Application to Extend

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

The Partnership Plan

November 23, 2005

Overview

In July 1997, New York State received approval from the Health Care Financing Administration 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*
- *improving the quality of health services delivered*
- *expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies*

The initial term of New York's 1115 waiver expired on March 31, 2003 and the waiver was extended for an additional three-year period ending March 31, 2006. With CMS approval, it is New York State's intent to continue the successes that it has achieved by extending the waiver for an additional three years pursuant to Section 1115(f) of the Social Security Act.

Project Status

New York began implementation of the Partnership Plan immediately after receiving federal approval. Implementation of the mandatory program was phased in geographically with the first 5 counties beginning in October 1997. Implementation in New York City began in August 1999. Today, New York has implemented the mandatory Medicaid managed care program in 23 counties and all areas of New York City. Voluntary Medicaid managed care programs operate in 21 additional counties. Eight of these counties have at least two plans and work plans are under development with the goal of converting these counties to mandatory programs in 2006. Statewide, Medicaid managed care enrollment has grown from approximately 650,000 in July 1997 to more than 2 million as of November 2005.

In May 2001, CMS approved an amendment to the 1115 waiver to provide for implementation of the Family Health Plus program (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% federal poverty level as of October 1, 2002. For adults without dependent children in their households, gross income can be up to 100% of the federal poverty level.

Enrollment into FHPlus began in September 2001 for all areas other than New York City. Implementation in New York City was delayed until February 2002 as a result of the World Trade Center disaster and the resulting telecommunications damage which seriously impeded access to the State's Welfare Management System. With CMS approval, the State implemented the temporary Disaster Relief Medicaid program and potential FHPlus eligibles were enrolled into this program through January 31, 2002. Individuals were transitioned to FHP or regular

Medicaid over the next year. Enrollment in FHP has grown steadily and today, FHPlus covers more than half a million previously uninsured New Yorkers, far more than initial projections. Changes to the FHP program were enacted by the State legislature in the spring of 2005 and required implementation of resource test for eligibility and co-payments on certain services. NYSDOH received CMS approval of these changes and implemented them during the summer of 2005.

In December 2004, CMS approved an amendment to the 1115 waiver that permits enrollment of dually-eligible individuals (i.e., individuals eligible for both Medicare and Medicaid) in the Partnership Plan. Prior to this amendment, dually eligible individuals 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. The program, known as Medicaid Advantage, builds on the strengths of the well-established Medicare Advantage Program and the state's Medicaid managed care program. Individuals voluntarily enroll in one plan that is approved as a Medicare Advantage and a Medicaid managed care plan to receive most of their Medicare and Medicaid benefits. Statewide, approximately 400,000 individuals are eligible to join Medicaid Advantage. Enrollment began in April 2005 and additional plans will begin participation in January 2006. New York is one of five States recently chosen by the Center for Health Care Strategies (CHCS) for grant funding to further advance efforts at Medicare/Medicaid integration.

In June 2004, New York State began an initiative to outreach to SSI and SSI-related beneficiaries to educate them on the benefits of the managed care program. As part of those efforts, the New York State Department of Health (NYSDOH) in conjunction with the New York City Department of Health and Mental Hygiene (CDOHMH) and Human Resources Administration (HRA), began voluntary mailings to all SSI and SSI-related beneficiaries in the five boroughs of the City. This population previously did not receive information in the mail on Medicaid managed care since New York enrolled SSI beneficiaries on a voluntary basis. The mailings were reminders to beneficiaries that they have an opportunity to choose Medicaid managed care as an option for their health care needs. In addition, a dedicated 800 hotline number was established at Maximus with call center agents trained on issues specific to the SSI population.

After a year of education and outreach to the SSI population, planning began for implementation of mandatory enrollment for this group in New York City. To prepare for this initiative, the State Department of Health worked with the City Department of Health and Mental Hygiene, the Human Resources Administration and Maximus. Preparations included analyzing network adequacy, determining member mailing specifications, modifying enrollment materials and processes, discussions with stakeholders, identifying training needs, and working with plans on ADA compliance and other readiness activities. Mandatory enrollment of this population began in New York City in early November 2005 with approximately 120,000 -130,000 individuals targeted for enrollment. Discussions with other counties for implementation of mandatory SSI enrollment will begin in 2006.

Program Objectives

In the more than seven years since initial approval of its 1115 waiver, New York has made significant progress in achieving the waiver's primary objectives: increasing access, improving quality and expanding coverage to low income New Yorkers. During the requested extension, New York expects this progress to continue and will work actively to bring these same improvements in access and quality to populations not currently enrolled in Medicaid managed care.

Access

An important goal of the Partnership Plan has been to improve access to healthcare services for the State's Medicaid population. Analysis conducted by the State Department of Health (SDOH) has consistently documented significantly improved access under the Medicaid Managed care program.

Primary Care Access

Improving access to primary care is a key objective of the Partnership Plan. To assess performance in this area, the SDOH conducts periodic analysis of physician participation in both Medicaid managed care plans and the Medicaid fee-for-service program. The most recent analysis of primary care and ob/gyn physicians, based on 2nd Quarter 2005 data, indicates the following:

	Fee-for-Service Participating	**Managed Care Participating**
New York City	7,454	8,584
Rest of State	8,498	9,259
Total	15,952	17,843

Primary care capacity in managed care has grown from 15,192 primary care providers in 2001 to 17,843 in 2005, a 17.4 percent increase.

Specialty Access

Access to specialty physicians for Partnership Plan enrollees is essential, especially given the special health care needs that many of these individuals have. . The most recent analysis of specialists, based on 2nd Quarter 2005 data, indicates the following:

	Fee-for-Service Participating	Managed Care Participating
New York City	7,749	13,443
Rest of State	9,551	13,524
Total	17,300	26,967

Managed care affords Partnership Plan enrollees greater access to specialty care, both in terms of the number and type of specialists. Improved access to specialty care is expected to be of major benefit to SSI enrollees as mandatory enrollment of this group is implemented.

Adequacy of Service Delivery Networks

New York has a variety of additional mechanisms to assess the overall adequacy and capacity of the Medicaid managed care plan networks. Plans are required to submit their entire provider network to SDOH on a quarterly basis, where staff reviews each plan to ensure that its network includes appropriate provider types including primary care and specialties, complies with geographic time and distance standards and can support the plan's enrollment based on a standard of 1 primary care provider (PCP) for every 1500 enrollees. Providers that exceed the 1 to 1500 ratio are reviewed and called by staff to verify appointment availability.

Provider network data submitted by health plans is periodically validated to ensure its accuracy. Findings from the third biannual audit of provider network data in fall of 2003 were consistent with earlier audits which showed a high degree of accuracy between what health plans reported and what health plan network physicians believed to be correct. Provider identification variables including name, address, zip code and license, were correct at a very high level (>90%). Primary specialty was correct for 98% of PCPs and for 93% of specialists. Other information verified through the survey included hospital affiliation and wheelchair accessibility, both of which was reported correctly in 89% of the records. Language was reported correctly in 76% of the records, with 21% of the respondents adding at least one language to the record submitted by the health plan.

Quality of Care

In implementing a mandatory Medicaid managed care program, one of New York's primary goals has been to improve the quality of care for the State's Medicaid population and, clearly, the Partnership Plan has established a new standard for accountability. The State's quality assurance monitoring is among the most sophisticated in the nation and provides State and federal agencies, health plans, providers and, most importantly, consumers with information about the quality of care delivered by managed care plans in addition to information about member satisfaction. In December 2004, the National Committee for Quality Assurance (NCQA) announced that three of the nation's "Top Ten" Medicaid managed care plans are New York State plans.

Comparison to National Benchmarks

New York has been publishing quality measures for Medicaid managed care since 1994. The reports, entitled *New York State Managed Care Plan Performance*, are published annually and the 2005 report which measures performance in calendar year 2004 is enclosed with this application. The data are obtained through the annual collection of data known as the Quality Assurance Reporting Requirements (QARR). Annual reports contain information on managed care quality, access, utilization and member satisfaction for the health plans that serve Medicaid managed care enrollees, as well as plans that serve Child Health Plus and commercial enrollees.

The 2005 Report shows continuous improvement in Medicaid managed care over prior years and results that compare favorably with national benchmarks. In fact, for 18 of 19 selected measures, New York's Medicaid managed care program meets or exceeds the national benchmarks. For example:

- New York's Medicaid managed care members with diabetes get more preventive diabetes care and are more likely to have their diabetes in control compared to the rest of the nation.

- Medicaid managed care members in New York with persistent asthma are more likely to have received appropriate medication for their asthma compared to the rest of the nation.

- Women in New York State Medicaid managed care plans are more likely to receive preventive obstetrical/gynecological care than women in Medicaid managed care outside of New York

The table that follows shows by measure how New York's Medicaid managed care program compares to national Medicaid benchmarks.

Measure	2004 National Medicaid Benchmark	2003 Medicaid QARR Rate	2004 Medicaid QARR Rate
Cervical Cancer Screening	65	NR	72
Breast Cancer Screening	54	NR	68
Timeliness of Prenatal Care	78	NR	84
Check Ups After Delivery	57	NR	68
Adult Asthma Medication	65	**71**	**72**
HbA1c Testing	76	**84**	**85**
*Poor Control of Diabetes	49	**42**	**37**
Lipid Profile	80	**88**	**92**
Lipids Controlled (<130)	51	**58**	**63**
Dilated Eye Exams for Diabetics	45	**55**	56
Nephropathy Screening	47	**52**	**56**
Access to Primary Care Providers 12-24 Months 25 Mos. – 6 Years 7 – 11 Years Adults 20-44 Years Adults 45-64 Years Adults 65 plus Years	 92 82 82 75 81 77	 **91** **85** **86** **77** **83** **84**	 91 87 89 77 84 88
Follow-up After Hospitalization for Mental Illness – 30 days	55	**70**	68
Follow-up After Hospitalization for Mental Illness – 7 days	38	**51**	51

* A low rate is desirable
NR = Not reported certain measures are reported every two years.

To achieve these results, the SDOH has worked closely with managed care plans on quality improvement activities. Quality performance matrices are prepared for all plans using QARR data. Plans prepare root cause analyses and action plans for HEDIS®/QARR measures that are identified for improvement. Since this process began, fewer measures have required action plans as a function of improved performance. A paper describing this process entitled *The Quality Performance Matrix: New York State's Model for Targeting Quality Improvement in Managed Care Plans* was published in the Winter 2001 issue of the Quality Management in Health Care Journal.

The SDOH has also made extensive efforts to assure that the results of health plan quality measurements are available to Medicaid beneficiaries. Quality data is published in regional brochures entitled "A Consumer's Guide to Medicaid Managed Care". These guides are available in local district offices and are included in the enrollment packets sent out by the enrollment broker in New York City. Each year since 2001, eQARR - An Interactive Report on Managed Care Performance has been made public on the New York State Department of Health's website. eQARR uses QARR results and the results of the Consumer Assessment of Health Plans survey (CAHPS) to provide consumers with statistical comparisons of health plan performance in six regions of the State.

Comparison to Medicaid Fee-for-Service

While the quality of care under New York State's Medicaid managed care program had been measured for years and results compared between plans and to national benchmarks, one important question remained to be answered: How does the quality of care under the Medicaid managed care program compare to the quality of care under the State's Medicaid fee-for-service program? To answer this question, the SDOH conducted the Fee-for-Service Managed Care Measurement Project. Seven HEDIS® quality performance measures were selected and rates were calculated following NCQA specifications. The table below compares the rates for each of the selected measures using administrative data and/or samples of medical records. The results show that performance in Medicaid managed care exceeded that of Fee-for-Service in all but two measures.

Measure	**Measure Detail**	**Medicaid Managed Care - 2000**	**Medicaid FFS - 2000**
Immunizations	4 DTP	**78%**	64%
	3 OPV/IPV	**83%**	71%
	1 MMR	**88%**	76%
	2 HIB	**79%**	66%
	3 HepB	**80%**	68%
	1 VZV	**72%**	63%
	4-3-1-2-3 Combination	**64%**	50%

Cervical Cancer Screening	Cervical Cancer Screening	**71%**	39%
Use of Appropriate Medications for Asthma	Asthma Age 5-17	**53%**	51%
	Asthma Age 18-56	**62%**	60%
Comprehensive Diabetes Care	HbA1c Testing	**76%**	32%
	Poor HbA1c Control*	**53%**	84%
	Dilated Eye Exam	49%	**51%**
	LDL-C Screening	**68%**	25%
	LDL-C Level	**38%**	15%
	Monitoring for Nephropathy	**45%**	18%
Well-Child and Preventive Care Visits in the First 15 Months of Life	No Visits*	**11%**	12%
	1-2 Visit	**15%**	10%
	3-4 Visits	**19%**	16%
	5 or More Visits	55%	**62%**
Well-Child and Preventive Care Visits in the Third, Fourth, Fifth and Sixth Year of Life	One or More Preventive Visits	**77%**	71%
Adolescent Well-Care and Preventive Visits	One or More Preventive Visits Ages 12-21	**64%**	47%

* A low rate is desirable

Quality Improvement Studies

The Department has conducted several quality initiatives involving Medicaid managed care plans. Three prenatal care focused clinical studies were conducted (1998, 2000 and 2003). A prenatal survey of Medicaid managed care enrollees was conducted in 2002 – 2003 to query experience of care and satisfaction from the enrollee's perspective. The Department also conducted surveys of enrollees with asthma (2001) and diabetes (2002). Fourteen Medicaid managed care plans are currently collaborating with the Center for Health Care Strategies (CHCS) to implement quality improvement interventions in asthma.

In 2002, the Department awarded $1.6 million in funding to collaborations of managed care organizations for projects to improve health status and quality of health care delivery to New York State enrollees. Entitled, *Innovative Approaches to Managed Care Quality Improvement*, 14 Medicaid managed care plans participated in one or more projects. The following is a list of the projects and collaborators:

- **Obesity Surgery's Delicate Balance** - Affinity Health Plan collaborated with AmeriChoice, Health Net of New York, Oxford Health Plans, Independent Health, Fidelis Care of NY, HIP, NY Health Plan Association, Capital District Physicians' Health Plan (CDPHP), Hudson Health Plan and MVP.

- **Collaborative Appropriate Antibiotic Prescribing Initiative** - Excellus Health Plan, Central NY collaborated with CDPHP and United Medical Associates.

- **Improving Adolescent Preventive Services in NYS –** Excellus BC/BS Rochester collaborated with University of Rochester Department of Pediatrics and Excellus Health Plans.

- **Cultural Competency Training-** Fidelis Care of NY collaborated with Neighborhood Health Providers, New York Health Plan Association, United Healthcare of NY, AmeriChoice and the Center for Immigrant Health.

- **Stop STDs –** HealthNow collaborated with CDPHP, MVP and Albany Medical Center.

- **A Model for Training PCPs to Appropriately Diagnose and Treat Depression in a Group Physician Practice –** HIP Health Plan collaborated with Queens-Long Island and Staten Island Medical Groups.

- **Eliminating Disparities in Pediatric Asthma Care –** Community Premier Plus collaborated with New York Presbyterian Hospital.

- **Save Antibiotic Strength New York (SASNY) –** Oxford Health Plan collaborated with Empire BC/BS, Health Net, CDPHP, NY Health Plan Association, Independent Health, MVP, Vytra, NYS Academy of Family Physicians, Medical Society of NYS, Coalition for Affordable Quality Health Care and the American College of Physicians – New York Society of Internal Medicine.

Quality Incentives

The SDOH has taken a lead in developing a system of rewarding health plans that score high on standardized quality and satisfaction measures. A quality incentive built into the auto-assignment algorithm used to assign individuals who do not select a health plan gives preference to plans that exceed specific quality and satisfaction measures. The formula rewards high quality plans with additional enrollment and helps ensure that individuals who do not make a plan selection are assigned to health plans with the highest quality and member satisfaction ratings.

To further strengthen its commitment to quality, the State has implemented a "pay for performance" program that provides financial rewards to plans that achieve high quality and member satisfaction ratings. Health plans can earn incentive payments up to 1% of premium for superior performance. About one-half of the health plans that participate in the Medicaid managed care program have earned incentive payments ranging from .25% to 1.0% of premium. Plans use these incentives to invest in quality improvement and to reward providers.

In 2005, the premium incentive was increased to a maximum of 3% of premium. The total value of the incentive payments is expected to be approximately $45 million in 2005 with 18 plans receiving some level of incentive payment. The Department is working with the Commonwealth Fund on grant funding to evaluate the effectiveness of the quality incentive program.

Beneficiary Satisfaction

SDOH conducts the Consumer Assessment of Health Plan Survey (CAHPS) for the Medicaid population every two years. In the most recent survey, Roper Starch Worldwide Inc. surveyed Medicaid managed care enrollees between March and May 2004. Of the 50,500 people in the original sample, one-half (25,250) were parents or guardians and were sent a survey asking them to answer questions about their child's care. The 19,789 respondents yielded an overall response rate of 44 percent. Highlights of the survey include:

- 79 percent rated their personal doctor or nurse an 8, 9, or 10 on a scale of 0 to 10 with 10 being the best possible,
- Only 9 percent called or wrote their health plan with a complaint,
- 69 percent indicated they received services quickly, and,
- 7 percent fewer enrollees indicated they had a problem with service compared to 2002 (26 percent vs. 33 percent).

Expanding Coverage

A major objective of New York's 1115 Waiver has been expanding coverage. The State's expectation was that providing health care services to Medicaid beneficiaries through managed care plans would generate cost savings for both the State and Federal government. In approving the waiver, CMS concurred with this assessment and agreed to permit the State to use the cost savings generated to provide health coverage to other low income New Yorkers.

Today, this expectation is a reality. The savings generated by New York State's 1115 waiver has enabled the State to cover nearly 1 million low-income New Yorkers. Approximately 476,000 of these are Safety Net recipients who prior to the waiver did not qualify for federal financial participation. An additional 530,000 low-income, previously uninsured individuals now have comprehensive health coverage as result of FHPlus. To permit the implementation of FHPlus, CMS approved an amendment to the 1115 waiver that expanded the eligibility and waived several provisions of the Medicaid statute and regulations so that New York State could expand eligibility for low-income New Yorker's consistent with the State legislation and receive federal financial participation in the costs of the FHPlus program. Through extensive discussions and analysis, the State was able to document that projected savings under the Partnership plan was sufficient to cover the cost of both the Safety Net population and the projected FHPlus enrollment.

Compliance with Terms and Conditions

New York State has worked diligently to assure compliance with the waiver Terms and Conditions (T&Cs). The Operational Protocol sets forth how the Partnership Plan is being implemented, consistent with the T&Cs and the SDOH has worked closely with CMS staff to assure that the Operational Protocol accurately reflects program operations and is kept up to date.

Program Monitoring

Monitoring of program compliance is ongoing. SDOH has conducted program reviews of local district operations to assess program implementation. Regular conference calls have been conducted between SDOH, the enrollment broker (Maximus), the New York City Department of Health and Mental Hygiene (NYCDOHMH) and the New York City Human Resources Administration (HRA) to discuss operational issues, resolve problems and discuss program improvements. Local District and NYCDOHMH staffs routinely monitor managed care plan marketing activities to evaluate compliance with marketing guidelines as set forth in the T&Cs and conditions. HRA conducts on site monitoring of Maximus operations on an ongoing basis.

CMS is able to assess State compliance with the T&Cs in numerous ways. Since the very beginning of the program, conference calls have been conducted first on a weekly basis, then biweekly and then monthly to discuss program implementation, report on problems and address CMS requirements. CMS has conducted readiness reviews prior to each county's implementation and before each phase of NYC implementation to assure that program requirements can be met. CMS conducted a statewide readiness review prior to the implementation of FHPlus. SDOH also provides CMS with monthly, quarterly and annual reports on program activities as required by the T&Cs. In addition, SDOH routinely shares other reports, studies and materials relating to the program with CMS. In preparation for mandatory enrollment of SSI, CMS was provided with all the consumer materials developed as well as SDOH analysis of plan capacity and characteristics of the SSI population. CMS staff also generally monitors meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP), an advisory body appointed by the Governor and the New York State legislature, where program activities are discussed in depth. Finally, in June of 2005 CMS staff conducted an onsite visit to meet with State and City staff, Maximus and two health plan to received an overview of Partnership Plan activities

Through ongoing dialogue, program monitoring and regular and extensive reporting, New York State has assured CMS that it is in substantial compliance with the Partnership Plan's T&Cs.

Financing Mechanisms and Monitoring

SDOH monitors financial solvency of plans and conducts financial capacity analysis to assure that plans have adequate financial capacity to meet the projected enrollment needs. Plan financial solvency is reviewed on a quarterly basis. Key financial indicators reviewed include net worth, contingent reserve requirement and escrow deposits which are liquid assets equal to 5% of projected medical expenses that must be set aside by the plan. All plans participating in the Partnership Plan are solvent.

A plan's financial solvency is determined using its total projected premium revenue and medical costs for the upcoming year to determine its reserves and escrow deposit as required by State regulation. SDOH calculates what each plan's required reserve and escrow deposit amounts would be based on these projections (5% of premium income for reserves and 5% of medical

costs for escrow), and compares them to the plan's actual amounts as reported on the plan balance sheet. Plans who meet the reserve and escrow requirements based on their projections, have met the solvency test. Plans that don't meet the test are required to either increase reserves/escrow, or reduce their projections t.

Once the overall enrollment projection is established, reviews are done periodically to ensure that plans do not exceed their overall enrollment target. If a plan's enrollment does exceed the target, it must demonstrate that it has adequate reserves to increase the enrollment target, or additional enrollment into the plan may be stopped pending such demonstration.

In general, New York State has established premium rates for managed care plans through individual negotiations with each participating plan. Plans provide SDOH with premium proposals reflecting the plan's historical cost experience as well projections for the rate year. Generally, every other year, plan premium rates are trended to reflect expected changes in medical costs and the efficiencies that have been gained as enrollment in the Medicaid managed care program has grown significantly. Over recent years, the State has been successful through this process at containing premium increases to an average of about 2%, significantly below national increases in Medicaid spending.

At the same time that the State has been successful at controlling cost increases, health plans have reported an overall modest surplus from Medicaid managed care operations in recent calendar years and somewhat larger than expected surpluses in FHPlus as a result of service utilization being lower than originally projected and the rapid growth of FHPlus enrollment which allowed for administrative efficiencies. The Partnership Plan's financial stability and its sizeable enrollment base (about 2.5 million people) has resulted in expanded plan participation at a time when other states have experienced declining health plan interest in Medicaid managed care. New plans have entered New York's Medicaid managed care market, one commercial plan that left the program several years ago has rejoined, and several Medicaid and commercial plans have expanded their service area to include more counties. Also as a result of the financial success of the Partnership Plan, several health plans sponsored by traditional Medicaid providers including hospitals and Federally Qualified Health Centers (FQHCs) have reinvested health plan surpluses in New York's health delivery system. Based on recent financial reports, however, some plans are experiencing worsening financial performance and we expect that premium increases next year will exceed the levels of recent years.

Consistent with federal laws and the waiver, the SDOH makes supplemental payments directly to FQHCs and other comprehensive health centers that serve primarily Medicaid and indigent populations. These two transitional payment programs reimburse all or a portion of the per visit difference between the amount the health center would have received under its fee-for-service rates and the amount it received under its managed care contracts. SDOH has reimbursed forty-three (43) health centers more than $162 million dollars for approximately three million visits to Medicaid managed care enrollees since the waiver began on October 1, 1997. For the waiver extension, SDOH will continue supplemental payment to FQHCs as required by federal regulations but will eliminate the transitional payments for non-FQHC clinics.

Compliance with Budget Neutrality Requirements

Section 1115 waivers require that the State demonstrate that the Partnership Plan is budget neutral. Under these provisions, New York State is subject to a limit on the amount of federal Title XIX funding that it may receive for certain Medicaid expenditures during the demonstration period.

In March 2002, New York submitted to the Centers for Medicare and Medicaid Services a request to extend the State's 1115 waiver. In securing approval of that extension, the State demonstrated that the Partnership Plan would achieve budget neutrality and generate savings. That analysis has now been updated to reflect recent cost and enrollment data. Through the end of the current waiver extension (March 31, 2006), the SDOH projects that the waiver will save approximately $6.9 billion, after taking into account the expansion of Medicaid eligibility through FHPlus and after funding the Community Health Care Conversion Demonstration Project which proved highly successful in helping hospitals to transition to managed care.

New York State's 1115 waiver has a documented track record of generating savings for both the State and federal government. Savings are expected to continue through the second waiver extension period and the State's initiatives to expand the Medicaid managed care program to populations currently not enrolled under the waiver creates opportunity for additional savings above and beyond those projected. The fiscal success of the waiver makes it possible to reinvest $1.5 billion in federal funds through the Federal-State Health Reform Program (F-SHRP). Through F-SHRP, New York State and the federal government will partner to consolidate and right-size New York's health care system by reducing excess capacity in the acute care system, shift emphasis in long-term care from institutional-based to community-based settings, and expand the use of health information technology, including e-prescribing, electronic medical records and regional health information organizations. These initiatives will result in additional savings to the Medicaid program through reduced medical costs and administrative efficiencies within the health delivery system. Equally as important, these initiatives will further improve quality of care and patient safety.

New York State has provided CMS with budget neutrality projections through the end of the current extension (March 31, 2006) and through the end of the requested extension (March 31, 2009). SDOH is prepared to respond to any further questions or provide additional information upon request.

State Notice Procedure

Public Notice

New York followed the state notice procedures as published in the *Federal Register* on September 27, 1994 and the consultation requirement with federally recognized tribes as outlined in CMS's State Medicaid Director's letter of July 17, 2001. Both the public notice and tribal letter are attached for your information.

Using 2000 census data, cities with a population of 100,000 or more were identified. A public notice will be published in the newspaper of widest circulation in each area. The chart below lists the cities and newspapers of publication.

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 Times* has virtually statewide circulation.

Newspaper/City	Population
Albany Times Union	95,658
Albany (Albany)	
Buffalo News	
Amherst (Erie)	116,510
Buffalo (Erie)	292,648
Newsday	
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	
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.

Tribal Nations

New York State is home to 8 tribal nations, four of which are federally recognized:

Cayuga Nation of Indians*
Onondaga Nation
Seneca Nation of Indians*
Oneida Indian Nation of New York*
St. Regis Mohawk Nation*
Shinnecock Indian Nation

Tonawanda Band of Senecas Tuscarora Indian Nation
Unkechaug Indian Nation

*Federally Recognized

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

Extension Request

New York State is seeking a three-year extension of the Partnership Plan pursuant to Section 1115 (f) of the Social Security Act. This includes extending existing waivers and Terms and Conditions to the extent that they are still necessary. New York is also seeking new waiver authority in order to continue the facilitated enrollment program. Since the inception of Child Health Plus in 1991, health plans have conducted the eligibility review and enrollment of children into the program. With the implementation of SCHIP (Title XXI), New York created facilitated enrollment as the tool to comply with the "screen and enroll" provisions of the law to ensure that children are enrolled into the correct program. The program was expanded to permit enrollment of adults into Medicaid and Family Health Plus in 2001. Facilitated enrollers may be health plans, providers, and community-based organizations. They perform outreach and application assistance to families. The facilitated enroller works with the family to complete the application, collect the documents, educate the family about managed care and provider choices, and submits the application to the appropriate entity for the eligibility determination (e.g., local district or health plan). Today, over 50 percent of all applications for Medicaid and Family Health Plus originate with facilitated enrollers (100 percent for SCHIP). [1903(b)4; 438.810(a)]

Furthermore, New York's request to amend the 1115 waiver to implement the F/SHRP initiatives is currently pending with CMS. The F/SHRP proposal seeks federal reinvestment of $1.5 billion in waiver savings for F/SHRP reform activities. New York's proposal is to begin F/SHRP during the last year of the existing waiver (April 1, 2005 through March 31, 2006) through a waiver amendment and to continue the program during the next waiver extension period (April 1, 2006 through March 31, 2009). Accordingly, New York seeks to incorporate F/SHRP into this waiver extension.

This application provides CMS with the assurances required under these provisions with respect to achievement of program objectives, compliance with T&Cs, compliance with budget neutrality requirements and evidence of public notice. Additional information can be provided as necessary to assist CMS in its review of this application to extend New York's 1115 waiver.