in 2006 and 31,828 in 2007.[12] The services received by these participants were primarily office visits, laboratory services and birth control/contraceptives. Between 2006 and 2007, participation in the program may have been effected by changes in eligibility requirements for the program. CMS imposed stricter proof of citizenship requirements and the period of eligibility was

[11] Women's Health Issues, July 2008. Making the Most of Medicaid. *Promoting the Health of Women and Infants with Preconception Care.*

[12] The number of participants is based on men and women who received a family planning service through the program during the year. For the birth rate and averted birth calculation, only female participants age 18 to 44 are included in the analysis.

reduced from two years to one year, with recertification required after one year. However, in 2007, NYS received approval from CMS to cover follow-up procedures to a family planning visit to include colposcopies, LEEP and medical treatment for STDs at 50 percent FFP, increasing benefits to participants.

A summary of results for 2006 and 2007 for the Family Planning Benefit Program includes the following (Tables 5-1-5):

- Over the two year time period there were 38,139 participants enrolled in FPBP in 2006 and 31,828 in 2007.
- The FPBP fertility rate was 8.7 births per 1000 enrollees in 2006, and dropped to 6.5 births per 1000 in 2007.
- Clinical referrals for primary care increased from 7.8 percent of enrollees in 2006 to 8.3 percent of enrollees in 2007.
- Over the two year period, there were a total of 8,786 averted births.
- Total cost savings for the Family Planning Benefit Program between 2006 and 2007 was $205,440,968.

Number of births

How many births occur to participants covered by the Demonstration?

Data from the Medicaid Management Information System (MMIS) indicate the birth rate per 1,000 FPBP enrollees was 8.73 in 2006 and decreased to 6.54 in 2007 for a 25 percent decline during the two year time period.

Table 5-1: Family Planning Benefit Program

Family Planning Benefit Program Participant Birth Rates			
Year	Number of Births	FPBP Participants	Birth Rate per 1,000
2006	329	37,665	8.73
2007	206	31,510	6.54
Percent Change in Rate			-25.2%

Clinical Referrals

To what extent did Family Planning Expansion Program participants receive a clinical referral for primary care?

Data for clinic referrals is provided by each family planning provider to the DOH and included in an Agency Annual Report. In total, 5,609 clinic referrals were made for participants in the program over the two year

period.[13] Using the total number of FPBP participants from the MMIS system results in an overall referral rate of 8.1 percent. Between 2006 and 2007 the average referral rate increased from 7.8 percent to 8.3 percent, a 6.0 percent improvement over the time period.

Table 5-2: Family Planning Benefit Program

Family Planning Benefit Program Clinical Referral Rate for Primary Care			
Year	Number Referrals	FPEP Participants	Referral Rate
2006	2,976	38,139	7.8%
2007	2,633	31,828	8.3%
Percent Change in Rate			6.0%

Averted Pregnancies

To what extent have pregnancies been averted as a result of the Demonstration?

The number of averted births was calculated with the formula provided in the RFP and approved by CMS: Averted births = (base-year fertility rate)-(fertility rate of Demonstration participants during Demonstration Year) * (number of Demonstration participants during Demonstration Year). The base-year fertility rate used in the formula was calculated by DOH for 2000 and provided to Delmarva. To calculate the base-year fertility rate, the number of women who would have been in the FPBP was estimated with the number of women age 18 – 44, not covered by Medicaid and living at 75 to 200 percent of the Federal Poverty Level. The number of FPBP participants, fertility rate, and number of averted births is presented in Table 5-3 for 2006 and 2007. Compared to the base-year (2000) fertility rate, the fertility rates for FPBP participants in 2006 and 2007 were lower by 126 and 128 births per thousand participants each year respectively. The formula for averted births indicates that 4,746 births for participants in the FPBP were averted in 2006 and 4,040 births were averted in 2007.

Table 5-3: Demonstration Program Fertility Rates/1,000 and Averted Births

Demonstration Program Fertility Rates/1,000 and Averted Births 2006 and 2007					
Year	Base-Year Fertility Rate	Fertility Rate	Difference in Rates	Participants	Averted Births
2006	134.72	8.73	-125.99	37,665	4,746
2007	134.72	6.54	-128.18	31,510	4,040

[13] The number of FPBP participants for the clinic referral analysis includes both men and women who received a family planning service through the program during the year.

Expenditures and Cost Savings

What expenditures are associated with Medicaid-funded births?

Information on expenditures was derived from the Medicaid Management Information System and cost savings were calculated using averted births. The cost of pregnancy related Medicaid births included prenatal average expenditures, delivery stay average expenditures, and infant birth and first year of life average expenditures. This information is displayed in the following tables. Data indicate the average cost for Medicaid births was $22,928 in 2006 and $23,917 in 2007, an increase of about four percent. The cost for infant birth and services through the first year of life displayed the greatest increase, by close to six percent, while the cost of prenatal care has remained fairly stable.

Table 5-4: Pregnancy Related Medicaid Costs

Pregnancy Related Medicaid Costs 2006 and 2007			
Average Expenditure	2006	2007	Percent Change
Prenatal	$2,475	$2,479	0.2%
Delivery and Stay	$6,066	$6,224	2.6%
Infant Birth/First Year of Life	$14,387	$15,214	5.7%
Total Average Expenditures	$22,928	$23,917	4.3%

To what extent have averted births resulting from the Demonstration yielded cost savings?

The formula to calculate the estimated average cost savings attributable to the Family Planning Benefit Program was provided in the Evaluation Plan approved by CMS: the number of averted births multiplied by the average expenditures for a Medicaid-funded birth each year. In 2006, with an estimated number of averted births of 4,746 and an average cost per birth of $22,928, the estimated savings through the FPBP Demonstration was $108,816,288. In 2007 the estimated savings were $96,624,680 for a two year total of $205,440,968.

Table 5-5: Cost Savings Attributable to the FPBP Demonstration

Cost Savings Attributable to the FPBP Demonstration 2006 and 2007			
Year	Averted Births	Average Costs	Estimated Cost Savings
2006	4,746	$ 22,928	$108,816,288
2007	4,040	$ 23,917	$ 96,624,680
Total	8,786		$205,440,968

Eligibility Re-determinations

In extracting data to evaluate the number of re-determinations made for FPBP enrollees, it was determined by DOH that a unique count of FPBP enrollees who received a re-determination and a unique count of enrollees who are due for a re-determination assessment were not currently available through the database. If these data become available in the coming year, an assessment of re-determinations will be completed for the final report.

Family Planning Benefit Program Summary

The goal of the FPBP is to avert unintended pregnancies by increasing access to publicly funded family planning services. Based on a calculated 2000 base-year fertility rate, the estimated number of "averted births" was 8,786 for the two year time period (2006 – 2007), resulting in an estimated cost savings of just over $205.4 million dollars. In addition, the rate of referrals made to clinics has increased by six percent over the same time period. These results indicate participants have access to family planning services and are successfully using the services provided through the program to reduce the number of unintended pregnancies. Even though the average Medicaid pregnancy-related costs increased slightly over the two year time period, the estimated cost savings for the program remains significant.

Based on the evaluation the FPBP data for 2006 and 2007, it appears the FPBP Demonstration helps women and men receive Medicaid family planning services that help avert unintended pregnancies, lower the birth rate among participants and provide significant cost savings. The program should be continued and expanded.

Report Summary

The Partnership Plan Medicaid Section 1115 Demonstration Plan was implemented in New York in July 1997. In 2001 the Family Health Plus program was implemented to provide comprehensive health coverage to low-income uninsured adults (with or without children) who had income and/or assets greater than Medicaid eligibility standards. In 2002, the Demonstration was further expanded with the Family Planning Expansion program, targeted at men and women of childbearing age who have income levels at or below 200 percent of the federal poverty level. In March 2006 New York was granted a three year extension to the program and Delmarva contracted with the NY Department of Health to evaluate the effectiveness of the extension program.

This is an interim report, detailing results of analysis to date, comparing findings on various indicators of plan performance in 2006 with results in 2007, the first year of the expansion. Each goal, as specifically described in the approved Evaluation Plan and the designated outcome measures, when possible, have been examined. Comparisons have been made not only between the base year of 2006 and 2007, but to commercial and national benchmarks where appropriate and available. Because only two years of data have been analyzed, results are preliminary and may not indicate a trend or pattern exists across the state. However, some preliminary findings are note worthy. To summarize, from 2006 to 2007 the Medicaid managed care organizations in New York improved performance on most indicators analyzed to measure quality of care. In addition, the disparity between the Medicaid and commercial plans has been reduced on most measures, with some areas moving from below the commercial rate in 2006 to above the rate in 2007. Where national benchmarks were available, the New York Medicaid managed care plans out-performed national averages on most measures of quality in both 2006 and 2007.

Enrollment in Medicaid managed care has increased in the state, but not consistently across all regions. Mandatory policies have been implemented resulting in increased enrollment in upstate New York, where Medicaid managed care enrollment has lagged behind New York State rates. Participation in the Family Planning Benefit Program has declined somewhat since 2006, however results in this report indicate the program has been successful at reducing the number of unintended pregnancies as well as providing significant cost savings to the state, and should therefore be continued. At the same time, measures of member satisfaction are less clear and should be tracked beyond the scope of this evaluation process, when new results from the 2009 CAHPS are available.

Medicaid managed care payment systems in New York have evolved substantially over time with the development of increasingly sophisticated and targeted payment mechanisms in support of continued quality improvement. An analysis of selected performance measures used in the quality incentive program shows

continued performance improvement in several indicators with the gap in performance between Medicaid managed care plans and commercial plans narrowing in the 2006-2007 period. It appears the HIV SNPs have been a somewhat successful model for delivery of care to persons living with HIV/AIDS and their eligible dependents. On measures of quality the program has shown success and enrollment, while low, has increased 21 percent from 2006 to 2007. Review of financial data, however, shows the program is facing financial challenges in two of three participating plans. A limited amount of data was available to examine the relatively new Medicaid Advantage program for dual eligible beneficiaries. The program has been successful in increasing plan participation and the geographic reach of the program, but plan enrollment remains low.

These and other findings will be tracked and further analysis will be completed when the 2008 data are available. The final report will include trends over the three year period, 2006 – 2008, and recommendations to the state where appropriate. Interim results would indicate a continued focus on Medicaid managed care may help the continued improvement of access and quality of care for many individuals in New York.

Exhibit 1-1: Medicaid Managed Care Penetration Rates by County Upstate, NYC, Boroughs, and Counties - 2006 and 2007										
		Enrollment			Eligibility			Penetration Rate		
Area		2006	2007	Percent Change	2006	2007	Percent Change	2006	2007	Change
NY State		2,003,754	2,097,188	4.66%	2,911,734	2,866,582	-1.55%	68.82%	73.16%	4.34%
Upstate		518,326	561,607	8.35%	931,929	913,427	-1.99%	55.62%	61.48%	5.86%
	Albany	16,215	16,858	3.97%	24,667	24,190	-1.93%	65.74%	69.69%	3.95%
	Allegany	1,090	2,945	170.18%	5,570	5,426	-2.59%	19.57%	54.28%	34.71%
	Broome	14,113	13,877	-1.67%	20,454	20,333	-0.59%	69.00%	68.25%	-0.75%
	Cattaraugus	5,699	5,603	-1.68%	7,620	7,477	-1.88%	74.79%	74.94%	0.15%
	Cayuga	0	0	0.00%	7,931	7,960	0.37%	0.00%	0.00%	0.00%
	Chautauqua	12,094	12,345	2.08%	15,922	15,770	-0.95%	75.96%	78.28%	2.32%
	Chemung	4,577	5,529	20.80%	11,644	11,455	-1.62%	39.31%	48.27%	8.96%
	Chenango	0	0	0.00%	6,245	6,067	-2.85%	0.00%	0.00%	0.00%
	Clinton	0	99	-	8,732	8,661	-0.81%	0.00%	1.14%	1.14%
	Columbia	2,461	2,724	10.69%	4,035	3,943	-2.28%	60.99%	69.08%	8.09%
	Cortland	907	2,762	204.52%	5,331	5,279	-0.98%	17.01%	52.32%	35.31%
	Delaware	0	0	0.00%	4,041	3,962	-1.95%	0.00%	0.00%	0.00%
	Dutchess	7,124	8,944	25.55%	15,143	14,733	-2.71%	47.04%	60.71%	13.66%
	Erie	68,693	71,442	4.00%	99,409	98,416	-1.00%	69.10%	72.59%	3.49%
	Essex	0	125	-	3,010	2,887	-4.09%	0.00%	4.33%	4.33%
	Franklin	0	0	0.00%	5,364	5,235	-2.40%	0.00%	0.00%	0.00%
	Fulton	984	4,304	337.40%	6,905	6,883	-0.32%	14.25%	62.53%	48.28%
	Genesee	3,535	3,480	-1.56%	4,665	4,553	-2.40%	75.78%	76.43%	0.66%
	Greene	2,977	2,954	-0.77%	4,098	3,991	-2.61%	72.65%	74.02%	1.37%
	Hamilton	0	12	-	268	267	-0.37%	0.00%	4.49%	4.49%

	Herkimer	4,759	4,936	3.72%	6,905	6,642	-3.81%	68.92%	74.31%	5.39%
	Jefferson	0	0	0.00%	11,047	10,803	-2.21%	0.00%	0.00%	0.00%
	Lewis	0	0	0.00%	2,862	2,698	-5.73%	0.00%	0.00%	0.00%
	Livingston	2,991	2,739	-8.43%	4,623	4,262	-7.81%	64.70%	64.27%	-0.43%
	Madison	0	0	0.00%	5,742	5,656	-1.50%	0.00%	0.00%	0.00%
	Monroe	54,968	57,936	5.40%	83,456	82,036	-1.70%	65.86%	70.62%	4.76%
	Montgomery	1,249	4,038	223.30%	6,359	6,196	-2.56%	19.64%	65.17%	45.53%
	Nassau	52,427	43,913	-16.24%	75,828	74,837	-1.31%	69.14%	58.68%	-10.46%
	Niagara	15,946	15,933	-0.08%	20,507	20,074	-2.11%	77.76%	79.37%	1.61%
	Oneida	17,305	18,396	6.30%	26,336	25,866	-1.78%	65.71%	71.12%	5.41%
	Onondaga	30,963	31,234	0.88%	47,319	46,879	-0.93%	65.43%	66.63%	1.19%
	Ontario	5,006	4,869	-2.74%	6,771	6,654	-1.73%	73.93%	73.17%	-0.76%
	Orange	12,728	26,266	106.36%	35,817	34,634	-3.30%	35.54%	75.84%	40.30%
	Orleans	3,163	3,262	3.13%	4,354	4,296	-1.33%	72.65%	75.93%	3.29%
	Oswego	10,934	10,763	-1.56%	14,706	14,082	-4.24%	74.35%	76.43%	2.08%
	Otsego	19	1,902	9910.53%	4,998	4,981	-0.34%	0.38%	38.19%	37.80%
	Putnam	583	1,265	116.98%	2,259	2,319	2.66%	25.81%	54.55%	28.74%
	Rensselaer	10,554	10,959	3.84%	14,202	14,258	0.39%	74.31%	76.86%	2.55%
	Rockland	28,804	30,383	5.48%	33,492	34,175	2.04%	86.00%	88.90%	2.90%
	St Lawrence	0	0	0.00%	13,251	13,024	-1.71%	0.00%	0.00%	0.00%
	Saratoga	6,036	6,057	0.35%	9,339	9,329	-0.11%	64.63%	64.93%	0.29%
	Schenectady	5,131	7,344	43.13%	14,847	14,310	-3.62%	34.56%	51.32%	16.76%
	Schoharie	98	119	21.43%	2,775	2,662	-4.07%	3.53%	4.47%	0.94%
	Schuyler	227	169	-25.55%	1,856	1,762	-5.06%	12.23%	9.59%	-2.64%
	Seneca	1,570	1,785	13.69%	2,759	2,617	-5.15%	56.90%	68.21%	11.30%
	Steuben	2,137	2,150	0.61%	11,551	11,209	-2.96%	18.50%	19.18%	0.68%
	Suffolk	50,909	50,201	-1.39%	83,015	78,850	-5.02%	61.33%	63.67%	2.34%

	Sullivan	4,135	5,631	36.18%	8,608	8,396	-2.46%	48.04%	67.07%	19.03%
	Tioga	209	248	18.66%	4,766	4,689	-1.62%	4.39%	5.29%	0.90%
	Tompkins	1,394	1,592	14.20%	6,864	6,737	-1.85%	20.31%	23.63%	3.32%
	Ulster	5,924	8,867	49.68%	13,980	13,270	-5.08%	42.37%	66.82%	24.45%
	Warren	564	596	5.67%	4,511	4,344	-3.70%	12.50%	13.72%	1.22%
	Washington	1,405	3,115	121.71%	5,661	5,485	-3.11%	24.82%	56.79%	31.97%
	Wayne	2,286	2,314	1.22%	6,904	6,723	-2.62%	33.11%	34.42%	1.31%
	Westchester	42,022	46,993	11.83%	67,745	66,398	-1.99%	62.03%	70.77%	8.75%
	Wyoming	0	0	0.00%	2,607	2,557	-1.92%	0.00%	0.00%	0.00%
	Yates	1,411	1,629	15.45%	2,253	2,229	-1.07%	62.63%	73.08%	10.45%
New York City		1,485,428	1,535,581	3.38%	1,979,805	1,953,155	-1.35%	75.03%	78.62%	3.59%
	Bronx	355,391	368,797	3.77%	487,273	479,416	-1.61%	72.93%	76.93%	3.99%
	Brooklyn	542,836	556,629	2.54%	703,775	694,060	-1.38%	77.13%	80.20%	3.07%
	Manhattan	202,868	208,514	2.78%	295,836	287,240	-2.91%	68.57%	72.59%	4.02%
	Queens	339,253	354,305	4.44%	433,164	432,573	-0.14%	78.32%	81.91%	3.59%
	Staten Island	45,079	47,336	5.01%	59,757	59,866	0.18%	75.44%	79.07%	3.63%

Source: Copy of EN06 and Copy of EN07

The Managed Care eligible counts are based upon November, 2006 total eligibles adjusted for excluded populations.

Exhibit 2-1: Number of Practitioners in Managed Care by County and Specialty: 2006 and 2007							
		Number in Medicaid			Participation Rate/1,000		
County	Specialty	2006	2007	Percent Change	2006	2007	Percent Change
Albany	Primary Care	383	378	-1.3%	23.6	22.4	-5.1%
	OB/GYN	104	99	-4.8%	6.4	5.9	-8.4%
	Behavioral Health	467	438	-6.2%	28.8	26.0	-9.8%
	Other Specialty	2,036	1,874	-8.0%	125.6	111.2	-11.5%
	Non-PCP NP	120	116	-3.3%	7.4	6.9	-7.0%
	Dentistry	20	27	35.0%	1.2	1.6	29.9%
	Total Practitioners	3,130	2,932	-6.3%	193.0	173.9	-9.9%
	Enrollment	16,215	16,858	4.0%			
Allegany	Primary Care	51	46	-9.8%	46.8	15.6	-66.6%
	OB/GYN	8	7	-12.5%	7.3	2.4	-67.6%
	Behavioral Health	16	15	-6.3%	14.7	5.1	-65.3%
	Other Specialty	125	141	12.8%	114.7	47.9	-58.3%
	Non-PCP NP	2	2	0.0%	1.8	0.7	-63.0%
	Dentistry	1	1	0.0%	0.9	0.3	-63.0%
	Total	203	212	4.4%	186.2	72.0	-61.3%
	Enrollment	1,090	2,945	170.2%			
Bronx	Primary Care	1,582	1,615	2.1%	4.5	4.4	-1.6%
	OB/GYN	470	457	-2.8%	1.3	1.2	-6.3%
	Behavioral Health	902	891	-1.2%	2.5	2.4	-4.8%
	Other Specialty	4,166	4,520	8.5%	11.7	12.3	4.6%
	Non-PCP NP	104	170	63.5%	0.3	0.5	57.5%
	Dentistry	440	428	-2.7%	1.2	1.2	-6.3%
	Total	7,664	8,081	5.4%	21.6	21.9	1.6%
	Enrollment	355,391	368,797	3.8%			
Broome	Primary Care	177	203	14.7%	12.5	14.6	16.6%
	OB/GYN	39	47	20.5%	2.8	3.4	22.6%
	Behavioral Health	166	189	13.9%	11.8	13.6	15.8%
	Other Specialty	537	581	8.2%	38.1	41.9	10.0%
	Non-PCP NP	19	27	42.1%	1.3	1.9	44.5%

	Dentistry	14	9	-35.7%	1.0	0.6	-34.6%
	Total	952	1,056	10.9%	67.5	76.1	12.8%
	Enrollment	14,113	13,877	-1.7%			
Cattaraugus	Primary Care	71	67	-5.6%	12.5	12.0	-4.0%
	OB/GYN	10	8	-20.0%	1.8	1.4	-18.6%
	Behavioral Health	32	32	0.0%	5.6	5.7	1.7%
	Other Specialty	305	346	13.4%	53.5	61.8	15.4%
	Non-PCP NP	13	14	7.7%	2.3	2.5	9.5%
	Dentistry	4	14	250.0%	0.7	2.5	256.0%
	Total	435	481	10.6%	76.3	85.8	12.5%
	Enrollment	5,699	5,603	-1.7%			
Cayuga	Primary Care	48	27	-43.8%	-	-	-
	OB/GYN	5	2	-60.0%	-	-	-
	Behavioral Health	8	12	50.0%	-	-	-
	Other Specialty	192	189	-1.6%	-	-	-
	Non-PCP NP	1	2	100.0%	-	-	-
	Dentistry	0	2	-	-	-	-
	Total	254	234	-7.9%	-	-	-
	Enrollment	0	0	0.0%			
Chautauqua	Primary Care	103	106	2.9%	8.5	8.6	0.8%
	OB/GYN	13	15	15.4%	1.1	1.2	13.0%
	Behavioral Health	58	61	5.2%	4.8	4.9	3.0%
	Other Specialty	461	452	-2.0%	38.1	36.6	-3.9%
	Non-PCP NP	16	15	-6.3%	1.3	1.2	-8.2%
	Dentistry	12	20	66.7%	1.0	1.6	63.3%
	Total	662	669	1.1%	54.7	54.2	-1.0%
	Enrollment	12,094	12,345	2.1%			
Chemung	Primary Care	74	61	-17.6%	16.2	11.0	-31.8%
	OB/GYN	6	8	33.3%	1.3	1.4	10.4%
	Behavioral Health	18	39	116.7%	3.9	7.1	79.4%
	Other Specialty	177	195	10.2%	38.7	35.3	-8.8%
	Non-PCP NP	1	2	100.0%	0.2	0.4	65.6%
	Dentistry	3	2	-33.3%	0.7	0.4	-44.8%
	Total	279	307	10.0%	61.0	55.5	-8.9%
	Enrollment	4,577	5,529	20.8%			
Chenango	Primary Care	31	27	-12.9%	-	-	-
	OB/GYN	5	4	-20.0%	-	-	-

	Behavioral Health	25	36	44.0%	-	-	-
	Other Specialty	87	83	-4.6%	-	-	-
	Non-PCP NP	1	1	0.0%	-	-	-
	Dentistry	0	0	0.0%	-	-	-
	Total	149	151	1.3%	-	-	-
	Enrollment	0	0	0.0%			
Clinton	Primary Care	55	53	-3.6%	-	535.4	-
	OB/GYN	23	14	-39.1%	-	141.4	-
	Behavioral Health	38	37	-2.6%	-	373.7	-
	Other Specialty	161	183	13.7%	-	1848.5	-
	Non-PCP NP	6	4	-33.3%	-	40.4	-
	Dentistry	3	4	33.3%	-	40.4	-
	Total	306	295	-3.6%	-	2979.8	-
	Enrollment	0	99	-			
Columbia	Primary Care	56	57	1.8%	22.8	20.9	-8.0%
	OB/GYN	12	12	0.0%	4.9	4.4	-9.7%
	Behavioral Health	77	68	-11.7%	31.3	25.0	-20.2%
	Other Specialty	278	165	-40.6%	113.0	60.6	-46.4%
	Non-PCP NP	17	15	-11.8%	6.9	5.5	-20.3%
	Dentistry	10	9	-10.0%	4.1	3.3	-18.7%
	Total	450	426	-5.3%	182.9	156.4	-14.5%
	Enrollment	2,461	2,724	10.7%			
Cortland	Primary Care	42	34	-19.0%	46.3	12.3	-73.4%
	OB/GYN	5	4	-20.0%	5.5	1.4	-73.7%
	Behavioral Health	14	25	78.6%	15.4	9.1	-41.4%
	Other Specialty	207	215	3.9%	228.2	77.8	-65.9%
	Non-PCP NP	3	3	0.0%	3.3	1.1	-67.2%
	Dentistry	8	8	0.0%	8.8	2.9	-67.2%
	Total	279	269	-3.6%	307.6	97.4	-68.3%
	Enrollment	907	2,762	204.5%			
Delaware	Primary Care	33	35	6.1%	-	-	-
	OB/GYN	4	3	-25.0%	-	-	-
	Behavioral Health	30	34	13.3%	-	-	-
	Other Specialty	195	188	-3.6%	-	-	-
	Non-PCP NP	0	1	-	-	-	-
	Dentistry	0	1	-	-	-	-
	Total	262	262	0.0%	-	-	-

	Enrollment	0	0	0.0%			
Dutchess	Primary Care	225	212	-5.8%	31.6	23.7	-25.0%
	OB/GYN	48	57	18.8%	6.7	6.4	-5.4%
	Behavioral Health	385	396	2.9%	54.0	44.3	-18.1%
	Other Specialty	974	1,005	3.2%	136.7	112.4	-17.8%
	Non-PCP NP	37	44	18.9%	5.2	4.9	-5.3%
	Dentistry	38	38	0.0%	5.3	4.2	-20.3%
	Total	1,707	1,752	2.6%	239.6	195.9	-18.2%
	Enrollment	7,124	8,944	25.5%			
Erie	Primary Care	936	961	2.7%	13.6	13.5	-1.3%
	OB/GYN	168	178	6.0%	2.4	2.5	1.9%
	Behavioral Health	571	574	0.5%	8.3	8.0	-3.3%
	Other Specialty	3,735	3,646	-2.4%	54.4	51.0	-6.1%
	Non-PCP NP	339	367	8.3%	4.9	5.1	4.1%
	Dentistry	88	106	20.5%	1.3	1.5	15.8%
	Total	5,837	5,832	-0.1%	85.0	81.6	-3.9%
	Enrollment	68,693	71,442	4.0%			
Essex	Primary Care	39	27	-30.8%	-	216.0	-
	OB/GYN	5	6	20.0%	-	48.0	-
	Behavioral Health	16	17	6.3%	-	136.0	-
	Other Specialty	118	96	-18.6%	-	768.0	-
	Non-PCP NP	2	2	0.0%	-	16.0	-
	Dentistry	4	3	-25.0%	-	24.0	-
	Total	184	151	-17.9%	-	1208.0	-
	Enrollment	0	125	-			
Franklin	Primary Care	30	32	6.7%	-	-	-
	OB/GYN	14	9	-35.7%	-	-	-
	Behavioral Health	27	23	-14.8%	-	-	-
	Other Specialty	71	90	26.8%	-	-	-
	Non-PCP NP	2	6	200.0%	-	-	-
	Dentistry	2	3	50.0%	-	-	-
	Total	146	163	11.6%	-	-	-
	Enrollment	0	0	0.0%			
Fulton	Primary Care	50	51	2.0%	50.8	11.8	-76.7%
	OB/GYN	8	8	0.0%	8.1	1.9	-77.1%
	Behavioral Health	25	30	20.0%	25.4	7.0	-72.6%
	Other Specialty	205	188	-8.3%	208.3	43.7	-79.0%

	Non-PCP NP	11	10	-9.1%	11.2	2.3	-79.2%
	Dentistry	2	2	0.0%	2.0	0.5	-77.1%
	Total	301	289	-4.0%	305.9	67.1	-78.0%
	Enrollment	984	4,304	337.4%			
Genesee	Primary Care	45	44	-2.2%	12.7	12.6	-0.7%
	OB/GYN	6	6	0.0%	1.7	1.7	1.6%
	Behavioral Health	27	28	3.7%	7.6	8.0	5.3%
	Other Specialty	243	265	9.1%	68.7	76.1	10.8%
	Non-PCP NP	16	17	6.3%	4.5	4.9	7.9%
	Dentistry	1	1	0.0%	0.3	0.3	1.6%
	Total	338	361	6.8%	95.6	103.7	8.5%
	Enrollment	3,535	3,480	-1.6%			
Greene	Primary Care	46	47	2.2%	15.5	15.9	3.0%
	OB/GYN	10	9	-10.0%	3.4	3.0	-9.3%
	Behavioral Health	27	32	18.5%	9.1	10.8	19.4%
	Other Specialty	184	181	-1.6%	61.8	61.3	-0.9%
	Non-PCP NP	7	8	14.3%	2.4	2.7	15.2%
	Dentistry	3	5	66.7%	1.0	1.7	68.0%
	Total	277	282	1.8%	93.0	95.5	2.6%
	Enrollment	2,977	2,954	-0.8%			
Hamilton	Primary Care	33	16	-51.5%	-	1333.3	-
	OB/GYN	2	0	-100.0%	-	0.0	-
	Behavioral Health	0	0	0.0%	-	0.0	-
	Other Specialty	9	6	-33.3%	-	500.0	-
	Non-PCP NP	1	1	0.0%	-	83.3	-
	Dentistry	0	0	0.0%	-	0.0	-
	Total	45	23	-48.9%	-	1916.7	-
	Enrollment	0	12	-			
Herkimer	Primary Care	58	61	5.2%	12.2	12.4	1.4%
	OB/GYN	7	9	28.6%	1.5	1.8	24.0%
	Behavioral Health	19	14	-26.3%	4.0	2.8	-29.0%
	Other Specialty	247	259	4.9%	51.9	52.5	1.1%
	Non-PCP NP	3	5	66.7%	0.6	1.0	60.7%
	Dentistry	1	4	300.0%	0.2	0.8	285.7%
	Total	335	352	5.1%	70.4	71.3	1.3%
	Enrollment	4,759	4,936	3.7%			
Jefferson	Primary Care	58	47	-19.0%	-	-	-

	OB/GYN	14	8	-42.9%	-	-	-
	Behavioral Health	17	31	82.4%	-	-	-
	Other Specialty	145	189	30.3%	-	-	-
	Non-PCP NP	0	0	0.0%	-	-	-
	Dentistry	10	16	60.0%	-	-	-
	Total	244	261	7.0%	-	-	-
	Enrollment	0	0	0.0%			
Kings	Primary Care	2,753	2,560	-7.0%	5.1	4.6	-9.3%
	OB/GYN	616	619	0.5%	1.1	1.1	-2.0%
	Behavioral Health	1,769	1,650	-6.7%	3.3	3.0	-9.0%
	Other Specialty	6,604	6,591	-0.2%	12.2	11.8	-2.7%
	Non-PCP NP	75	75	0.0%	0.1	0.1	-2.5%
	Dentistry	1,044	962	-7.9%	1.9	1.7	-10.1%
	Total	12,861	12,457	-3.1%	23.7	22.4	-5.5%
	Enrollment	542,836	556,629	2.5%			
Lewis	Primary Care	20	16	-20.0%	-	-	-
	OB/GYN	6	4	-33.3%	-	-	-
	Behavioral Health	1	4	300.0%	-	-	-
	Other Specialty	41	30	-26.8%	-	-	-
	Non-PCP NP	0	2	-	-	-	-
	Dentistry	0	1	-	-	-	-
	Total	68	57	-16.2%	-	-	-
	Enrollment	0	0	0.0%			
Livingston	Primary Care	45	44	-2.2%	15.0	16.1	6.8%
	OB/GYN	6	7	16.7%	2.0	2.6	27.4%
	Behavioral Health	23	30	30.4%	7.7	11.0	42.4%
	Other Specialty	108	113	4.6%	36.1	41.3	14.3%
	Non-PCP NP	3	3	0.0%	1.0	1.1	9.2%
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	185	197	6.5%	61.9	71.9	16.3%
	Enrollment	2,991	2,739	-8.4%			
Madison	Primary Care	64	45	-29.7%	-	-	-
	OB/GYN	9	8	-11.1%	-	-	-
	Behavioral Health	21	25	19.0%	-	-	-
	Other Specialty	248	195	-21.4%	-	-	-
	Non-PCP NP	2	1	-50.0%	-	-	-
	Dentistry	1	1	0.0%	-	-	-

	Total	345	275	-20.3%	-	-	-
	Enrollment	0	0	0.0%			
Manhattan	Primary Care	2,161	2,168	0.3%	10.7	10.4	-2.4%
	OB/GYN	665	670	0.8%	3.3	3.2	-2.0%
	Behavioral Health	3,083	2,551	-17.3%	15.2	12.2	-19.5%
	Other Specialty	9,243	9,445	2.2%	45.6	45.3	-0.6%
	Non-PCP NP	120	154	28.3%	0.6	0.7	24.9%
	Dentistry	543	541	-0.4%	2.7	2.6	-3.1%
	Total	15,815	15,529	-1.8%	78.0	74.5	-4.5%
	Enrollment	202,868	208,514	2.8%			
Monroe	Primary Care	727	756	4.0%	13.2	13.0	-1.3%
	OB/GYN	178	186	4.5%	3.2	3.2	-0.9%
	Behavioral Health	522	543	4.0%	9.5	9.4	-1.3%
	Other Specialty	2,051	2,274	10.9%	37.3	39.3	5.2%
	Non-PCP NP	57	60	5.3%	1.0	1.0	-0.1%
	Dentistry	22	33	50.0%	0.4	0.6	42.3%
	Total	3,557	3,852	8.3%	64.7	66.5	2.7%
	Enrollment	54,968	57,936	5.4%			
Montgomery	Primary Care	43	48	11.6%	34.4	11.9	-65.5%
	OB/GYN	7	6	-14.3%	5.6	1.5	-73.5%
	Behavioral Health	27	33	22.2%	21.6	8.2	-62.2%
	Other Specialty	316	274	-13.3%	253.0	67.9	-73.2%
	Non-PCP NP	12	10	-16.7%	9.6	2.5	-74.2%
	Dentistry	3	4	33.3%	2.4	1.0	-58.8%
	Total	408	375	-8.1%	326.7	92.9	-71.6%
	Enrollment	1,249	4,038	223.3%			
Nassau	Primary Care	1,374	1,060	-22.9%	26.2	24.1	-7.9%
	OB/GYN	277	248	-10.5%	5.3	5.6	6.9%
	Behavioral Health	1,317	935	-29.0%	25.1	21.3	-15.2%
	Other Specialty	4,472	4,040	-9.7%	85.3	92.0	7.9%
	Non-PCP NP	42	48	14.3%	0.8	1.1	36.4%
	Dentistry	266	248	-6.8%	5.1	5.6	11.3%
	Total	7,748	6,579	-15.1%	147.8	149.8	1.4%
	Enrollment	52,427	43,913	-16.2%			
Niagara	Primary Care	155	152	-1.9%	9.7	9.5	-1.9%
	OB/GYN	35	38	8.6%	2.2	2.4	8.7%
	Behavioral Health	99	99	0.0%	6.2	6.2	0.1%

	Other Specialty	812	836	3.0%	50.9	52.5	3.0%
	Non-PCP NP	45	46	2.2%	2.8	2.9	2.3%
	Dentistry	20	33	65.0%	1.3	2.1	65.1%
	Total	1,166	1,204	3.3%	73.1	75.6	3.3%
	Enrollment	15,946	15,933	-0.1%			
Oneida	Primary Care	229	189	-17.5%	13.2	10.3	-22.4%
	OB/GYN	32	29	-9.4%	1.8	1.6	-14.7%
	Behavioral Health	140	146	4.3%	8.1	7.9	-1.9%
	Other Specialty	642	607	-5.5%	37.1	33.0	-11.1%
	Non-PCP NP	24	26	8.3%	1.4	1.4	1.9%
	Dentistry	6	7	16.7%	0.3	0.4	9.7%
	Total	1,073	1,004	-6.4%	62.0	54.6	-12.0%
	Enrollment	17,305	18,396	6.3%			
Onondaga	Primary Care	518	372	-28.2%	16.7	11.9	-28.8%
	OB/GYN	108	103	-4.6%	3.5	3.3	-5.5%
	Behavioral Health	316	344	8.9%	10.2	11.0	7.9%
	Other Specialty	1,762	1,641	-6.9%	56.9	52.5	-7.7%
	Non-PCP NP	65	69	6.2%	2.1	2.2	5.2%
	Dentistry	31	42	35.5%	1.0	1.3	34.3%
	Total	2,800	2,571	-8.2%	90.4	82.3	-9.0%
	Enrollment	30,963	31,234	0.9%			
Ontario	Primary Care	78	78	0.0%	15.6	16.0	2.8%
	OB/GYN	25	22	-12.0%	5.0	4.5	-9.5%
	Behavioral Health	48	49	2.1%	9.6	10.1	5.0%
	Other Specialty	400	432	8.0%	79.9	88.7	11.0%
	Non-PCP NP	3	3	0.0%	0.6	0.6	2.8%
	Dentistry	0	1	-	0.0	0.2	-
	Total	554	585	5.6%	110.7	120.1	8.6%
	Enrollment	5,006	4,869	-2.7%			
Orange	Primary Care	363	355	-2.2%	28.5	13.5	-52.6%
	OB/GYN	101	95	-5.9%	7.9	3.6	-54.4%
	Behavioral Health	272	279	2.6%	21.4	10.6	-50.3%
	Other Specialty	1,202	1,221	1.6%	94.4	46.5	-50.8%
	Non-PCP NP	28	33	17.9%	2.2	1.3	-42.9%
	Dentistry	44	52	18.2%	3.5	2.0	-42.7%
	Total	2,010	2,035	1.2%	157.9	77.5	-50.9%
	Enrollment	12,728	26,266	106.4%			

Orleans	Primary Care	26	24	-7.7%	8.2	7.4	-10.5%
	OB/GYN	12	13	8.3%	3.8	4.0	5.0%
	Behavioral Health	12	12	0.0%	3.8	3.7	-3.0%
	Other Specialty	62	81	30.6%	19.6	24.8	26.7%
	Non-PCP NP	7	7	0.0%	2.2	2.1	-3.0%
	Dentistry	0	1	-	0.0	0.3	-
	Total	119	138	16.0%	37.6	42.3	12.4%
	Enrollment	3,163	3,262	3.1%			
Oswego	Primary Care	115	75	-34.8%	10.5	7.0	-33.7%
	OB/GYN	12	12	0.0%	1.1	1.1	1.6%
	Behavioral Health	41	43	4.9%	3.7	4.0	6.5%
	Other Specialty	315	294	-6.7%	28.8	27.3	-5.2%
	Non-PCP NP	8	12	50.0%	0.7	1.1	52.4%
	Dentistry	12	15	25.0%	1.1	1.4	27.0%
	Total	503	451	-10.3%	46.0	41.9	-8.9%
	Enrollment	10,934	10,763	-1.6%			
Otsego	Primary Care	76	81	6.6%	4000.0	42.6	-98.9%
	OB/GYN	15	13	-13.3%	789.5	6.8	-99.1%
	Behavioral Health	47	60	27.7%	2473.7	31.5	-98.7%
	Other Specialty	345	302	-12.5%	18157.9	158.8	-99.1%
	Non-PCP NP	0	5	-	0.0	2.6	-
	Dentistry	3	3	0.0%	157.9	1.6	-99.0%
	Total	486	464	-4.5%	25578.9	244.0	-99.0%
	Enrollment	19	1,902	9910.5%			
Putnam	Primary Care	40	46	15.0%	68.6	36.4	-47.0%
	OB/GYN	18	18	0.0%	30.9	14.2	-53.9%
	Behavioral Health	86	118	37.2%	147.5	93.3	-36.8%
	Other Specialty	231	249	7.8%	396.2	196.8	-50.3%
	Non-PCP NP	3	7	133.3%	5.1	5.5	7.5%
	Dentistry	10	9	-10.0%	17.2	7.1	-58.5%
	Total	388	447	15.2%	665.5	353.4	-46.9%
	Enrollment	583	1,265	117.0%			
Queens	Primary Care	2,157	2,061	-4.5%	6.4	5.8	-8.5%
	OB/GYN	441	418	-5.2%	1.3	1.2	-9.2%
	Behavioral Health	1,612	1,507	-6.5%	4.8	4.3	-10.5%
	Other Specialty	5,365	5,270	-1.8%	15.8	14.9	-5.9%
	Non-PCP NP	71	68	-4.2%	0.2	0.2	-8.3%

	Dentistry	839	808	-3.7%	2.5	2.3	-7.8%
	Total	10,485	10,132	-3.4%	30.9	28.6	-7.5%
	Enrollment	339,253	354,305	4.4%			
Rensselaer	Primary Care	163	145	-11.0%	15.4	13.2	-14.3%
	OB/GYN	32	30	-6.3%	3.0	2.7	-9.7%
	Behavioral Health	104	119	14.4%	9.9	10.9	10.2%
	Other Specialty	774	691	-10.7%	73.3	63.1	-14.0%
	Non-PCP NP	32	27	-15.6%	3.0	2.5	-18.7%
	Dentistry	8	10	25.0%	0.8	0.9	20.4%
	Total	1,113	1,022	-8.2%	105.5	93.3	-11.6%
	Enrollment	10,554	10,959	3.8%			
Richmond	Primary Care	478	405	-15.3%	10.6	8.6	-19.3%
	OB/GYN	100	87	-13.0%	2.2	1.8	-17.1%
	Behavioral Health	364	303	-16.8%	8.1	6.4	-20.7%
	Other Specialty	1,355	1,289	-4.9%	30.1	27.2	-9.4%
	Non-PCP NP	9	9	0.0%	0.2	0.2	-4.8%
	Dentistry	116	123	6.0%	2.6	2.6	1.0%
	Total	2,422	2,216	-8.5%	53.7	46.8	-12.9%
	Enrollment	45,079	47,336	5.0%			
Rockland	Primary Care	224	219	-2.2%	7.8	7.2	-7.3%
	OB/GYN	69	67	-2.9%	2.4	2.2	-7.9%
	Behavioral Health	213	294	38.0%	7.4	9.7	30.9%
	Other Specialty	730	727	-0.4%	25.3	23.9	-5.6%
	Non-PCP NP	7	7	0.0%	0.2	0.2	-5.2%
	Dentistry	87	88	1.1%	3.0	2.9	-4.1%
	Total	1,330	1,402	5.4%	46.2	46.1	-0.1%
	Enrollment	28,804	30,383	5.5%			
St Lawrence	Primary Care	41	44	7.3%	-	-	-
	OB/GYN	7	8	14.3%	-	-	-
	Behavioral Health	5	10	100.0%	-	-	-
	Other Specialty	112	134	19.6%	-	-	-
	Non-PCP NP	0	0	0.0%	-	-	-
	Dentistry	7	7	0.0%	-	-	-
	Total	172	203	18.0%	-	-	-
	Enrollment	0	0	0.0%			
Saratoga	Primary Care	184	167	-9.2%	30.5	27.6	-9.6%
	OB/GYN	56	49	-12.5%	9.3	8.1	-12.8%

	Behavioral Health	193	179	-7.3%	32.0	29.6	-7.6%
	Other Specialty	965	858	-11.1%	159.9	141.7	-11.4%
	Non-PCP NP	43	19	-55.8%	7.1	3.1	-56.0%
	Dentistry	12	15	25.0%	2.0	2.5	24.6%
	Total	1,453	1,287	-11.4%	240.7	212.5	-11.7%
	Enrollment	6,036	6,057	0.3%			
Schenectady	Primary Care	138	136	-1.4%	26.9	18.5	-31.1%
	OB/GYN	32	26	-18.8%	6.2	3.5	-43.2%
	Behavioral Health	122	112	-8.2%	23.8	15.3	-35.9%
	Other Specialty	601	535	-11.0%	117.1	72.8	-37.8%
	Non-PCP NP	29	11	-62.1%	5.7	1.5	-73.5%
	Dentistry	9	19	111.1%	1.8	2.6	47.5%
	Total	931	839	-9.9%	181.4	114.2	-37.0%
	Enrollment	5,131	7,344	43.1%			
Schoharie	Primary Care	17	19	11.8%	173.5	159.7	-8.0%
	OB/GYN	1	1	0.0%	10.2	8.4	-17.6%
	Behavioral Health	15	22	46.7%	153.1	184.9	20.8%
	Other Specialty	61	30	-50.8%	622.4	252.1	-59.5%
	Non-PCP NP	1	2	100.0%	10.2	16.8	64.7%
	Dentistry	0	1	-	0.0	8.4	-
	Total	95	75	-21.1%	969.4	630.3	-35.0%
	Enrollment	98	119	21.4%			
Schuyler	Primary Care	12	11	-8.3%	52.9	65.1	23.1%
	OB/GYN	3	2	-33.3%	13.2	11.8	-10.5%
	Behavioral Health	1	5	400.0%	4.4	29.6	571.6%
	Other Specialty	36	42	16.7%	158.6	248.5	56.7%
	Non-PCP NP	0	0	0.0%	0.0	0.0	-
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	52	60	15.4%	229.1	355.0	55.0%
	Enrollment	227	169	-25.6%			
Seneca	Primary Care	11	11	0.0%	7.0	6.2	-12.0%
	OB/GYN	1	1	0.0%	0.6	0.6	-12.0%
	Behavioral Health	3	2	-33.3%	1.9	1.1	-41.4%
	Other Specialty	13	15	15.4%	8.3	8.4	1.5%
	Non-PCP NP	0	0	0.0%	0.0	0.0	-
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	28	29	3.6%	17.8	16.2	-8.9%

	Enrollment	1,570	1,785	13.7%			
Steuben	Primary Care	77	69	-10.4%	36.0	32.1	-10.9%
	OB/GYN	10	11	10.0%	4.7	5.1	9.3%
	Behavioral Health	23	29	26.1%	10.8	13.5	25.3%
	Other Specialty	195	193	-1.0%	91.2	89.8	-1.6%
	Non-PCP NP	2	2	0.0%	0.9	0.9	-0.6%
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	307	304	-1.0%	143.7	141.4	-1.6%
	Enrollment	2,137	2,150	0.6%			
Suffolk	Primary Care	942	721	-23.5%	18.5	14.4	-22.4%
	OB/GYN	185	172	-7.0%	3.6	3.4	-5.7%
	Behavioral Health	1,252	846	-32.4%	24.6	16.9	-31.5%
	Other Specialty	3,127	2,931	-6.3%	61.4	58.4	-4.9%
	Non-PCP NP	101	89	-11.9%	2.0	1.8	-10.6%
	Dentistry	223	207	-7.2%	4.4	4.1	-5.9%
	Total	5,830	4,966	-14.8%	114.5	98.9	-13.6%
	Enrollment	50,909	50,201	-1.4%			
Sullivan	Primary Care	76	87	14.5%	18.4	15.5	-15.9%
	OB/GYN	20	21	5.0%	4.8	3.7	-22.9%
	Behavioral Health	46	50	8.7%	11.1	8.9	-20.2%
	Other Specialty	270	293	8.5%	65.3	52.0	-20.3%
	Non-PCP NP	9	11	22.2%	2.2	2.0	-10.2%
	Dentistry	15	16	6.7%	3.6	2.8	-21.7%
	Total	436	478	9.6%	105.4	84.9	-19.5%
	Enrollment	4,135	5,631	36.2%			
Tioga	Primary Care	17	21	23.5%	81.3	84.7	4.1%
	OB/GYN	1	0	-100.0%	4.8	0.0	-100.0%
	Behavioral Health	17	38	123.5%	81.3	153.2	88.4%
	Other Specialty	12	16	33.3%	57.4	64.5	12.4%
	Non-PCP NP	0	2	-	0.0	8.1	-
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	47	77	63.8%	224.9	310.5	38.1%
	Enrollment	209	248	18.7%			
Tompkins	Primary Care	56	64	14.3%	40.2	40.2	0.1%
	OB/GYN	17	17	0.0%	12.2	10.7	-12.4%
	Behavioral Health	48	54	12.5%	34.4	33.9	-1.5%
	Other Specialty	197	221	12.2%	141.3	138.8	-1.8%

	Non-PCP NP	1	1	0.0%	0.7	0.6	-12.4%
	Dentistry	4	4	0.0%	2.9	2.5	-12.4%
	Total	323	361	11.8%	231.7	226.8	-2.1%
	Enrollment	1,394	1,592	14.2%			
Ulster	Primary Care	180	161	-10.6%	30.4	18.2	-40.2%
	OB/GYN	28	29	3.6%	4.7	3.3	-30.8%
	Behavioral Health	226	239	5.8%	38.1	27.0	-29.3%
	Other Specialty	643	648	0.8%	108.5	73.1	-32.7%
	Non-PCP NP	15	25	66.7%	2.5	2.8	11.3%
	Dentistry	11	11	0.0%	1.9	1.2	-33.2%
	Total	1,103	1,113	0.9%	186.2	125.5	-32.6%
	Enrollment	5,924	8,867	49.7%			
Warren	Primary Care	103	84	-18.4%	182.6	140.9	-22.8%
	OB/GYN	29	23	-20.7%	51.4	38.6	-24.9%
	Behavioral Health	76	74	-2.6%	134.8	124.2	-7.9%
	Other Specialty	419	358	-14.6%	742.9	600.7	-19.1%
	Non-PCP NP	15	8	-46.7%	26.6	13.4	-49.5%
	Dentistry	10	6	-40.0%	17.7	10.1	-43.2%
	Total	652	553	-15.2%	1156.0	927.9	-19.7%
	Enrollment	564	596	5.7%			
Washington	Primary Care	74	42	-43.2%	52.7	13.5	-74.4%
	OB/GYN	5	2	-60.0%	3.6	0.6	-82.0%
	Behavioral Health	31	30	-3.2%	22.1	9.6	-56.4%
	Other Specialty	99	80	-19.2%	70.5	25.7	-63.6%
	Non-PCP NP	5	0	-100.0%	3.6	0.0	-100.0%
	Dentistry	1	1	0.0%	0.7	0.3	-54.9%
	Total	215	155	-27.9%	153.0	49.8	-67.5%
	Enrollment	1,405	3,115	121.7%			
Wayne	Primary Care	42	41	-2.4%	18.4	17.7	-3.6%
	OB/GYN	13	12	-7.7%	5.7	5.2	-8.8%
	Behavioral Health	9	10	11.1%	3.9	4.3	9.8%
	Other Specialty	110	118	7.3%	48.1	51.0	6.0%
	Non-PCP NP	0	0	0.0%	0.0	0.0	-
	Dentistry	1	1	0.0%	0.4	0.4	-1.2%
	Total	175	182	4.0%	76.6	78.7	2.7%
	Enrollment	2,286	2,314	1.2%			
Westchester	Primary Care	650	654	0.6%	15.5	13.9	-10.0%

	OB/GYN	208	207	-0.5%	4.9	4.4	-11.0%
	Behavioral Health	787	989	25.7%	18.7	21.0	12.4%
	Other Specialty	2,512	2,506	-0.2%	59.8	53.3	-10.8%
	Non-PCP NP	25	34	36.0%	0.6	0.7	21.6%
	Dentistry	164	145	-11.6%	3.9	3.1	-20.9%
	Total	4,346	4,535	4.3%	103.4	96.5	-6.7%
	Enrollment	42,022	46,993	11.8%			
Wyoming	Primary Care	34	30	-11.8%	-	-	-
	OB/GYN	4	4	0.0%	-	-	-
	Behavioral Health	13	11	-15.4%	-	-	-
	Other Specialty	127	117	-7.9%	-	-	-
	Non-PCP NP	2	3	50.0%	-	-	-
	Dentistry	0	0	0.0%	-	-	-
	Total	180	165	-8.3%	-	-	-
	Enrollment	0	0	0.0%			
Yates	Primary Care	16	15	-6.3%	11.3	9.2	-18.8%
	OB/GYN	5	4	-20.0%	3.5	2.5	-30.7%
	Behavioral Health	4	6	50.0%	2.8	3.7	29.9%
	Other Specialty	21	33	57.1%	14.9	20.3	36.1%
	Non-PCP NP	1	0	-100.0%	0.7	0.0	-100.0%
	Dentistry	0	0	0.0%	0.0	0.0	-
	Total	47	58	23.4%	33.3	35.6	6.9%
	Enrollment	1,411	1,629	15.5%			

Exhibit 2-2: Access to Care HEDIS/CAHPS Measures New York and National Results by Year, 2006 and 2007							
	New York			National			
Primary Care	2006	2007	Percent Change	2006	2007	Percent Change	Difference
Well-Child Visits in the First 15 Months of Life (5 or more visits)*	69%	79%	14.5%	67%	70%	4.5%	10.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	76%	81%	6.6%	63%	65%	3.2%	3.4%
Adolescent Well-Care and Preventive Visits*	49%	58%	18.4%	41%	42%	2.4%	15.9%
Getting Needed Care*	70%	75%	N/A	74%	75%	N/A	
Getting Care Quickly*	74%	78%	N/A	72%	80%	N/A	
Timeliness of Prenatal Care**	86%			81%			
Post-partum Care**	70%			59%			
CAP 12-24 months	93%	95%	2.2%	94%	93%	-1.1%	3.2%
CAP 25-26 years	89%	90%	1.1%	85%	84%	-1.2%	2.3%
CAP 7-11y	91%	93%	2.2%	86%	86%	0.0%	2.2%
CAP 12-19y	87%	88%	1.1%	83%	83%	0.0%	1.1%
AAP 20-44	79%	80%	1.3%	78%	77%	-1.3%	2.5%

AAP 45-64	86%	87%	1.2%	83%	82%	-1.2%	2.4%
AAP 65+	89%	88%	-1.1%	80%	79%	-1.3%	0.1%
Childhood Immunization Status (combo 3)	47%	70%	48.9%		65%		
Specialty Care							
Ratings of Specialist seen most often*	74%	71%	N/A	76%	76%	N/A	
How much of a problem was it to get a referral to a specialist (Not a Problem)?*	70%	71%	N/A	65%	73%	N/A	

* Measure was rotated out in 2006, 2005 data displayed for 2006.
** Measure was rotated out in 2007, 2006 data displayed for 2007.
CAP=Children and Adolescents/ Access to Primary Care Practitioner
AAP= Adults' Access to Preventive/Ambulatory Services

Exhibit 3-1: Quality Performance Measures, 2006 and 2007
Medicaid Managed Care and Commercial Managed Care Plans

	New York Medicaid MCO			New York Commercial MCO			Gap Medicaid to Commercial			Medicaid Benchmarks		%age Point Difference NY to National	
Quality Measures	2006	2007	Percent Change	2006	2007	Percent Change	Gap 2006	Gap 2007	%age Point Change	2006	2007	2006	2007
Child Preventive Care													
Childhood Immunization Status (Combination 2:4-3-1-3-3-1)*	73%			76%			-3%			70%		3%	
Childhood Immunization Status (Combination 3:4-3-1-3-3-1-4)*		70%			73%			-3%			65%		5%
Lead Screening in Children*	86%	86%	0%	72%	77%	7%	14%	9%	-5%	NA	NA		
Well-Child Visits in first 15 months (5+ Visits)*	69%	79%	14%	90%	91%	1%	-21%	-12%	9%	67%	70%	2%	9%
Well-Child Visits in 3rd, 4th, 5th, or 6th Year of Life*	76%	81%	7%	82%	82%	0%	-6%	-1%	5%	63%	65%	13%	16%
Adolescent Well-Care Visits*	49%	58%	18%	55%	59%	7%	-6%	-1%	5%	41%	42%	8%	16%
Annual Dental Visit	44%	45%	2%							42%	44%	2%	1%
Adolescent Preventive Care													
BMI Screening	39%	61%	56%	46%	53%	15%	-7%	8%	15%	NA	NA		
Nutrition	61%	71%	16%	72%	71%	-1%	-11%	0%	11%	NA	NA		
Exercise	49%	60%	22%	70%	65%	-7%	-21%	-5%	16%	NA	NA		

Sexual Health	61%	73%	20%	66%	67%	2%	-5%	6%	11%	NA	NA		
Depression	40%	53%	33%	44%	44%	0%	-4%	9%	13%	NA	NA		
Tobacco Use	63%	76%	21%	72%	69%	-4%	-9%	7%	16%	NA	NA		
Substance Use	64%	74%	16%	73%	70%	-4%	-9%	4%	13%	NA	NA		
Caring for Children and Adolescents with Illness													
Appropriate Treatment for Children With Upper Respiratory Infection	86%	89%	3%	85%	85%	0%	1%	4%	3%	83%	84%	3%	5%
Appropriate Testing for Children With Pharyngitis	64%	73%	14%	80%	83%	4%	-16%	-10%	6%	56%	59%	8%	14%
Use of Appropriate Medicaitons in People With Asthma (Ages 5-9 and 10-17 years)	92%	92%	0%	95%	95%	0%	-3%	-3%	0%	NA	NA		
Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)	39%	53%	36%	36%	37%	3%	3%	16%	13%	32%	34%	7%	19%
Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)	39%	59%	51%	36%	40%	11%	3%	19%	16%		39%		20%
Women's Health													
Breast Cancer Screening	62%	64%	3%	68%	68%	0%	-6%	-4%	2%	49%	50%	13%	14%
Cervical Cancer Screening**	74%			82%			-8%			66%		8%	
Chlamydia Screening in Women (16-20 years)	48%	53%	10%	43%	45%	5%	5%	8%	3%	51%	49%	-3%	4%
Chlamydia Screening in Women (21-25 years)	53%	60%	13%	49%	51%	4%	4%	9%	5%	55%	54%	-2%	6%
Prenatal and Postpartum Care- Timeliness of Prenatal Care**	86%			92%	92%	0%	-6%			81%		5%	
Prenatal and Postpartum Care- Postpartum Care**	70%			76%			-6%			59%		11%	

Frequency of Ongoing Prenatal Care**	69%												
Risk-Adjusted Low Birthweight (LBW)**	8%			5%			3%						
Prenatal Care in the Fisrt Trimester**	71%			88%			-17%						
Percent of LBW Births at Level II/III/IV Facitlities**	93%			91%			2%						
Adults Living with Illness													
Managing Acute Illness													
Colorectal Cancer Screening*				59%	61%	3%							
Use of Imaging Studies for Low Back Pain	82%	81%	-1%	79%	78%	-1%	3%	3%	0%	78%	77%	4%	4%
Avoidance of Antibiotics for Adults With Bronchitis	28%	27%	-4%	27%	24%	-11%	1%	3%	2%	28%	26%	0%	1%
Medical Assistance With Smoking -Advising Smokers to Quit*	72%	74%	3%	77%	80%	4%	-5%	-6%	-1%	66%	69%	6%	5%
Medical Assistance With Smoking -Discussing Smoking Cessation Medications*		50%			56%			-6%			39%		11%
Medical Assistance With Smoking -Discussing Smoking Cessation Strategies*		46%			50%			-4%			39%		7%
Flu Shots for Older Adults*		43%			49%			-6%			NA		
Managing Cardiovascular and Respiratory Conditions													
Controlling High Blood Pressure**	60%			58%			2%			53%		7%	
Cholesterol Management for Patients With Cardiovascular Conditions- Cholesterol Screening	89%	89%	0%	90%	91%	1%	-1%	-2%	-1%	76%	76%	13%	
Cholesterol Management for Patients With Cardiovascular Conditions- Cholesterol Level Controlled (<100 mg/dL)	46%	47%	2%	54%	60%	11%	-8%	-13%	-5%	35%	38%	11%	9%

Persistence of Beta-Blocker Treatment After a Heart Attack				74%	77%	4%							
Appropriate Use of Medications in People With Asthma (18-56 years)	89%	90%	1%	91%	92%	1%	-2%	-2%	0%	85%	84%	4%	6%
Use of Spirometry Testing for COPD	40%	40%	0%	46%	46%	0%	-6%	-6%	0%	27%	28%	13%	12%
Comprehensive Diabetes Care													
Hemoglobin A1c (HbA1c) testing	86%	87%	1%	88%	88%	0%	-2%	-1%	1%	78%	77%	8%	10%
HbA1c good control (<7.0%)	35%			43%			-8%			30%		5%	
HbA1c poor control (>9.0%)		34%			28%			6%			48%		-14%
Eye exam (retinal) performed	57%	62%	9%	59%	60%	2%	-2%	2%	4%	51%	50%	6%	12%
LDL-C screening	85%	85%	0%	87%	87%	0%	-2%	-2%	0%	71%	71%	14%	14%
LDL-C control (<100 mg/dL)	39%	41%	5%	44%	45%	2%	-5%	-4%	1%	31%	31%	8%	10%
Medical attention for nephropathy	80%	82%	2%	79%	81%	3%	1%	1%	0%	75%	74%	5%	8%
Blood Pressure Controlled (<130/80 mm Hg)	30%	31%	3%	27%	30%	11%	3%	1%	-2%	30%	30%	0%	1%
Blood Pressure Controlled (<140/90 mm Hg)													
Annual Monitoring for Patients on Persistent Medications													
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (DMARD)	72%	74%	3%	83%	81%	-2%	-11%	-7%	4%	68%	68%	4%	6%
Annual Monitoring for Patients on Persistent Medications-ACE Inhibitors/ARBs	84%	85%	1%	78%	81%	4%	6%	4%	-2%	80%	83%	4%	2%
Annual Monitoring for Patients on Persistent Medications-Digoxin	87%	91%	5%	78%	83%	6%	9%	8%	-1%	83%	85%	4%	6%

Annual Monitoring for Patients on Persistent Medications-Diuretics	82%	84%	2%	77%	80%	4%	5%	4%	-1%	79%	81%	3%	3%
Annual Monitoring for Patients on Persistent Medications-Anticonvulsants	65%	65%	0%	61%	61%	0%	4%	4%	0%	64%	66%	1%	-1%
Annual Monitoring for Patients on Persistent Medications-Combined Rate	82%	84%	2%	77%	80%	4%	5%	4%	-1%	78%	80%	4%	4%
Pharmacotherapy Management of COPD Exacerbation - Corticosteroid*		50%			44%			6%					
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator*		77%			65%			12%					
Use of Appropriate Asthma Medications Ages 5-56 Yrs- 3+ Controllers (new 2007)		76%											
Antidepressant Medication Management													
Optimal Practitioner Contacts	29%			23%			6%			21%		8%	
Effective Acute Phase Treatment	42%	46%	10%	61%	62%	2%	-19%	-16%	3%	43%	43%	-1%	3%
Effective Continuation Phase Treatment	27%	29%	7%	45%	46%	2%	-18%	-17%	1%	28%	28%	-1%	1%
Follow-up After Hospitalization for Mental Illness													
Withing 7 Days	60%	60%	0%	63%	67%	6%	-3%	-7%	-4%	39%	43%	21%	17%
Within 30 Days	76%	77%	1%	78%	81%	4%	-2%	-4%	-2%	58%	61%	18%	16%
Access and Service													
Childeren and Adolescents' Access to Primary Care Practitioners 12-24m	93%	95%	2%	97%	96%	-1%	-4%	-1%	3%	94%	93%	-1%	2%
Childeren and Adolescents' Access to Primary Care Practitioners 25m-6y	89%	90%	1%	93%	94%	1%	-4%	-4%	0%	85%	84%	4%	6%
Childeren and Adolescents' Access to Primary Care Practitioners 7-11y	91%	93%	2%	94%	95%	1%	-3%	-2%	1%	86%	86%	5%	7%

Childeren and Adolescents' Access to Primary Care Practitioners 12-19y	87%	88%	1%	91%	91%	0%	-4%	-3%	1%	83%	83%	4%	5%
Adults' Access to Preventive/Ambulatory Health Services 20-44	79%	80%	1%	94%	94%	0%	-15%	-14%	1%	78%	77%	1%	3%
Adults' Access to Preventive/Ambulatory Health Services 45-64	86%	87%	1%	95%	95%	0%	-9%	-8%	1%	83%	82%	3%	5%
Adults' Access to Preventive/Ambulatory Health Services 65+	89%	88%	-1%	95%	95%	0%	-6%	-7%	-1%	80%	79%	9%	9%
Member Satisfaction													
Satisfaction with Provider Communication*	88%	88%	N/A	94%	93%	N/A	-6%	-5%		86%	87%	2%	1%
Satifaction with Personal Doctor or Nurse*	79%	74%	N/A	79%	81%	N/A	0%	-7%		77%	76%	2%	-2%
Satisfaction with Specialist*	74%	71%	N/A	80%	81%	N/A	-6%	-10%		76%	76%	-2%	-5%
Getting Care Needed*	70%	75%	N/A	86%	86%	N/A	-16%	-11%		74%	75%	-4%	0%
Received Services Quickly*	74%	78%	N/A	88%	88%	N/A	-14%	-10%		72%	80%	2%	-2%
Rating of All Health Care*	77%	65%	N/A	75%	75%	N/A	2%	-10%		73%	67%	4%	-2%
Customer Service*	75%	80%	N/A	80%	84%	N/A	-5%	-4%		69%	79%	6%	1%
Overall Rating of Health Plan*	75%	66%	N/A	62%	62%	N/A	13%	4%		72%	71%	3%	-5%

* Measure rotated out in 2006
** Measure rotated out in 2007

Exhibit 3-2: Statewide Average Rates of Selected Performance Measures, by Time Period and Plan Type						
	Commercial Plans			Medicaid Managed Care Plans		
Performance Measures	Pre-QI (1996-1999)	Post-QI (1%) (2000-2004)	Post-QI (3%) (2006-2007)	Pre-QI (1996-1999)	Post-QI (1%) (2000-2004)	Post-QI (3%) (2006-2007)
Women's Health						
Breast Cancer Screening						
Statewide Average Rate	71.7%	73.4%	68.3% *b	56.0% a	66.4% * a	63.1% c
Standard Error (N)	0.9	1.0	0.9	2.8	1.4	1.1
N	36	33	33	96	82	49
Postpartum Care						
Statewide Average Rate	70.9%	72.2%	NA	48.9% a	62.6% * a	NA
Standard Error	2.1	2.2	NA	1.9	1.3	NA
N	34	34	NA	85	111	NA
Children						
Lead Testing						
Statewide Average Rate	56.0%	65.7% *	NA	71.2% a	75.1% a	NA
Standard Error	2.3	1.4	NA	1.9	1.8	NA
N	35	19	NA	123	112	NA
Access to Primary Care, 12-24 Months						
Statewide Average Rate	86.3%	95.5% *	96.7% *	80.7%	88.5% * a	94.0% * b c
Standard Error	2.0	0.6	0.4	2.8	1.3	0.6
N	33	54	33	106	138	49
Access to Primary Care, 25 Months to 6 Years						
Statewide Average Rate	85.7%	90.6% *	93.5% *	74.7% a	83.5% * a	89.6% * b c
Standard Error	1.5	1.2	0.5	2.8	1.3	0.7
N	34	54	33	109	138	49
Access to Primary Care, 7-11 Years						
Statewide Average Rate	86.8%	91.0% *	94.3% * b	73.0% a	85.8% * a	91.9% * b c

Standard Error	1.5	1.2	0.5	3.7	1.1	0.6
N	33	53	33	102	138	49
Chronic Diseases						
Diabetes HbA1c Testing						
Statewide Average Rate	71.6%	81.4%*	88.1%*b	70.2%	81.8%*	85.4%*c
Standard Error	1.9	1.5	0.6	2.4	1.3	0.6
N	26	43	33	58	112	49
Diabetes Poor Control						
Statewide Average Rate	44.0%	37.4%	27.7%*b	53.7%a	44.0%*a	36.7%*b c
Standard Error	3.3	2.4	1.3	3.4	2.3	1.2
N	26	43	33	58	112	49
Mental Health						
Follow-Up After Hospitalization for Mental Illness, 30 Days						
Statewide Average Rate	63.0%	73.4%*	79.2%*b	47.4%a	66.6%*a	76.8%*b
Standard Error	2.0	1.7	1.5	3.7	2.3	1.2
N	42	43	33	113	109	49
Antidepressant Med. Mgmt. - 180 Day Effective Phase Treatment						
Statewide Average Rate	39.4%	42.5%	45.8%*b	25.1%a	28.8%a	27.9%c
Standard Error	3.0	0.9	0.6	2.3	2.1	1.4
N	21	54	33	54	134	49
Antidepressant Med. Mgmt. - 84 Day Acute Phase Treatment						
Statewide Average Rate	52.0%	58.2%	61.7%*b	41.8%a	44.3%a	43.6%c
Standard Error	4.1	0.8	0.8	2.7	2.2	1.6
N	21	54	33	54	134	49

Source: QARR Files, 1996-2004, 2006-2007. 1996-2004 analysis conducted by the Urban Institute.

*Significant difference from pre-QI period for either Medicaid or Commercial rates, p=.05.

[a] Significant difference between Medicaid and Commercial rates between the pre-QI and post-QI(1%) periods, p=.05.

[b] Significant difference for Medicaid and Commercial rates between pre-QI and post-QI (3%) periods, p=.05

[c] Significant difference between Medicaid and Commercial rates in post-QI(3%) period, p=.05.

Figure 3-1: Percentage of New York Medicaid Managed Care Plans Receiving A Quality Incentive 2001 - 2007

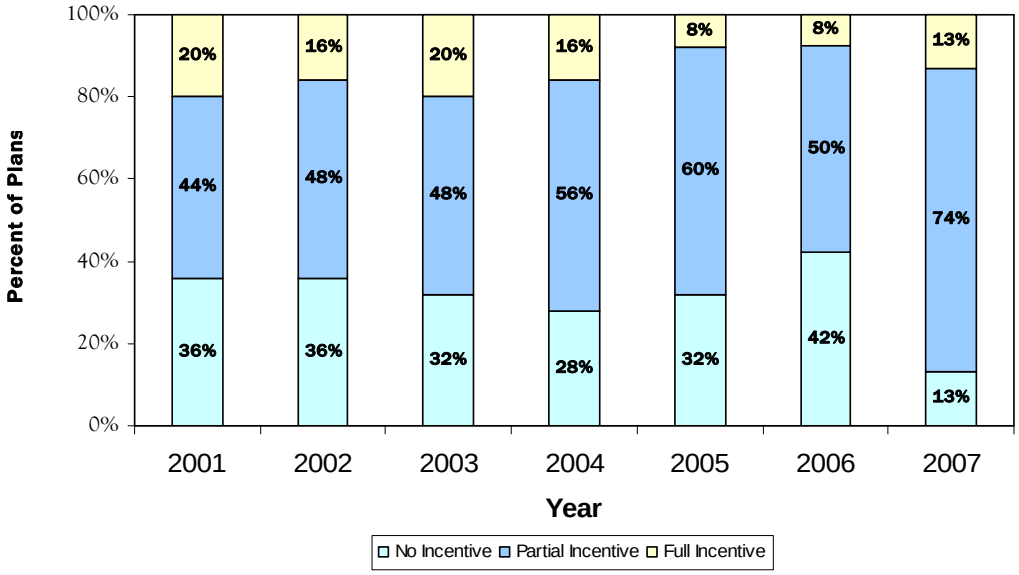

Exhibit 4-1: Family Health Plus Program Enrollment by County, 2006 and 2007			
	Number Enrolled		
County	2006	2007	Percent Change
Albany	2,979	2,929	-1.7%
Allegany	907	838	-7.6%
Broome	2,902	3,054	5.2%
Cattaraugus	1,602	1,544	-3.6%
Cayuga	981	954	-2.8%
Chautauqua	2,413	2,338	-3.1%
Chemung	1,462	1,373	-6.1%
Chenango	936	861	-8.0%
Clinton	1,187	1,168	-1.6%
Columbia	581	710	22.2%
Cortland	947	944	-0.3%
Delaware	586	627	7.0%
Dutchess	1,975	1,967	-0.4%
Erie	13,979	13,827	-1.1%
Essex	737	774	5.0%
Franklin	809	784	-3.1%
Fulton	1,083	1,247	15.1%
Genesee	951	921	-3.2%
Greene	673	599	-11.0%
Hamilton	75	70	-6.7%
Herkimer	1,459	1,414	-3.1%
Jefferson	1,939	1,852	-4.5%
Lewis	480	462	-3.8%
Livingston	677	712	5.2%
Madison	969	927	-4.3%
Monroe	9,019	8,876	-1.6%
Montgomery	968	1,017	5.1%
Nassau	19,703	15,015	-23.8%
Niagara	2,983	3,029	1.5%
Oneida	3,816	3,915	2.6%
Onondaga	6,409	6,152	-4.0%
Ontario	1,139	1,080	-5.2%
Orange	3,394	3,766	11.0%
Orleans	804	758	-5.7%
Oswego	2,780	2,762	-0.6%

Otsego	821	793	-3.4%
Putnam	379	372	-1.8%
Rensselaer	1,638	1,481	-9.6%
Rockland	4,788	4,950	3.4%
St Lawrence	1,657	1,603	-3.3%
Saratoga	1,931	1,976	2.3%
Schenectady	1,262	1,236	-2.1%
Schoharie	513	463	-9.7%
Schuyler	347	331	-4.6%
Seneca	442	441	-0.2%
Steuben	1,552	1,360	-12.4%
Suffolk	12,088	11,002	-9.0%
Sullivan	1,152	1,252	8.7%
Tioga	697	705	1.1%
Tompkins	740	719	-2.8%
Ulster	2,099	2,262	7.8%
Warren	761	717	-5.8%
Washington	831	850	2.3%
Wayne	954	955	0.1%
Westchester	7,330	8,024	9.5%
Wyoming	547	504	-7.9%
Yates	516	517	0.2%
NYC	370,342	387,100	4.5%
Bronx		56,506	
Brooklyn		133,677	
Manhattan		53,749	
Queens		130,532	
Staten Island		12,636	
NY Total	507,691	518,879	2.2%