Application for Extension

New York State Section 1115 Demonstration
Project No. 11-W-00114/2

The Partnership Plan

Submitted by the New York State Department of Health

March 31, 2009

TABLE OF CONTENTS

5. **Public Notice**
6. **Sample Letter to Federally Recognized Tribal Nations**

Section 1 The Partnership Plan's Role in Reforming Medicaid

Operating since 1997, New York State's Section 1115 Partnership Plan waiver program has played a critical role in improving access to health services and outcomes for the poorest and most at risk residents. The waiver allows the State to operate a mandatory Medicaid managed care program designed to improve the health of recipients by providing comprehensive and coordinated health care; offer comprehensive health coverage to low-income uninsured adults who have income and/or assets above Medicaid eligibility standards (Family Health Plus Program) and provide family planning services to women losing Medicaid eligibility at the conclusion of their postpartum period and certain other adults of child bearing age (Family Planning Expansion Program).

The State's goal in implementing the program was to improve the health status of low-income New Yorkers by:

- *improving access to health care for the Medicaid population*
- *improving the quality of health services delivered*
- *expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies*

During its 11 years of operation, the Partnership Plan has been extraordinarily successful in achieving these objectives and has also generated savings well beyond the amounts needed to fund expansions. Quality of care is the cornerstone of the Partnership Plan and data show continuous improvement in the quality of care provided by Medicaid managed care plans. Through Medicaid managed care, Medicaid beneficiaries have access to a larger number of health care providers in managed care than in fee-for-service (FFS) Medicaid. In addition, more previously uninsured New Yorkers have joined the ranks of the insured due to expansion initiatives within the Partnership Plan.

The initial term of New York's 1115 waiver expired on March 31, 2003 and subsequent approvals extended the waiver through September 30, 2009. With Centers for Medicare and Medicaid (CMS) approval, the State intends to continue and expand on the successes already achieved by extending the waiver for an additional three years to September 30, 2012.

This request for a waiver extension comes at a time when New York's Medicaid program is undergoing the most significant reform in its history. Revisions to outdated reimbursement systems that do not incentivize appropriate ambulatory care have been implemented and there is a new emphasis on quality of care and expanding coverage to the State's uninsured. In many respects, the Partnership Plan has demonstrated a valuable lesson -- if we can be successful in lowering costs and improving quality, we can expand coverage to those in need.

Section 2 The Partnership Plan's Successes

Over the course of the waiver, the Partnership Plan has become one of the largest and, arguably, one of the most successful Medicaid managed care programs in the nation.

2.1. Expanding Medicaid Managed Care

New York began implementation of the Partnership Plan immediately after receiving federal approval 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 initial Partnership Plan was approved to enroll most SN and TANF Medicaid beneficiaries into managed care. Effective October 1, 2006, mandatory managed care was expanded to Medicaid beneficiaries who qualify for the federal Supplemental Security Income program (SSI) or are certified as blind or disabled and those who reside in 14 additional counties throughout the State that had not previously implemented mandatory programs. These populations were moved from the Partnership Plan to the Federal-State Health Reform (F-SHRP) waiver.

For New York City Medicaid recipients with both SSI and serious mental illness, mandatory managed care enrollment began in March 2007. For those residing in non-New York City counties, including those with serious mental illness, mandatory managed care enrollment began in the fall of 2007. By the fall of 2008, 37 counties plus New York City had implemented mandatory SSI programs. As of February 2009, more than 250,000 SSI and SSI-related individuals were enrolled in Medicaid managed care statewide, representing almost 64 percent of the total eligible to enroll.

2.2 Insuring More New Yorkers through Family Health Plus

In May 2001, CMS approved an amendment to the 1115 waiver to provide for implementation of Family Health Plus (FHPlus). Enacted by the State legislature in December 1999, FHPlus is a major 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 the World Trade Center disaster and the resulting telecommunications damage to the State's eligibility system. With CMS approval, the State instead implemented the temporary Disaster Relief Medicaid program in New York City. Potential FHPlus eligibles were enrolled into this program through January 31, 2002 and transitioned to FHPlus or regular Medicaid over the next year. Today, FHPlus covers almost 440,000 previously uninsured New Yorkers.

2.3. Partnering with Private Insurers

To increase coverage rates among uninsured but employed New York State residents with access to private insurance, State legislation was enacted in July 2007 to authorize the Employer Sponsored Health Insurance Initiative. This initiative, called the FHPlus Premium Assistance Program, allows individuals who are eligible for FHPlus and have access to cost effective employer sponsored health insurance to enroll in the employer sponsored health insurance. The State subsidizes the employee's share of the premium and reimburses any deductibles and co-payments in excess of the enrollee's co-payment obligations under FHPlus. FHPlus wrap-around benefits are provided to the extent such benefits are not covered by the enrollee's employer sponsored health plan. As of January 2009, one year after going into effect, approximately 900 individuals are enrolled in this program.

In July 2007, State legislation also created the Family Health Plus Buy-in Program which allows employers and Taft-Hartley plans to purchase FHPlus insurance coverage from participating health plans. Enrollment in the FHPlus Buy-in program began April 1, 2008, with Service Employees International Union (SEIU) 1199 home care union employees. Under this program, the State subsidizes premiums for enrollees eligible for Medicaid, FHPlus or Child Health Plus (CHPlus), the State's SCHIP program. For those not eligible for government programs, SEIU 1199 pays the full premium for the employees. As of February 2009, approximately 47,500 individuals were enrolled in the FHPlus Buy-in program through SEIU 1199. Of these, about 2,000 are enrolled in Medicaid managed care, 2,590 are enrolled in FHPlus, 3,270 are enrolled in Child Health Plus and the balance is non-subsidized. There has been much interest among labor unions and employers in expanding the FHPlus Buy-in to additional employers and the State is currently developing program features to extend the program.

2.4 Enrolling Dual Eligibles in Coordinated Managed Care Models

NY Medicaid covers 650,000 persons who are dually eligible for Medicare and Medicaid, including persons who reside in nursing homes. Although duals represent a relatively small portion of total enrollment, their costs in 2007 totaled approximately $16 million. Dual eligibles tend to have more serious and complex medical needs and having coverage divided between two payers can be confusing and result in fragmented care and misaligned incentives. Given the cost of the dual population and, as importantly, the untapped opportunity to improve and better coordinate care, New York like many other states began to develop new models to coordinate coverage and financing of Medicare and Medicaid services.

In December 2004, CMS approved an amendment to the 1115 waiver that permits enrollment of dually-eligible individuals in the Partnership Plan. Prior to this amendment, dual eligibles were excluded from participation in Medicaid managed care and enrollees who joined a health plan prior to becoming eligible for Medicare had to disenroll when they became Medicare eligible. Known as Medicaid Advantage, the program builds on the strengths of the well-established Medicare Advantage Program and the State's Medicaid managed care program. Individuals voluntarily enroll in an approved Medicare Advantage plan that also has a Medicaid managed care product to receive most of their Medicare and Medicaid benefits. Enrollment began in April 2005; nearly 5,000 individuals are enrolled in 15 Medicaid Advantage plans as of February 2009.

2.5. Expanding Access to Family Planning Services

The Family Planning Benefit Program (FPBP) is a program for women and men of childbearing age who are not otherwise eligible for Medicaid but are in need of, but may not be able to afford, family planning services. The program is intended to increase access to family planning services and enable individuals of childbearing age to prevent or reduce the incidence of unintentional pregnancies. Once determined eligible, participants remain eligible for the program for 12 months, after which recertification is required. Participation in the program has declined from 96,780 enrollees (82,213 women and 14,567 men) in 2006 to 69,613 participants (59,794 women and 9,819 men) in 2008.

As the goal of the FPBP is to prevent unintended pregnancies, CMS measures program success in terms of the number of averted births. Using a methodology agreed on with CMS and using 2000 as the base year, the fertility rate for FPBP enrollees is 134.7. Based on this fertility rate, there were 4,746 averted births in 2006 and 4,040 averted births in 2007.

In 2006, the New York State Department of Health (the Department) and CMS worked together to improve the identification of family planning services using a list of CMS-approved procedure codes, which include family planning related services (e.g., colposcopy) and follow-up visits and treatment for sexually transmitted diseases. Edits were later developed in the State's Medicaid Management Information System (MMIS) to ensure that only CMS approved family planning procedures are claimed for enrollees in the FPBP and that the federal share was claimed appropriately (90% for some services and 50% for others).

Program policies, procedures and referral lists are in place to refer a FPBP member to primary care when family planning providers identify health care needs during a family planning visit. If a client is referred for non-family planning or emergency clinical care, the family planning agencies make the necessary arrangements and advise their patients on the importance of follow-up. Special follow-up procedures also exist for individuals with significant abnormal physical examination or laboratory test results, such as abnormal PAP tests and breast exams and diagnosed conditions such as hypertension.

2.6. Increasing the Number of Health Care Providers Available to Beneficiaries

Through the Partnership Plan, the Department has greatly expanded access for Medicaid beneficiaries to appropriately credentialed physicians, nurse practitioners and physician extenders. As evidenced in the table below, the number of primary care and specialist physicians available to Medicaid beneficiaries is significantly greater in a managed care delivery system than in the State's current fee-for-service program.

Physician Participation in Medicaid, December 2008

Type of Care/Region	Participating in Fee-for-Service	Participating in Managed Care
Primary Care:		
New York City	7,485	8,584
Rest of State	8,498	9,259
Total	15,952	17,843
Specialty Care:		
New York City	7,749	13,443
Rest of State	9,551	13,524
Total	17,300	26,967

New York has a variety of mechanisms to assess the overall adequacy and capacity of Medicaid managed care plan networks. Provided to the Department quarterly, plan network submissions are reviewed to ensure plans have the appropriate provider types, comply with geographic, time and distance standards and can support enrollment based on a standard of one primary care provider (PCP) for every 1,500 enrollees.

The provider network data is also periodically validated to ensure its accuracy. In general, audits consistently show a high degree of accuracy between what the health plans report and what health plan network physicians report as correct. For example, the most recent audit in the fall of 2007 found that provider identification variables including name, address, zip code and license were correct at a very high level (>90%) and primary specialty was correct for 99% of PCPs and for 94% of specialists.

2.7. Improving the Quality of Health Services Delivered

Improvement in the care provided to Medicaid recipients who are enrolled in managed care plans under the Partnership Plan is well documented and is one of the major accomplishments of the waiver. The State's rates of performance on most standardized measures of quality and satisfaction continue to exceed each prior year's state benchmarks as well as current year national benchmarks. The increases in performance continue even as the State enrolls more chronically ill beneficiaries into the program, demonstrating the added benefit a managed care delivery system can provide.

Over the past 12 years, the Department's quality measurement and improvement systems have become more extensive and sophisticated. Submitted annually, plan-specific quality performance data provide state and federal agencies, health plans, providers and consumers with information about the quality of care delivered by the plans and member satisfaction within those plans. In particular, extensive efforts have been made to assure that health care quality information is readily available to Medicaid beneficiaries when they choose a plan. Regional brochures entitled "A Consumer's Guide to Medicaid Managed Care" are disseminated via enrollment packets and on the Department's web site.

Assessing Quality of Care:

Medicaid Managed Care: Overall access and quality of care have improved over time with large improvements in childhood immunization, adolescent health, monitoring individuals on long-term medications and ambulatory follow-up after a hospitalization for mental illness. The October 2008 of the National Committee on Quality Assurance's (NCQA) annual report, *The State of Health Care Quality*, indicates that New York's Medicaid managed care plans continue to exceed national benchmarks for preventive care and acute and chronic disease assessment and management. New York State Medicaid managed care plans exceeded national benchmarks in six domains of care: 1) Managing Acute and 2) Chronic Illness, 3) Monitoring Medications, 4) Children's and 5) Women's Preventive Health Services, and 6) Behavioral Health. A table with the most recent Medicaid managed care performance results as compared to national benchmarks is included as Attachment 1.

HIV Special Needs Plan Quality of Care: Data on quality of care in the HIV Special Needs Plans (HIV SNPs) are obtained through the annual collection of HIV-specific quality measures (see table below), which are based on the HIVQUAL Project, a joint effort of the Department's AIDS Institute and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau. The SNP HIVQUAL average scores indicate the percent of records reviewed which met measure criteria.

Special Needs Plan Quality Reviews 2006
HIVQUAL Project

Indicator	2006 SNP Average Score
ARV Appropriate Mgt-Stable, Patients	74
ARV Appropriate Mgt-Unstable, Patients	40
Medication Adherence	67
CD4 Count every 4 months	82
VL every 4 months	87
Pelvic Exam	76
PPD	55
Hepatitis C Screening	84
Substance Use Screening	94
Tobacco Use Screening	92
Mental Health – All Components	59

Note: Adherence indicator measured by periods (3 periods per year). Other indicators measured by patients.

Beginning in 2007, the HIV SNPs were also required to submit HEDIS measures for controlling high blood pressure; breast cancer screening; and comprehensive diabetes care (which encompasses eight measures). The HIV SNPs met or exceeded national Medicaid benchmarks in all but one of the ten HEDIS measures for which a national benchmark was established (see Attachment 1 for national benchmarks).

Assessing Satisfaction with Care:

Since members' experience with care is an important dimension of quality, the Department has administered a number of surveys to measure member satisfaction. Using the survey results, the Department works very closely with managed care plans on identifying and resolving quality improvement issues and working toward improving satisfaction results. Plans not performing at expected levels must develop root cause analyses and action plans for targeted areas. All plans must conduct focused clinical studies and performance improvement projects.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: The biennial CAHPS survey assesses plan members' experience accessing health care services, providers and health plans. Conducted in 2006 and 2008, the survey results are used to determine variation in member satisfaction among the plans. Since different versions of the survey were used most recently, the ability to trend results is limited.

2006 Experience with Children and Adults: Overall, both adults and parents of children were largely happy with the care received.

2006 NYS Medicaid Managed Care CAHPS Survey

	2006 NYS Medicaid Managed Care CAHPS Survey			
	Children Only (%)	Adults Only (%)	Children & Adults Combined (%)	NCQA Medicaid Benchmark (%)
Access to Care				
Getting Care Needed (No Problem)	74	68	70	73.9
Getting Care Quickly (Usually or Always)	78	70	74	72.3
Experience with Care				
Doctor Communication (Usually or Always)	89	86	88	86
Rating of the Doctor (8, 9, or 10)	84	74	79	77
Rating of Specialist (8, 9, or 10)	77	73	74	76
Rating of Overall Care (8, 9, or 10)	84	70	77	73
Health Plan				
Customer Service (No Problem)	75	74	75	68.5
Rating of Health Plan (8, 9, or 10)	79	70	75	72

Source of the NCQA Medicaid benchmarks are the *State of Health Care Quality Report* 2006.

Experience with Adults: Focusing on adults, the 2008 CAHPS survey found that New York State Medicaid slightly trailed the national benchmarks in some member satisfaction measures. Overall, enrollees outside of New York City were more satisfied with their health care than those living in New York City.

2008 NYS Medicaid Managed Care CAHPS Survey

	2008 NYS Medicaid Managed Care CAHPS Survey			NCQA Medicaid Benchmark (%)
	NYC (%)	Rest of State (%)	NYS Overall (%)	
Access to Care				
Getting Care Needed (Usually or Always)	69	80	75	75
Getting Care Quickly (Usually or Always)	71	84	78	80
Experience with Care				
Doctor Communication (Usually or Always)	86	89	88	87
Rating of the Doctor (8, 9, or 10)	71	77	74	76
Rating of Specialist (8, 9, or 10)	65	76	71	76
Rating of Overall Care (8, 9, or 10)	60	70	65	67
Health Plan				
Customer Service (Usually or Always)	77	82	80	79
Rating of Health Plan (8, 9, or 10)	61	69	66	71

Source of the NCQA Medicaid benchmarks are the *State of Health Care Quality Report* 2008

A comparison of the 2006 and 2008 surveys indicates consistency in results with the exception of rating of overall care and rating of health plan. In response to the declines in these measures, the Department included them in the Quality Incentive program and held quality improvement conferences on the topic. The NCQA national Medicaid benchmark for rating of overall care also fell from 73 to 67 between the two years.

2006 and 2008 NYS Medicaid Managed Care CAHPS Survey Comparison

NYS Medicaid Managed Care CAHPS Survey	2006 Adults (%)	2008 Adults (%)
Experience with Care		
Doctor Communication (Usually or Always)	86	88
Rating of the Doctor (8, 9, or 10 out of 10)	74	74
Rating of Specialist (8, 9, or 10)	73	71
Rating of Overall Care (8, 9, or 10)	70	65
Health Plan		
Rating of Health Plan (8, 9, or 10)	70	66

Survey of SSI Beneficiaries: A survey of New York City SSI adults and parents of children who had transitioned into Medicaid managed care was conducted in the spring of 2008 to evaluate the experiences of this population and compare enrollee perceptions of access in FFS with those in managed care. The survey was administered according to a mail-only methodology with three mailing cycles to maximize the response rate, which was 32.4%.

This population differs from the respondents to the CAHPS survey in that the SSI population tends to have considerably more health care issues. For example, 63% of adult respondents to the SSI survey self-reported having three or more chronic conditions compared to 29% of the adult respondents to the 2008 CAHPS.

With regard to continuity of care, 69% of respondents indicated they stayed with the same doctor after joining a health plan and 9% indicated they did not have a doctor prior to joining managed care. Regarding access to care, a majority of respondents stated that it was easier or as easy to get appointments with their doctors since joining a plan (88%) and that the quality of care they received was the same or better since joining their health plan.

2008 SSI Beneficiary Satisfaction Survey

Accessing Health Care:	**Easier**	**Same**	**Harder**
Ease in Getting Doctor Appointments	31.6%	56.0%	12.4%
Quality of Health Care:	**Better**	**Same**	**Worse**
Primary Care Doctor	23.4%	71.2%	5.5%
Specialist	34.7%	46.1%	19.2%
Overall Health Care	28.0%	59.8%	12.2%

2006 Dental Survey: A 2006 survey of enrollees between the ages of four years and 65 years was conducted to assess access to and satisfaction with dental care. Oral health was reported to be excellent or very good by 32% of respondents, good by 34%, and fair or poor by 34%. Two-thirds reported that they have a dentist they see on a regular basis and the same percent visited a dentist within the past year with almost one half (47%) reporting going at least twice. Half of respondents went to the dentist as often as they needed within the past year. Seventy-one percent of respondents go to a private dental office for care. Overall satisfaction rates were high; 68%

were satisfied with the wait time to get an appointment, 77% with the office hours, and eight in ten were satisfied with the convenience of location, friendliness/helpfulness of staff and the cleanliness of their dentist's office.

Survey of HIV SNP Enrollees: The Choices in Care Study, which examined perceptions of care received by HIV-positive individuals either enrolled in an HIV SNP or receiving care through the FFS system, was conducted in conjunction with the Memorial Sloan-Kettering Cancer Center. The survey was conducted after three months of enrollment and after six months of enrollment.

After three months of enrollment, HIV SNP enrollees reported fewer interruptions in their relationships with providers than the FFS recipients and were more likely than those in FFS to receive referrals for needed care from their primary care physician or case managers. HIV SNP enrollees also reported greater availability of medical specialists and fewer barriers to receiving help than their FFS counterparts. HIV SNP enrollees who were actively engaged in care had more favorable outcomes in terms of problem resolution than their counterparts.

After six months of enrollment in an HIV SNP, survey respondents who reported the occurrence of medical symptoms at baseline reported fewer symptoms as compared with those in FFS. HIV SNPs require the delivery of prevention counseling in the context of medical care which has impacted risk behaviors among members. HIV SNP members who were receiving services reported a decrease in unprotected sex with HIV-negative or unknown partners, while those in FFS reported an increase in unprotected sex with HIV-negative or unknown partners.

Plan Performance Projects and Quality Improvement Initiatives:

Clinical Study on Attention Deficit Hyperactivity Disorder: The Department and its external quality review organization conducted a clinical study on Attention Deficit Hyperactivity Disorder (ADHD) to: 1) assess the quality of care provided by Medicaid managed care plans for members aged 6 to 12 years with a diagnosis of ADHD; 2) evaluate the presence of regional and racial/ethnic disparities in the quality of care for children with ADHD; 3) identify specific areas of improvement in the assessment, treatment, medication management and coordination of care for children with ADHD; 4) establish achievable benchmarks for key quality indicators; and 5) identify best practices for improving quality of care for children with ADHD.

To assist with creating objectives for an ADHD Collaborative project, an analysis of Medicaid encounter data and a medical record review was conducted, which indicated that 26% of those with ADHD had no documentation of initiated treatment, behavioral or pharmacological. Parent focus groups and provider interviews identified the critical role of schools in diagnosis of ADHD, the negative attitudes of some parents toward ADHD medication and barriers accessing behavioral health care outside of New York City.

Three Medicaid managed care health plans participated in the ADHD Collaborative and an additional four conducted ADHD Performance Improvement Projects (PIPs) from 2007 to 2008. Interventions pursued by health plans included partnering with a primary care practice, promoting use of standardized tools for diagnosis, case management, dissemination of provider toolkits, and coordination of behavioral health consultations. In June 2008 a one-day training entitled "Assessment, Diagnosis and Management of Pediatric ADHD" was attended by 44 primary care providers in Medicaid managed care plans. Over the next four months, these

providers participated in clinical case-based teleconference sessions. A February 2009 conference, "Building Bridges to Effective Pediatric ADHD Practice," summarized the two year ADHD collaborative. The final ADHD PIP Reports from the seven plans are due in July 2009.

Performance Improvement Projects: New York's Medicaid managed care plans are required to conduct annual performance improvement projects. In the past, the projects have encompassed a wide range of topics such as: Child and Adolescent Health, Women's Health, Depression Screening, Cardiovascular Health, and other topics important to the health and well being of New York State residents. Each year plans receive a compendium of results from all plans as a way of sharing best practices.

Implementing New Standards for Care:

Primary Care Standards: The Department has developed standards for primary care providers in Medicaid that make use of existing health plan contract standards, 'upweighted' requirements for primary care training programs, and portions of the National Committee for Quality Assurance (NCQA) Patient Centered Medical Home requirements for physician recognition. These standards will be used as the basis for the state's primary care medical home initiative which will provide increased financial support for those practices meeting these standards. Over the next six months, the Department will be meeting with stakeholders, including professional associations, provider groups, health plans, training programs and others, to finalize our primary care standards for this program initiative which will improve the provision of care to all Medicaid recipients.

Perinatal Care Standards Development: The Department is undertaking a comprehensive review of perinatal care standards and reimbursement methodologies to ensure that New York is providing quality care for pregnant women enrolled in the Medicaid program. ("Perinatal" in this context excludes the care provided at the time of delivery.) To prepare for updating the standards, IPRO conducted a comprehensive comparison of current Medicaid perinatal care standards (10 NYCRR, Part 85.40) to ACOG/AAP guidelines for perinatal care and other published evidence-based findings and programs in other states. Discussions with key external stakeholders and clinical experts in perinatal care assisted in developing recommendations for a set of standards that would apply to all Medicaid providers.

Using the ACOG/AAP guidelines for perinatal care as the basis of the standards, the New York State standards will also address areas such as access and timeliness of care, facilitation of health plan enrollment, provider capacity, mental health, health disparities, quality assurance, assistance with smoking cessation, dental care, inter-pregnancy and preconception care and psychosocial issues such as chemical dependency, teen pregnancy, domestic violence, unstable housing and unintended pregnancies.

Selectively Contracting with Providers:

As part of the effort to ensure the purchase of quality, cost-effective care for Medicaid beneficiaries, the Department is undertaking initiatives to review and, as warranted, limit the providers with which it contracts for certain services. Two of these initiatives have recently been announced. The first initiative limits the number of providers who may perform mastectomy and lumpectomy procedures within New York State and the second initiative will select five providers to perform bariatric surgery for weight loss in New York City. These initiatives will

apply to patients both in the FFS program and in managed care. The goal for these initiatives is to channel beneficiaries to experienced providers where they will receive the best care and have the best outcomes.

- **Breast Cancer Surgery:** Section 504.3 (i) of Title 18 of the New York Codes, Rules and Regulations provides the authority to limit the number of providers that perform inpatient and outpatient surgical procedures for breast cancer.

  In light of the numerous studies that have described the more positive long-term outcomes (e.g., decreased rates of five year mortality) at facilities that perform a higher volume of breast cancer surgery, the Department stopped reimbursing for mastectomy and lumpectomy procedures associated with breast cancer at low-volume hospitals and ambulatory surgery centers as of March 1, 2009. The Department will re-examine the all payer surgery volume annually and will modify the list of hospitals and ambulatory surgery centers with which Medicaid will contract for such surgery accordingly. Medicaid managed care plans may not use these restricted facilities. Plans are required to contract with eligible facilities or provide out-of-network authorization to those facilities for their members in need of breast cancer surgery.

- **Bariatric Surgery:** It is well documented that the United States has experienced an "obesity epidemic" during recent decades. Research shows that diet, exercise and the normally prescribed medical therapies alone are not always effective treatment, especially for the severely and morbidly obese. Bariatric surgery has emerged as an alternative method of weight loss and long term weight maintenance for many obese and morbidly obese individuals. In addition to the substantial potential benefits of this type of procedure, there are also substantial potential risks. In fact, recent research using 2003 New York State hospital discharge data reveals that 6.8% of adults undergoing surgery in 2003 experienced one or more postoperative complications and that 7.6% of patients were readmitted to the hospital within 30 days of discharge after their operation. Preliminary research conducted by the Department utilizing 2006 New York State hospital discharge data shows very similar results as well as tremendous variation in the risk-adjusted complication rates among hospitals which range from 1.36 to 21.58 per 100 surgeries. Given such wide variation in performance among hospitals, the Department on behalf of the Medicaid program issued a request for applications (RFA) on February 20, 2009 to all hospitals that performed bariatric surgery for weight loss in New York City in order to selectively contract with hospitals that have bariatric surgical experience and with the most favorable outcomes. This is consistent with the Centers for Medicare and Medicaid Services decision to certify bariatric surgical programs for Medicare. The selected hospitals will be designated as "Bariatric Specialty Centers" and both Medicaid FFS beneficiaries and managed care enrollees in New York City needing such services will be required to use these hospitals.

Rewarding Quality:

Since 2001, the Department has provided a financial reward to Medicaid managed care plans that do well on a defined set of quality and member satisfaction measures. In the most recent cycle,

more than $60 million was awarded to over 20 qualifying plans. The State has also made the decision to auto-assign individuals only to plans that meet the requirements for earning a Quality Incentive reward.

The Quality Incentive is one of the primary drivers of observed increases in a variety of performance measures over time. It provides plans with additional resources that can be used for improving data capture, providing case management and member outreach, developing provider incentive programs and other performance improvement activities. A detailed comparison of QARR rates over the last three years (2005 – 2007) is found in Attachment 1.

Pay for Performance Consortia:

In 2007, the Department awarded grants to four regional consortia for the purpose of evaluating innovative pay for performance strategies. The consortia are comprised of local health plans, hospitals and physicians and are using standardized performance measures to evaluate success. The grants are supported with $10 million in state funding which is being used to pay for administrative expenses and matching incentive funds for providers who meet established benchmarks.

All of the grantees included Medicaid product lines in their project designs. Projects are expected to end in December 2009 and an evaluation of program accomplishments will be conducted in spring of 2010.

Section 3 Extension Request

New York is seeking a three-year extension of the Partnership Plan pursuant to Section 1115(f) of the Social Security Act. While this includes extending the existing Terms and Conditions to the extent they are still necessary, the waiver extension also seeks to build upon the features of the Partnership Plan that will allow New York to expand health coverage to more individuals who are in need of health care, support reform initiatives designed to improve health care in the State and update waiver provisions to reflect recently enacted state law.

3.1 Partnership for Coverage

Despite the successes achieved in expanding coverage under the waiver, 2.5 million non-elderly New Yorkers, 78 percent of whom have family incomes at or below 300 percent of FPL, remain uninsured. Maximizing enrollment in public programs is a high priority for the State. New York took a major step in expanding coverage for children when it increased eligibility under Child Health Plus to 400% of FPL effective September 1, 2008 making every child in the State eligible for affordable heath care coverage. But, as President Obama remarked when signing the Children's Health Insurance Program Bill, this is just one step in a broader commitment to cover the uninsured.

Lack of health insurance coverage seriously affects the health of the uninsured and their families. The uninsured are less likely to receive needed care, tend to be more severely ill when diagnosed, and receive fewer preventive services. Approximately 20% of the uninsured, as compared with three percent of those with health insurance, report that their usual source of care is the emergency room. Moreover, the uninsured are 30% to 50% more likely to be hospitalized for an avoidable condition. Additionally, research shows that children whose parents are

enrolled in public insurance programs are much more likely to be enrolled than eligible children whose parents are not enrolled.

To address the large number of uninsured residents, the Governor has called for the development of a building-block reform initiative to "ensure access to affordable, high quality medical care for every single New Yorker." Moving forward as the "Partnership for Coverage," the Departments of Health and Insurance were charged with developing, evaluating and recommending proposals for achieving high quality, affordable health insurance for all New Yorkers.

To lay the foundation for universal health coverage, the Departments solicited extensive public input as well as the services of an experienced consultant, the Urban Institute, to develop microsimulation models of alternative proposals for broad coverage expansion. The modeling results will help predict the strengths and limitations of implementing various health reform proposals and allow for effective comparison across proposals. Four reform proposals are being modeled: a single payer option; a proposal that allows all New Yorkers to enroll in the FHPlus program delivered by various health plans under contract with the State; a public-private reform that builds on simplification and expansion of existing public health insurance programs combined with reforms to improve New York's private health insurance markets and a market-based model that promotes private market reform.

The ultimate recommendation for reform will draw on the experience of other states but be uniquely tailored to New York's uninsured population and health care challenges. In developing recommendations, the Departments were asked to consider the extent to which proposals: (1) rapidly expand coverage to the people of New York; (2) control the cost of health insurance and health care; (3) fairly and equitably distribute the cost of health insurance and health care; (4) improve the state's economy and the competitiveness of the state's businesses; (5) promote the economic viability of health care providers and (6) embrace increased use of preventive medicine to improve quality and reduce health care costs.
In a report to the Governor in the spring of 2009, the Departments will present their analysis of a number of health reform proposals and provide recommendations on the steps the State might take to make affordable coverage available to all New Yorkers. In the meantime, the State has implemented a multi-pronged strategy to expand coverage; important progress has been made already. Most important was the expansion of CHPlus eligibility from 250 percent FPL to 400 percent FPL effective September 1, 2008.

Complementing this expansion are efforts to streamline the eligibility rules for public health insurance programs to make it easier for people to get and keep coverage. In addition, the State has implemented a number of new programs that subsidize employee premiums and co-payments for workers eligible for public programs, expand consumer protections under managed care, rationalize the Medicaid payment system and promote primary and preventive care.

Although the recommendations from the Partnership for Coverage are not yet available, the Departments anticipate that the recommendations may result in New York requesting amendments to the Terms and Conditions of the Partnership Plan.

3.2 Expanding FHPlus Eligibility to 200% of the Federal Poverty Level

The next and critical step in moving New York toward the goal of universal coverage is the Governor's 2009-10 proposal to expand eligibility under FHPlus to adults with and without children up to 200% of the FPL. This expansion would make more than 400,000 additional New Yorkers eligible for FHPlus. Currently, FHPlus covers adults with children up to 150% of the FPL and single adults and childless couples up to 100% FPL. When fully implemented, and assuming that 65% of those newly eligible for FHPlus as a result of the expansion enroll, the additional annual cost of the expansion will be $680 million. New York seeks to finance this expansion by securing, through the waiver extension agreement, federal match for state-only funded health programs, commonly referred to as Designated State Health Programs (DSHPs) and, subject to enactment of state legislation proposed in the 2009-10 budget, by redirecting to programs that cover the uninsured all or a portion of the non-federal share of funding historically used to support Upper Payment Limit and/or Disproportionate Share Hospital payments to public hospitals. Under the second approach, social services districts which are responsible for the non-federal share of this funding could voluntarily elect to participate in programs to fund services to uninsured persons and/or expand FHPlus. Elections by the social services district would be subject to the approval of the Commissioner of Health, with the consent of public hospitals which are located in the district.

3.3. Simplifying the Eligibility Process

Over recent years, the Governor and the Legislature have enacted a series of progressive steps to make it easier for consumers to navigate the eligibility process. The goal of these initiatives is to enroll more eligible New Yorkers in public programs and to help ensure that they stay enrolled. In 2007, State laws were revised to strengthen continuity of coverage by permitting self-attestation of income and residency at renewal and providing for continuous coverage for FHPlus enrollees and for certain Medicaid beneficiaries for a period of 12 months from the date of initial eligibility and subsequent redetermination(s) of eligibility. This change will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid. A request to amend the Partnership Plan to allow for implementation of the 12 month continuous coverage proposal was submitted to CMS in November 2008.

The 2008-09 enacted budget followed with a number of additional changes that expanded eligibility, aligned program rules across eligibility categories and improved continuity of coverage. The eligibility expansion included allowing children aging out of foster care to remain eligible for Medicaid to age 21. Program alignment included simplifying income and resource rules across eligibility categories; removing public assistance requirements such as alcohol and drug screening from the Medicaid application process; and aligning resource levels for Medicaid and FHPlus. Improved continuity and retention included making it easier for enrollees to maintain coverage when moving from county to county and the authorization and funding for a Statewide Enrollment Center. The Department issued a Request for Proposals for the Enrollment Center in October 2008 and a contract award is expected in mid-2009. The Enrollment Center will start by processing phone renewals, an important step in reducing "churning" within the program.

Governor Paterson's 2009-10 budget further builds on initiatives to streamline and simplify the eligibility process. Among the proposals included in the 2009-10 budget is a change that would align coverage for parents and children, using gross rather than net income to determine

eligibility. Under this proposal, all children, teens and young adults over age 1 and under age 21, and their parents, would be eligible for Medicaid or FHPlus at 160% of FPL based on gross income. Medicaid eligibility for 19 and 20 year olds not living with parents would be set at 100% of FPL based on gross income, and their FHPlus eligibility would be at 160% of FPL regardless of whether or not they live at home. The increase in FHPlus eligibility to 160% is an interim step to simplify eligibility until such time as the expansion to 200% of FPL is implemented. The 2009-10 budget also proposes to eliminate administrative requirements not required by federal rules that act as barriers to enrollment and do little but keep eligible people from getting health care coverage. Under the proposal, New York would no longer require a face-to-face interview, a resource test for community Medicaid or finger imaging for beneficiaries. The State requests that the Special Terms and Conditions of the Partnership Plan be amended as needed to reflect changes in State law.

3.4. Allowing Government Employees to Enroll in the Family Health Plus Premium Assistance Program

The 2009-10 State budget also proposes to repeal a provision of current State law that precludes federal, state, county, municipal or school district employees from enrolling in FHPlus and the FHPlus Assistance Program even when they otherwise meet the eligibility requirements. While most Federal and State employees pay a minimal portion of their health insurance premiums and their income does not fall below the FHPlus levels, many county, municipal, and school district employees have lower incomes and are required to pay a more substantial share of the cost of their health insurance premiums, forcing them to choose between health care and basic living necessities. Current State law creates an inequity whereby a municipal or school district employee, for example, cannot join the FHPlus Premium Assistance Program while an employee of a private company who earns the same amount and has the same level of resources can join. Correcting this inequity by allowing government employees with cost effective health insurance to enroll in the FHPlus Premium Assistance Program will enable more working New Yorkers and their families to continue to be covered by health insurance and further the goal of health insurance for all New Yorkers.

3.5 Expanding Mandatory Managed Care to Additional Counties

Over the course of the waiver extension, New York anticipates expanding mandatory managed care into additional counties of the State consistent with the requirements of Section 1932(a)(3) of the Social Security Act.

The State's current Special Terms and Conditions appear to require a formal waiver amendment to add additional counties. Specifically, the Demonstration Amendment Process section of the Special Terms and Conditions state that, "Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, family planning services covered under this Demonstration, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration." The Special Terms and Conditions, moreover, list individually each county that is approved to operate a mandatory program. New York requests that language be added to the Special Terms and Conditions to clarify that the State may implement mandatory programs under the Partnership Plan in counties that meet the choice criteria established in federal law without the need for an amendment.

Although not described in this document, on November 3, 2008, the State submitted a request to amend the Partnership Plan and F-SHRP waivers to mandatorily enroll Medicaid beneficiaries with HIV/AIDS and to implement twelve-month continuous coverage for FHPlus enrollees and certain adult Medicaid beneficiaries. CMS has not yet acted on this request.

3.6 Allowing Special Spousal Budgeting Provisions for Home and Community Based Waivers

Under normal Medicaid eligibility rules, spouses living together at home would be treated as a household of two and the basic two-person income and resource standards would be applied. However, under Social Security Act (SSA) § 1924, when an institutionalized person with a spouse in the community applies for Medicaid, special spousal budgeting provisions act to allow the community spouse to retain substantial amounts of the couple's combined income and resources. This prevents the community spouse, who is legally responsible for the institutionalized spouse, from having to exhaust all of the couple's resources to help pay for institutional care. The Department believes that not being able to apply special spousal budgeting provisions to home and community based waivers would have the unintended consequence of acting as a serious disincentive for individuals to either come home from a nursing home or to avoid nursing home placement in the first instance. To address this issue and incentivize care in the community, the waiver extension proposes to add a new demonstration eligibility group to the Partnership Plan waiver to be defined as participants of the LTHHCP authorized under the state's 1915(c) waiver who are married with a community spouse and who would be eligible for Medicaid if institutionalized and spousal impoverishment eligibility and post-eligibility rules were used, and who would otherwise have an income spenddown if community budgeting rules were used to determine income eligibility. The spenddown amount that the waiver participant would otherwise have had to make will be funded through savings.

3.7 Supporting Community Clinics that Care for Low-Income Uninsured New Yorkers

Section 1923 of the Social Security Act allows the State to draw federal matching funds for payments to disproportionate share hospitals for services provided to uninsured patients. Community clinics also play a critical role in providing care to New York's uninsured; however, New York is unable to draw federal matching funds for services provided by these clinics, many of which are located in medically underserved communities and act as critical access points to care. With a primary and preventive care focus, these clinics engage the uninsured in health screening and examinations providing cost effective early detection and treatment of chronic health conditions. These facilities also assist uninsured patients in applying for public benefit programs or other subsidized health coverage.

For more than a decade, New York State has funded, through state only dollars, an indigent care pool to partially support voluntary, non-profit and publicly sponsored diagnostic and treatment centers to meet the expenses of uncompensated care for uninsured patients. This waiver extension requests federal matching funds for this pool. It is important to note that this request does not seek funding above the State's DSH allocation.

3.8 Advancing the Health Care Improvement Act of 2009

In order for New York to achieve the intertwined goals of expanding coverage and a high performing health care system it must optimize the value of public dollars - state, local and

federal - spent on health care. In fact, in its final recommendations, the Berger Commission identified reimbursement reform as the next critical step in delivery system reform. Today, even after full implementation of the Berger downsizing recommendations, with support from F-SHRP, New York's Medicaid program still over-invests in inpatient care and under-invests in primary and preventive care. And, the federal government's most recently released state rankings show that New York ranks low as compared to other states in respect to hospitalizations that could have been avoided if New Yorkers had access to primary and preventive care and chronic care management. New York can both cut its costs and increase the quality of care its residents receive by better targeting its spending and requiring transparency and accountability for every dollars it invests.

Last year, Governor Paterson made a down-payment on reform of New York's health care system including: a reduction of inpatient hospital rates by over $170 million; a $300 million investment in hospital clinics, community health centers and physicians; replacement of a flawed outpatient reimbursement methodology; and, implementation of Doctors Across NY to support new physicians in medically underserved communities. The Health Care Improvement Act of 2009 (HCIA) builds on those achievements offering New Yorkers real reform in coverage, quality and efficiency, the bedrocks of a sound health care system for the 21st century. Significantly, these health care reforms parallel those advanced by President Obama.

Complementing the outpatient methodological reforms adopted in last year's budget, the HCIA includes a new inpatient rate methodology that will be transparent, recognizing appropriate differences in hospitals and more effectively matching payment to patient complexity and quality. The payment level will bring rates more in line with current costs rather than 1981 costs that have been artificially inflated and enhanced over the last quarter century.

The HCIA also includes initiatives to strengthen primary and preventive care and chronic care, perhaps the weakest part of New York's health care system. As begun in the 2008-09 Budget, continuing investments will be made in hospital clinics, community health centers and physicians and rate enhancements will be available for facilities that meet medical home standards. Care coordination will also get a boost in rural areas of the State through an Adirondack Medical Home Pilot and through expansion of Medicaid's primary care case management program in counties with limited or no managed care.

With over four million covered lives and accounting for one out of every three dollars spent on health care in the State, Medicaid is the lever for changing the delivery of health care for all New Yorkers. But, changing a system as large and complex as New York's will require the delivery system to adapt to new reimbursement methodologies and incentives that reward the provision of primary and preventive care needed to improve quality of care for all New Yorkers and contain costs, making it possible to cover more uninsured. New York and CMS have a long and successful history in partnering to bring about significant reform in New York's health care system; first, under New York's initial 1115 waiver to support the transition of millions of Medicaid beneficiaries from Medicaid fee-for-service to Medicaid managed care, followed by the partnership formed under F-SHRP to reduce excess capacity in the acute care hospital industry and shift emphasis in long-term care from institutional to community-based settings. This waiver extension seeks to again partner with CMS under the Partnership Plan to access enhanced financial participation to support state reform activities embodied in the HCIA of 2009 in order to promote patient-centered care and improve access to and the quality of primary and ambulatory care.

Section 4 Program Evaluation

The Partnership Plan Special Terms and Conditions require an evaluation of the degree to which the key goals of the demonstration have been achieved and the key activities have been implemented. The evaluation must, to the extent possible, isolate the contribution of the demonstration programs to any observed effects as well as describe the relative contributions of other factors influencing the observed effects. An analysis of the impact of the family planning expansion program, particularly among the target family planning population, is also required.

In October 2007, the State released a Request for Proposals (RFP) for up to two contractors to conduct evaluations of the Partnership Plan/Family Planning Expansion Program and F-SHRP. Separate bid reviews were conducted for the Partnership Plan evaluation and the F-SHRP evaluation. A contract with Delmarva Foundation for Medical Care to conduct the Partnership Plan evaluation was approved on October 24, 2008, and work began shortly thereafter. As required by the Special Terms and Conditions, an Interim Evaluation of the Partnership Plan Demonstration Program is included in this application as Attachment 2. A draft evaluation is due to CMS on January 28, 2010 and the final evaluation by May 28, 2010. The State intends to use this report to identify areas for improvement.

Section 5 Compliance with Special Terms and Conditions

New York State has successfully completed all deliverables required by the Partnership Plan Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. A July 30, 2008 letter from CMS acknowledged that "the Department has submitted all the specific deliverables in accordance with the STCs." In addition, the State maintains a comprehensive Operational Protocol, which is regularly updated to reflect the most current operational policies and procedures of the Partnership Plan program and is made available to CMS.

5.1 Program Monitoring

Through ongoing dialogue, program monitoring and regular and extensive reporting, New York State has assured CMS that it remains in substantial compliance with the Partnership Plan terms and conditions.

The State employs a multi-prong approach to monitoring program compliance. Program reviews of local district operations are conducted on a routine basis to assess program implementation and operations. Regular conference calls are conducted among the Department, the enrollment broker, the New York City Department of Health and Mental Hygiene (NYC DOHMH) and the New York City Human Resources Administration (HRA) to discuss operational issues, resolve problems and discuss program improvements. Periodic coalition meetings attended by State staff are conducted with regionally-based groups of local districts and managed care plans to share program information and provide technical assistance. Local district and NYC DOHMH staffs routinely monitor managed care plan marketing activities to evaluate compliance with marketing guidelines. HRA conducts on-site monitoring of the enrollment broker's operations. Auto-assignment rates are monitored on a monthly basis for all mandatory counties and technical assistance is provided to counties as necessary to help maintain high rates of choice. In addition,

surveys of managed care plan operations are conducted annually to ensure compliance with statutory, regulatory and contractual requirements.

CMS assesses State compliance with the terms and conditions in numerous ways. Since the beginning of the Partnership Plan, conference calls have been conducted regularly, first on a weekly basis, then biweekly and then monthly to discuss any significant actual or anticipated developments affecting the program. The State submits to CMS both quarterly and annual operational reports presenting an analysis of and the status of various operational areas and program accomplishments. Quarterly CMS-64 reports are provided to report total expenditures for services under the Partnership Plan. The State also provides CMS with any other reports, studies and materials related to the program. CMS staff monitors regular meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP), an advisory body appointed by the Governor and the New York State legislature.

Under the previous waiver, CMS conducted readiness reviews prior to each county's implementation to ensure that program requirements would be met. In addition, CMS conducted a statewide readiness review prior to the implementation of FHPlus.

In 2005 and again in 2007, CMS staff conducted an onsite visit for an overview of Partnership Plan activities and to discuss specific program issues. Finally, an independent evaluation of the Partnership Plan is currently underway by a contracted vendor, Delmarva Foundation for Medical Care.

5.2 Financing Mechanisms

In the past, the State established premium rates for the managed care program through individual negotiations with each participating plan. These negotiations were based on the plans' historical cost experience and projections made by the plans for the rate year. Every two years, the rates were trended to reflect predicted changes in medical costs and operational efficiencies.

In April 2008, the Department began phasing in a risk-adjusted rate setting methodology whereby capitation rates are established based on the relative medical acuity of each plan's membership compared to the regional average. Using 3M's Clinical Risk Group (CRG) software, each member of a health plan is assigned a risk score based on their health status as determined by encounter and claims data. The risk score of all members enrolled in a plan are used to derive a plan risk score, or case mix. Plans with a higher than average case mix are reimbursed more; plans with lower than average case mix are reimbursed less. This change in methodology allows the State to more fairly reimburse plans with a more severe case mix of members and provides support for activities such as case management. It also ensures that variation in reimbursement from plan to plan is based on the health status of their members rather than inefficiencies. In the first year of the phase in, the rates are a blend of 25% risk based and 75% trended negotiated rates; in year two the blend will be 50%-50%, year three 75%-25% and in year four, beginning in April 2011, 100% risk based rates will be in place. The Department will monitor the efficacy of the CRG risk model in predicting medical costs and will make adjustments as needed.

5.3 Financial Monitoring

The Department monitors the financial solvency of health plans on a quarterly basis via a review of plans' financial reports, including revenue and expense statements and balance sheets. These reports measure the plans' compliance with minimum net worth (contingent reserve) and cash escrow fund requirements.

Under New York State regulation, the contingent reserve is equal to 12.5% of premium revenue for the previous calendar year. Plans are allowed to phase in the contingent reserve beginning at 5% of premium revenue in year one, 6.5% in year two and thereafter in 1% increments per year until the full reserve of 12.5% is reached. The contingent reserve for most plans in 2009 is equal to 8.5% of 2008 premium revenue across all product lines (commercial, Medicaid, Medicare, etc.) and will reach 12.5% in 2013. The escrow fund is a cash requirement equal to 5% of projected medical expenses for the coming year. The cash deposits are held in a Deed of Trust regulated by the State Insurance Department (SID) and withdrawals from the fund can not be made without SID's approval.

The Department compares the required reserves to the amounts reported on the plan's balance sheets quarterly. Failure to meet the reserve requirements results in the Department issuing a Statement of Deficiency and the plan must then submit a Plan of Correction that demonstrates how the reserve requirements will be met. Plans must also submit bank statements on an annual basis showing that the Deed of Trust escrow accounts area is fully funded.

New York continues to pay supplemental rates to FQHCs under the requirements of federal law (42 U.S.C. §1396a(bb)(5)(A)). By June 1, 2008, FQHCs operating in mandatory counties and/or where a plan offers a FHPlus product were required to document that contracts were in place with all managed care plans operating in the county. The initial Partnership Plan waiver included a Supplemental Transitional Payment Program (STPP) under which the State made supplemental payments directly to non-FQHC comprehensive health centers that primarily serve Medicaid and indigent populations. A transitional payment program reimbursed up to 90% of the per visit difference between the amount the health center would have received under its FFS rates and the amount it received under its managed care contracts. The STPP ended on September 30, 2006.

Section 6 Compliance with Budget Neutrality Requirements

The Special Terms and Conditions of New York State's Section 1115 waiver require that the Partnership Plan be budget neutral, that is, the cost to the federal government under the waiver can not be more than the cost that would have occurred without the waiver. The State has demonstrated to CMS that the waiver has been successful in not only achieving budget neutrality but in realizing savings for the State and federal government.

6.1. Budget Neutrality Monitoring

The neutrality formula consists of two components: Without Waiver expenditures and With Waiver expenditures. Budget neutrality is continuously updated and monitored to ensure that the projections are current and that the waiver is budget neutral.

Without Waiver expenditures consist of the number of persons eligible for the waiver in each of the agreed upon Medicaid eligibility groups (MEGS) times the trended per member per month

allowance agreed to with CMS. The Department updates eligible member months every three months and uses the most current available data in its budget neutrality projections.

With Waiver expenditures consist primarily of medical claim costs for individuals eligible under the waiver. Medical costs represent a combination of managed care capitation payments for waiver eligible recipients enrolled in managed care and FFS payments for recipients who are not enrolled in managed care plans or for services that are carved out of the managed care benefit package. Examples of these services include prescription drugs which are carved out of the managed care benefit package under State law and certain mental health and substance abuse services. With Waiver expenditures are updated periodically using reports developed for the waiver eligible population. Because providers have up to two years to submit claims to MMIS for payment, actual claims data is lagged for 21 months to allow it to "mature" before it is considered final in the budget neutrality calculation. Once actual final data is incorporated into the budget neutrality calculation it becomes the basis for projecting future medical costs.

Also included in the With Waiver expenditures is non HR disproportionate share hospital (DSH), Upper payment limit (UPL) payments, payments under the family planning expansion and expenditures under the Community Health Care Conversion Demonstration Project. An adjustment is made to With Waiver costs to reflect the reduction in spending due to pharmacy rebates and audit recoveries.

6.2. Budget Neutrality Summary

The Partnership Plan waiver has always demonstrated significant savings. A chart showing the calculation of the budget neutrality savings is included as Attachment 3. Savings are expected to grow even more during the waiver extension period (see Attachment 4).

Section 7 Public Notice Procedures

7.1 Public Notice

New York followed the notice procedures as published in the Federal Register on September 27, 1994 as well as the requirement for consultation with federally recognized tribes as outlined in the CMS State Medicaid Director's letter of July 17, 2001. Both the public notice and a sample tribal letter are included as Attachments 5 and 6.

The public notice was published in major New York State newspapers on February 27 and February 28, 2009. [1] The notice was published in the newspapers of widest circulation in cities and areas with a population of 100,000 or more. The notice describes the Department's intent to extend the Partnership Plan for an additional three years as well as the two proposed amendments to the Partnership Plan submitted in November 2008. There was a public comment period of 45 days. The chart below lists the newspapers of publication and their main catchment cities and population. It should be noted that these newspapers enjoy broad circulation in surrounding areas as well. For example, the *Albany Times Union* is circulated throughout the entire Capital region including Columbia, Greene, Saratoga and Rensselaer counties. *The New York Time*s has virtually statewide circulation.

[1] Some upstate newspapers published a notice with a 30-day comment period, however, comments will be accepted for 45 days.

Newspaper/City	Population (2000 data)	
Albany Times Union	Albany (Albany)	95,658
Buffalo News	Amherst (Erie)	116,510
	Buffalo city (Erie)	292,648
Newsday	Babylon (Suffolk)	211,792
	Brookhaven (Suffolk)	448,248
	Hempstead (Nassau)	755,924
	Huntington (Suffolk)	195,289
	Islip (Suffolk)	322,612
	North Hempstead (Nassau)	222,611
	Oyster Bay (Nassau)	293,925
	Smithtown (Suffolk)	115,715
New York Times	New York City	8,008,278
	Ramapo (Rockland)	108,905
	Yonkers (Westchester)	196,086
Rochester Democrat and Chronicle	Greece (Monroe)	94,141
	Rochester (Monroe)	219,773
Syracuse Post-Standard	Syracuse (Onondaga)	147,306

In addition to public notice in newspapers, the Department announced its intent to apply for an extension of the waiver at public meetings of the Medicaid Managed Care Advisory Review Panel. A summary of the waiver application is also available on the Department of Health website at**:**
http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm#partnership_plan.

7.2. Tribal Nations

New York State is home to seven federally-recognized Tribal Nations:

Cayuga Nation of Indians	Oneida Indian Nation of New York
Onondaga Nation	St. Regis Mohawk Nation
Seneca Nation of Indians	Tonawanda Band of Senecas
Tuscarora Indian Nation	

Pursuant to CMS guidelines, SDOH advised the above mentioned tribes of our intent to request an extension of the 1115 waiver, the Partnership Plan.

This application provides CMS with the necessary assurances as to the State's achievement of program objectives, compliance with waiver terms and conditions, compliance with budget neutrality requirements and evidence of public notice. Additional information will be provided

as necessary to assist CMS in its review of this application to extend New York's Section 1115 waiver, the Partnership Plan.

Attachment 1: QARR/National Benchmark Comparison 2005-2007

Measure	2005 NYS SW Avg	2006 NYS SW Avg	2007 NYS SW Avg	2007 National Medicaid	NYS Above National
Children's Access to Care 12-24 Mos.	91.8	93.1	94.8	94.1	✓
Children's Access to Care 25 Mos. - 6 Yrs.	88.0	89.0	90.3	84.9	✓
Children's Access to Care 7-11 Yrs.	90.0	91.2	92.6	85.9	✓
Children's Access to Care 12-19 Yrs.	85.7	86.6	88.1	83.2	✓
Adult Access to Care (Ages 20-44)	77.2	79.0	80.2	78.2	✓
Adult Access to Care (Ages 45-64)	84.4	85.6	86.8	83.1	✓
Adult Access to Care (Ages 65+)	87.8	88.6	88.0	79.9	✓
Advising Smokers to Quit	72.1		73.6	69.5	✓
Discussing Smoking Cessation Medications	42.0		50.3	38.7	✓
Discussing Smoking Strategies	42.0		46.2	39.2	✓
Follow-up After Hosp. for Mental Illness (7Days)	52.9	60.0	60.4	42.5	✓
Follow-up After Hosp. for Mental Illness (30Days)	70.0	76.4	76.8	61.0	✓
Antidepressant Med. Mgmnt. (84 Days)	44.8	41.9	45.6	42.8	✓
Antidepressant Med. Mgmnt. (180 Days)	28.2	26.7	29.3	27.4	✓
Appropriate Asthma Meds (Age 5-9)	91.2	92.9	93.1	89.3	✓
Appropriate Asthma Meds (Age 10-17)	89.5	90.8	90.9	86.8	✓
Appropriate Asthma Meds (Age 18-56)	88.6	89.4	89.6	84.4	✓
Appropriate Asthma Meds (Age 5-56)	89.6	90.8	90.9	86.9	✓
Cervical Cancer Screening		73.9		64.7	✓
Chlamydia Screening (Ages 16-20)		47.9	53.2	48.8	✓
Chlamydia Screening (Ages 21-25)		53.4	60.0	54.2	✓
Cholesterol Management (Level <100)		46.2	46.8	38.3	✓
Cholesterol Management (Screening)		88.6	89.1	76.3	✓
Disease Modifying Anti-Rheumatic Drug Therapy	70.0	72.3	74.4	68.2	✓
Annual Dental Visit (Ages 4-21)	46.6	47.7	48.1	42.5	✓
Diabetes – Cholesterol Screened		84.9	85.1	70.8	✓
Diabetes – Cholesterol <100		38.9	40.7	31.3	✓
Diabetes - Eye Exam		57.3	62.0	49.9	✓
Diabetes - Nephropathy Screening		80.5	82.1	74.4	✓
Diabetes - Poor Control (A lower rate is desirable.)		35.4	33.6	47.9	✓
Diabetes - HbA1c Tested		86.2	87.0	77.3	✓
Diabetes - BP Control <130		30.2	31.4	29.5	✓
Diabetes - BP Control <140		61.2	60.7	55.5	✓
Use of Imaging Studies for Low Back Pain	81.4	82.2	80.9	77.3	✓
Avoiding Antibiotic Treatment for Bronchitis	29.5	28.2	27.1	25.9	✓
Frequency of On-Going Prenatal Care (>80%)		69.5		58.6	✓
Controlling High Blood Pressure (46-85)		60.8		53.4	✓
Childhood Immunization (1MMR)	91.9		91.5	90.5	✓

Measure	2005 NYS SW Avg	2006 NYS SW Avg	2007 NYS SW Avg	2007 National Medicaid	NYS Above National
Childhood Immunization (1VZV)	88.4		89.2	88.8	✓
Childhood Immunization (3HepB)	89.3		90.8	87.2	✓
Childhood Immunization (3HIB)	89.7		91.1	87.6	✓
Childhood Immunization (3IPV)	87.5		89.9	87.3	✓
Childhood Immunization (4DTP)	81.1		82.8	77.8	✓
Childhood Immunization (C431331)	73.5		77.4	72.2	✓
Childhood Immunization (C4313314)	47.4		69.7	65.5	✓
Lead Testing	86.0		86.4	61.4	✓
Breast Cancer Screening (52-69)	66.1	66.7	67.7	49.9	✓
App. Testing for Pharyngitis	52.3	64.4	72.6	59.0	✓
App. Treatment for URI	85.3	86.2	89.3	84.0	✓
Persistent Medications – ACE	78.1	84.0	85.3	82.5	✓
Persistent Medications - Anticon	60.0	65.4	65.1	65.9	
Persistent Medications - Digoxin	82.4	86.6	90.5	84.9	✓
Persistent Medications - Diuretic	75.8	81.7	83.7	81.4	✓
Persistent Medications - Combined		82.0	84.0	80.1	✓
Pharmacotherapy Management of COPD – Bronchodilator			76.5		
Pharmacotherapy Management of COPD – Corticosteroid			50.4		
Postpartum Care		69.6		58.8	✓
Prenatal Care		86.7		81.4	✓
Use of Spirometry Testing	37.0	40.3	39.9	28.4	✓
Well Child - 15 Mos. (5+ Visits)			79.4	72.9	✓
Well Child - 3-6 Yrs.			80.6	66.8	✓
Adolescent Well Care			57.7	43.6	✓
Adolescent AOD	57.6	63.5	74.4		
Adolescent BMI	25.8	39.0	60.7		
Adolescent Depression	31.6	40.6	52.6		
Adolescent Exercise		49.2	59.8		
Adolescent Nutrition		60.7	71.2		
Adolescent Sex	53.7	60.7	73.4		
Adolescent Tobacco	57.8	63.0	75.6		
ADHD Initiation	35.9	38.9	53.3	33.5	✓
ADHD Continuation ***	71.3	39.3	58.5	38.9	✓
Board Certification – Geriatrics	78.6	77.1	74.4	77.4	
Board Certification - OB/GYN	73.3	75.2	73.7	77.3	
Board Certification – Other	79.0	80.1	78.5	79.8	
Board Certification – PCP	83.5	84.4		81.1	✓
Board Certification - Internal Medicine			79.1		
Board Certification - Family Medicine			80.0		
Board Certification – Pediatrics	75.7	74.4	79.2	76.5	✓

ATTACHMENT 3
New York State Partnership Plan
Projected 115 Waiver Budget Neutrality Impact Through September 30, 2009

Budget Neutrality Cap (Without Waiver)	DY 1 -8 (10/1/97 - 9/30/06) Actual	DY 9 (10/01/06 - 09/30/07) Actual	DY 10A (10/01/07 - 09/30/08) Actual	DY 11 (10/1/08-9/30/09) Projected	BIPA Extension (10/1/06 - 9/30/09) Projected	DY 1 - 11 (10/1/97 - 9/30/09) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$8,636,926,524	$9,002,703,172	$9,791,355,835	$27,430,985,531	
Demonstration Group 2 - TANF Adults 21-64		$3,085,034,886	$3,175,752,447	$3,529,816,622	$9,790,603,955	
Demonstration Group 6 - FHP Adults w/Children		$1,696,175,603	$1,809,276,603	$1,801,716,297	$5,307,168,503	
W/O Waiver Total	$144,639,878,523	$13,418,137,013	$13,987,732,222	$15,122,888,755	$42,528,757,990	$187,168,636,513

Budget Neutrality Cap (With Waiver)	DY 1 -8 (10/1/97 - 9/30/06) Actual	DY 9 (10/01/06 - 09/30/07) Actual	DY 10A (10/01/07 - 09/30/08) Actual	DY 11 (10/1/08-9/30/09) Projected	BIPA Extension (10/1/06 - 9/30/09) Projected	DY 1 - 11 (10/1/97 - 9/30/09) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$3,467,797,850	$3,188,677,789	$4,453,593,894	$11,110,069,532	
Demonstration Group 2 - TANF Adults 21-64		$1,883,759,956	$1,763,943,437	$2,309,857,375	$5,957,560,767	
Demonstration Group 5 - Safety Net Adults		$2,730,183,801	$2,456,862,175	$3,956,827,781	$9,143,873,757	
Demonstration Group 6 - FHP Adults w/Children		$802,061,116	$866,160,610	$827,626,590	$2,495,848,316	
Demonstration Group 7 - FHP Adults without Children		$582,051,368	$556,341,836	$386,366,948	$1,524,760,152	
Demonstration Group 8 - Family Planning Expansion		$0	$6,471,007	$6,471,007	$12,942,014	
Demonstration Group 9 - LTHHCP Spousal Program		$0	$0	$0	$0	
With Waiver Total	$123,931,127,812	$9,465,854,091	$8,838,456,854	$11,940,743,595	$30,245,054,540	$154,176,182,352
Expenditures (Over)/Under Cap	$20,708,750,711	$3,952,282,922	$5,149,275,369	$3,182,145,160	$12,283,703,450	$32,992,454,161

Attachment 4
Budget Neutrality Assumptions for the 3 Year Extension

- **Without Waiver PMPMs and Trend Factors:** The current Without Waiver TANF per member per months (PMPMs) and trend factors will be used to determine the Without Waiver PMPM expenditure cap for the three year extension. These are the same Without Waiver TANF PMPM and trend factors that have been approved by CMS through the end of the F-SHRP waiver (September 30, 2011) and will be carried forward to the final year of the proposed Partnership Plan waiver extension (September 30, 2012). The current FHPlus Adults with Children PMPM and trend factors will also be extended through September 30, 2012.

- **With Waiver PMPMs:** With Waiver PMPMs will be based on actual expenditures and member months incurred by the Partnership Plan waiver population and submitted to CMS on the quarterly CMS-64 report. The PMPMs associated with the latest fully completed demonstration year, i.e. where all four quarters have 21 months of lagged claims, will be used to project to the end of the waiver period. Trend factors will be developed based on actual experience of the Partnership Plan waiver population by aid category.

- **Enrollment Projections:** Medicaid enrollment projections will be based on actual county level managed care eligible recipients and enrollment for the latest available month. Medicaid managed care eligible recipients exclude recipients who are precluded from enrolling in managed care. A listing of the exclusion categories is included in the Partnership Plan's Special Terms and Conditions. Medicaid managed care eligible recipients are projected forward by a growth factor developed by the Department based on historical experience and taking into account seasonal fluctuations and policy initiatives.

  Medicaid and FHPlus managed care enrollment projections will be based on actual enrollment as of the end of the report month and thus includes retroactive enrollments and disenrollments occurring during the month. The historical enrollment experience of each program will be used to estimate monthly enrollment growth by MEG. Medicaid projections will use accelerated enrollment assumptions for counties that have initiated mandatory TANF or SSI enrollment.

  Enrollment projections will take into account the proposed expansion of FHPlus eligibility to 200% of the Federal Poverty Level and expected mandatory enrollment of HIV infected recipients.

  Based on these assumptions the savings are expected to grow during the waiver extension period to $42 billion.

ATTACHMENT 4
New York State Partnership Plan
Projected 1115 Waiver Budget Neutrality Impact Through September 2012

Budget Neutrality Cap (Without Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09- 9/30/10) Projected	DY 13 (10/1/10- 9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	BIPA Extension (10/1/09 - 9/30/12) Projected	DY 1 - 14 (10/1/97 - 9/30/12) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$10,933,031,897	$12,295,581,979	$14,227,709,506	$37,456,323,382	
Demonstration Group 2 - TANF Adults 21-64		$3,934,327,564	$4,419,400,534	$5,139,349,996	$13,493,078,093	
Demonstration Group 6 - FHP Adults w/Children		$1,913,259,744	$2,221,648,326	$2,764,151,858	$6,899,059,928	
W/O Waiver Total	**$187,168,636,513**	**$16,780,619,204**	**$18,936,630,839**	**$22,131,211,359**	**$57,848,461,403**	**$245,017,097,916**

Budget Neutrality Cap (With Waiver)	DY 1 - 11 (10/1/97 - 9/30/09) Projected	DY 12 (10/1/09- 9/30/10) Projected	DY 13 (10/1/10- 9/30/11) Projected	DY 14 (10/1/11-9/30/12) Projected	BIPA Extension (10/1/09 - 9/30/12) Projected	DY 1 - 14 (10/1/97 - 9/30/12) Projected
Demostration Group 1 - TANF Children under age 1 through 20		$4,966,834,516	$5,579,121,696	$6,431,823,892	$16,977,780,104	
Demonstration Group 2 - TANF Adults 21-64		$2,551,412,367	$2,849,133,158	$3,296,420,297	$8,696,965,822	
Demonstration Group 5 - Safety Net Adults		$5,154,238,408	$6,145,332,146	$7,104,700,554	$18,404,271,109	
Demonstration Group 6 - FHP Adults w/Children		$873,765,762	$1,008,432,864	$1,246,905,790	$3,129,104,415	
Demonstration Group 7 - FHP Adults without Children		$384,519,744	$449,293,939	$566,449,136	$1,400,262,820	
Demonstration Group 8 - Family Planning Expansion		$6,471,007	$6,471,007	$6,471,007	$19,413,021	
Demonstration Group 9 - LTHHCP Spousal Program		$30,000,000	$30,000,000	$30,000,000	$90,000,000	
With Waiver Total	**$154,176,182,352**	**$13,967,241,804**	**$16,067,784,811**	**$18,682,770,676**	**$48,717,797,290**	**$202,893,979,642**
Expenditures (Over)/Under Cap	**$32,992,454,161**	**$2,813,377,400**	**$2,868,846,029**	**$3,448,440,684**	**$9,130,664,113**	**$42,123,118,274**

NOTE (1): Net savings do not reflect Community Clinic Indigent Care Pool Federal Financial Support.

Attachment 5
Public Notice

On July 15, 1997, New York State's Medicaid Managed care demonstration program, "The Partnership Plan," was approved by the Federal government under Section 1115 of the Social Security Act. The demonstration requires mandatory enrollment of Medicaid beneficiaries in managed care plans and is designed to improve the health status of low income New Yorkers by: improving access to health services, providing enrollees with a medical home, improving the quality of service provided and expanding coverage to the uninsured with resources generated by managed care efficiencies. The Partnership Plan has resulted in a cost-effective program that has achieved these goals. Amendments to the waiver have expanded coverage through the implementation of the Family Health Plus (FHPlus) program and the Family Planning Expansion Program. On September 29, 2006, New York received approval from the Federal government to extend The Partnership Plan for an additional three years through September 30, 2009.

With the Partnership Plan due to expire on September 30, 2009, the State is preparing a request for federal approval to extend the demonstration for an additional three years through September 30, 2012. The extension will also include requests to expand mandatory enrollment to additional counties when there is sufficient capacity and to expand coverage under government health insurance programs pursuant to recommendations from the Partnership for Coverage.

On September 29, 2006 New York received approval of a second 1115 waiver the "Federal State Health Reform Partnership" (F-SHRP). Through the F-SHRP waiver, New York joined in a partnership with the Centers for Medicare and Medicaid Services (CMS) to reform and restructure the State's healthcare delivery system.

The 1115 waivers require the State to seek Federal approval of any amendments. In addition to a three year extension of The Partnership Plan, New York is seeking approval of an amendment to both waivers to implement mandatory managed care enrollment of Medicaid beneficiaries with HIV/AIDS and to provide twelve months continuous coverage for certain Medicaid and FHPlus beneficiaries statewide.

Additional information concerning the Partnership Plan, F-SHRP and the proposed amendments can be obtained by writing to:

New York State Department of Health
Division of Managed Care
Bureau of Program Planning and Implementation
Empire State Plaza
Corning Tower, Rm 1927
Albany, New York 12237

A detailed summary of the requests will be available to the public on-line at http://www.health.state.ny.us/health_care/managed_care/index.htm.
Written comments will be accepted at the above address and at omcmail@health.state.ny.us for a period of forty-five (45) days from the date of this notice.

ATTACHMENT 6

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

August 8, 2008

Chief Irving Powless, Jr.
Clerk Onondage Nation Territory
Hemlock Rd, Box 319-B
Nedrow, NY 13120

Dear Chief Powless:

In July 1997, New York State received approval from the federal government of its Section 1115 waiver request, known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. The State's goal in implementing this program was to improve the health status of low income New Yorkers by:

- *improving access to health care for the Medicaid population*
- *providing beneficiaries with a medical home*
- *improving the quality of health services delivered*
- *expanding coverage to additional low income New Yorkers with resources generated by managed care efficiencies*

We received approval from the federal government to extend the Partnership Plan through September 30, 2009. As part of that request, we corresponded with you to solicit your comments. This extension expires on September 30, 2009 and it is the State's intent to continue the significant progress made towards achieving its goals by extending the waiver once again. To date, New York has implemented the mandatory Medicaid managed care program in 38 counties and all of New York City. As you know, under the Partnership Plan, Native Americans with Medicaid coverage may enroll in managed care plans but are not required to do so. Under any extension of the 1115 waiver, this exemption from mandatory enrollment for Native Americans will be continued. In addition, for Native Americans who choose to enroll in managed care plans, existing policies relating to tribal providers will be continued.

Prior to submitting a formal request to the Centers for Medicare and Medicaid Services (CMS) for a three-year extension of the waiver, we would welcome your input. We anticipate this extension will have minimal impact on Tribal Nations since it will provide for continuation of existing policies. However, any comments and/or questions you might have concerning the Partnership Plan and its proposed extension should be forwarded to this office by September 11, 2008. We look forward to your continued collaboration on Partnership Plan implementation.

Sincerely,

Vallencia Lloyd
Deputy Director
Division of Managed Care