STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Commissioner

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August 19, 2009

Mr. Clark Cagey
Director, Division of State Demonstrations and Waivers
Family and Children's Health Group
Centers for Medicare and Medicaid Services
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Baltimore, Maryland 21244-1850

Dear Mr. Cagey:

This is in response to your request for additional information dated July 21, 2009, in regard to New York's request for a three-year extension of its 1115 Partnership Plan waiver. The attached document responds to most of the specific questions raised. Additional information requested concerning financing mechanisms, budget neutrality, and advancing the Health Care Improvement Act of 2009 will be submitted under separate cover.

We appreciate your prompt review of our extension request. Please do not hesitate to contact us if you have additional questions regarding this material.

Sincerely,

Jay Laudato
Director
Division of Managed Care

Cc: Camille Dobson
Sue Kelly

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Section 2.7 - Improving the Quality of Health Services Delivered

Assessing Quality of Care (p. 8)

1) **If CMS approves the Department's request to require recipients living with HIV/AIDS to enroll in managed care on a mandatory basis, will the HIVQUAL project be expanded to include mainstream plans? If not, please provide a rationale for excluding enrollees in mainstream plans from the benefits of this quality oversight program.**

The Department's HIVQUAL program was designed for assessing quality of care at the provider level and is not currently planned for use to measure quality at a managed care plan level. The Department's Office of Health Insurance Programs and AIDS Institute have worked collaboratively on the development of a set of HIV-specific quality measures which were added to the QARR measurement set in October 2008. First year data for these measures was received in June of 2009 and are currently being analyzed.

It should be noted that approximately 70% of all persons with HIV enrolled in a mainstream plan are receiving care at either a Designated AIDS Center hospital or some other hospital or clinic that is subject to HIVQUAL reviews. The Department expects to continue using HIVQUAL in these facilities. Quality improvement activities related to HIVQUAL results will clearly impact plan rates for measures that are included in both HIVQUAL and QARR measurement sets.

2) **Even in the HIV Special Needs Plans (SNPs), a few of the quality measures need improvement (e.g. Medication Adherence, PPD). Please provide more detail on the initiatives in place to improve these results.**

HIV SNPs are required to conduct at least one internal performance improvement project each year in a priority topic area of their choosing with the approval of the AIDS Institute. The purpose of these projects is to promote quality improvement within the SNP. Each year SNPs present their results to the other SNPs as a way of sharing best practices, facilitating peer learning and highlighting creative and unique quality improvement projects. The AIDS Institute distributes quality results to the SNPs annually. The SNPs also receive provider level results for their own network providers in order to understand provider level performance and address any issues in performance.

Comparable quality data for Medicaid fee-for-service is collected as part of an all payor sample conducted by HIV providers as part of the AIDS Institute HIV QUAL program. For several measures SNP results are higher than the all payor sample. This includes VL and CD4 monitoring, pelvic exam, substance use and tobacco use screening and medication adherence**.** Adherence measure results for all sites pooled for this group during CY2006 was 60% compared with 67% in SNPs. The PPD measure (test placed and read in second visit within 48-72 hours) was 65% compared with 55% in the SNP Medicaid only group.

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With regard to the medication adherence measure, SNPs are putting substantial effort into ensuring that appropriate HIV medication is prescribed, dispensed and used by enrollees. In 2008, one SNP conducted a project which examined pharmacy dispensing patterns and their clinical impact. This project related directly to the appropriateness of medication regimens and adherence. Based on issues identified, the SNP intervened by, for example, providing HIV education, scheduling earlier PCP visits, performing community outreach (if unable to contact the member by phone) and informing the PCP team.

Assessing Satisfaction with Care – Experience of Adults (p. 10)

3) **The CAHPS results for adults living in New York City are uniformly lower than those for adults living elsewhere. The application states that these measures were included in the Quality Incentive program. Please provide additional information on initiatives undertaken by the MCOs operating in NYC to improve the patient experience for enrollees.**

Plans with rates below the statewide average and trending downward from previous year's result must conduct a barrier analysis and then develop an action plan which is submitted to and monitored by the Department's Quality Improvement staff. Attachment 1 is a brief description of planned actions the health plans have submitted in response to low CAHPS scores for the CAHPS measures Getting Care Needed and Customer Service.

In addition to having plans develop improvement strategies, the Department also sponsors CAHPS-related quality improvement conferences and offers plan-specific technical assistance. The most recent CAHPS improvement conference was held in October, 2008 in New York City.

Survey of HIV SNP Enrollees (p. 12)

4) **Is the Choices in Care Study an ongoing study initiative, or was it time-limited (e.g. one year only)?**

Recruitment of SNP members into the Choices of Care Study began in May, 2003 with recruitment of new SNP members ending in January, 2007. The study initiative ended once a 12 month cycle of individual interviews were completed. There has been some discussion about resuming the study once mandatory managed care enrollment is implemented.

5) **The application notes that the comparison group for the Choices in Care study was FFS recipients. Was any similar assessment done for those enrollees living with HIV/AIDS who were enrolled in mainstream MCOs? Can the Department provide any information about the experience of recipients living with HIV/AIDS who get their health care through mainstream MCOs?**

The Choices of Care study did not include recipients in mainstream managed care plans. However, recipients with HIV enrolled in mainstream plans are included in the biennial

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CAHPS survey sponsored by the Department. Recipients with HIV in Medicaid managed care are identified using administrative criteria and then matched to the respondent set from the CAHPS survey. The table below describes how recipients with HIV enrolled in mainstream plans rate their plans and their health care compared with recipients who do not have HIV.

Satisfaction Ratings of Persons in Medicaid Managed Care
Comparison of those with and without HIV+
(CAHPS)
Rates Adjusted by Respondent Age, Education, General Health Rating

Responders Measures:	HIV Rate	Non-HIV Rate
Getting Care Needed	71.3	76.0
Getting Care Quickly	77.3	79.4
Rating of Health Plan	57.0	66.3
Recommend Plan	88.7	90.4
Rating of all Healthcare	65.3	66.2
Provider Communication	92.2	88.2
Wellness Discussion	62.9	53.9
Rating of Personal Doctor	77.3	74.8

Implementing New Standards for Care (p. 13)

6) **Please explain "upweighted" requirements for primary care training programs in the context of PCP standards.**

Upweighted requirements refer to a New York State program in which primary care training programs are eligible for enhanced reimbursement if they agree to enhanced standards related to ambulatory training structure, ambulatory training time, etc. We made use of some of those requirements during the development of primary care standards that would apply to care in all primary care residency training programs seeing Medicaid members

7) **Please provide more detail about the structure of the planned Patient-Centered Medical Home initiative.**

The Statewide Medical Home initiative, authorized in this year's state legislation, will provide enhanced reimbursement to physicians/practices who meet New York State standards for 'medical home'. After review, the Department selected NCQA's Patient-Centered Medical Home certification as evidence of meeting those standards. Payments will be made both in fee-for-service (FFS) and managed care. NYS is in the process of submitting a SPA for this program.

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Pay for Performance Consortia (p. 14)

8) **What types of providers will the consortia be rewarding for performance? How are such determinations made?**

There are currently three active Pay for Performance Demonstration Projects funded through the Department, all of which have designed incentive programs that reward primary care physicians. Incentive awards were constructed differently for each. One intends to reward physicians who access their data via a web portal and complete a survey regarding the quality of the data and their performance standing compared to regional benchmarks. For the other two projects, rewards will be based upon physician achievement compared with established benchmarks. A final report on the Pay for Performance Demonstration Projects will be available in the second half of 2010.

Section 3.1 - Partnership for Coverage

9) **Since this application was submitted in March, presumably the Departments have presented the results of their study to the Governor. Please provide a summary of those recommendations, and what, if any, impact those recommendations may have on the Partnership Plan demonstration.**

The Departments released the findings from the Urban Institute's analysis of four proposals for health care reform in New York State along with a transmittal report to the Governor. The report did not make recommendations on how the State should proceed with health care reform. The Transmittal Report submitted to the Governor is in Attachment 2 and is also on the DOH website at:
http://partnership4coverage.ny.gov/reports/docs/2009-07-17_release_of_urban_institute_report.pdf

Section 3.2 - Expanding FHPlus Eligibility to 200% of the Federal Poverty Level (FPL)

10) **Please clarify the Department's intent for this proposal: a two-step phase in (from current FPL levels to 160% FPL and then from 160% FPL to 200% FPL), or complete expansion (from current FPL levels to 200% FPL) of eligibility.**

If Federal Financial Participation is approved, the Department's intent is a complete expansion from current FPLs to 200% of the FPL.

11) **Please provide the effective date the Department is seeking for either a two-step phase-in or complete expansion of FHPlus eligibility.**

The Department is seeking to implement the expansion to 200% effective April 1, 2010.

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12) **Please provide enrollment and expenditure projections by demonstration year for either a two-step phase-in or complete expansion of FHPlus eligibility.**

The accompanying chart shows estimated enrollment and expenditures for an expansion of Family Health Plus eligibility to 200% FPL. Based on our experience with the current program, we assume that participation rates will vary based on category (singles/parents) and geography (NYC/rest-of-state), ranging from 37% to 72% across those groups. We anticipate obtaining legislation to authorize a $15 monthly premium contribution for FHP eligible individuals with incomes above 160%. Requiring a contribution at this income level is consistent with current Child Health Plus premium requirements. The participation rates for those above 160% FPL were adjusted to 75% of the above values to reflect the effect of a required $15 per month premium contribution in that group. Based on enrollment patterns in the original program implementation, we assume it will take four years to reach those participation rates, with low participation rates in the initial six months of the expansion. That phase-in is reflected in the annual estimates. Gross annual program costs were estimated based on a $255 PMPM cost and inflated by 6% annually, less any required premium contribution.

The estimates are derived from the Census Bureau's Annual Social and Economic Supplement to the Current Population Survey (CPS). We reconstituted CPS households into groups that would apply together for public health insurance programs and derived their gross income and "case size" accordingly, to determine income as a percentage of the poverty income guidelines. As shown in the top panel of the chart, we estimate there are 446,400 adults with income between the current and proposed eligibility levels for Family Health Plus. The chart breaks this "newly eligible" population into those up to 160% of FPL and those above that level. The latter group is subject to a $15 per person monthly premium contribution. The analysis assumes both groups will be eligible upon implementation of the expansion.

Applying our estimated participation rates to that population, we estimate that 226,900 new eligibles will participate in the expansion, but it will take four years to reach that "full enrollment" figure. When that enrollment level is reached, the annual cost of those enrollees is estimated to be $812.6M. By the end of the third year, we estimate 192,500 newly eligible adults will be enrolled in the program. The gross annual cost associated with the (increasing) enrollment during each program year was derived by multiplying each month's enrollment by the PMPM cost, less any required premium contribution.

We anticipate that the promotional activities associated with the expansion will induce some adults who are currently eligible to enroll in Family Health Plus. This spill-over effect was derived using participation rates that were one-fifth of those used for the newly eligible adults. Among the estimated 272,800 currently eligible adults, we estimate that 33,600 will enroll within four years of the expansion. Adding these currently eligible enrollees to the newly

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eligible enrollees, gross expenditures in the first year are estimated at $41.1M, reflecting the gradual addition of new enrollees, and reach $649.2M in the third year.

Participation and Costs for FHPlus Expansion to 200% of FPL

		Total New Enrollees	Income as % of FPL: To 160%	Income as % of FPL: 160% to 200%	Currently Eligible	TOTAL w/ CURRENT
Single/Childless Eligibles		370,600	259,000	111,600	122,800	493,400
Parent Eligibles		75,800	11,300	64,500	150,000	225,800
Combined Eligibles		446,400	270,300	176,100	272,800	719,200
Full Enrollment		226,900	147,300	79,600	33,600	260,500
Full Annual Cost ($M)		$812.6	$536.8	$275.8	$122.5	$782.8
End of Year Enrollment by SFY	**Year 1**	35,800	23,200	12,600	5,300	41,100
	Year 2	127,600	82,800	44,800	18,900	146,500
	Year 3	192,500	125,000	67,500	28,500	221,000
Gross Annual Cost by SFY	**Year 1**	$35.7	$23.6	$12.0	$5.4	$41.1
	Year 2	$281.0	$186.0	$94.9	$42.4	$323.4
	Year 3	$564.1	$373.1	$191.1	$85.1	$649.2

Assumes participation rates ranging from 37% to 72% for newly eligible singles and parents in NYC and rest-of-state who do not pay premiums. Those over 160% of FPL pay $15 per month toward premiums, and their participation rates were reduced by one-quarter of the above rates. Based on current program, we allow four years to reach those rates.
'Total of New' shows effect on new eligibles. 'Total w/ Current' adds enrollment among current eligibles, at one fifth of above rates. Costs reflect $255 PMPM in Year 1 and 6% inflation.

13) **The narrative in this section references two mechanisms for funding the additional approximately $2 billion (over the 3-year extension period) it will cost to expand eligibility for FHPlus. Please provide a detailed list of State health programs for which the Department is seeking Federal match, as well as the State appropriations in SFY 2009-2010 associated with each. Additionally, provide a detailed explanation of the potential DSH diversion option, including the participation of both the State and local governments and projected potential funding by county.**

The requested information will be submitted under separate cover.

Section 3.3 - Simplifying the Eligibility Process

14) **The Department resubmitted an amendment request on November 4, 2008 to provide 12 months of continuous eligibility for certain Medicaid recipients and all Family Health Plus enrollees after negotiations to provide continuous eligibility through the State plan were**

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unsuccessful. Please provide a revised eligibility crosswalk chart between the State plan and the populations included in this demonstration only along with estimates of additional months of eligibility in each extension year for each population.

The chart below only includes populations included in the Partnership Plan. We estimate that an average of six additional months of eligibility per recipient per year may result from the provision of continuous coverage.

FHPlus eligibles and Single and Childless Couples in Medicaid: *Statewide*
Other eligible groups: *Albany, Broome, Cattaraugus, Chautauqua, Columbia, Erie, Genesse, Greene, Herkimer, Livingston, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Rockland, Saratoga, Suffolk, Westchester*

State Plan Group	**Partnership Plan Waiver Group**
Single Individuals and Childless Couples- Not a State Plan group	Adults who were in receipt or eligible for Safety Net Cash Assistance but are otherwise ineligible for Medicaid
FHPlus eligibles- Not a State Plan group	FHPlus eligibles: * - families with gross income up to 150% with resources that do not exceed 150% of the medically needy income standard - childless adults age 19-64 with gross income up to 100%FPL with resources that do not exceed 150%FPL of the medically needy income standard
Sec. 1905(a)(i) Under 21 year olds -children eligible at the medically needy income level -19 and 20 year olds	-Children through age 18 with income between the Medicaid Standard (formerly PA Standard of Need) and the Medically Needy Income Level. -Children 19-20
Sec. 1905 (a)(ii) Caretaker relatives of dependent children	Adults (21-64) AFDC-related family member
Sec. 1931 Low Income Families	Adults (21-64) AFDC-related family member
Sec. 1902(a)(10)(A)(i)(III) Qualified pregnant women	Pregnant women with incomes up to the Medicaid Standard

*Current levels; does not reflect proposal to expand to 160% or 200%.

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15) **Please confirm that the Department will operationalize this process by relieving recipients of the obligation to report changes in income and resources between redeterminations.**

The Department's intent is to relieve recipients included under continuous coverage of the obligation to report changes in income and resources between redeterminations.

16) **Will recipients be required to report other changes that may affect eligibility (e.g., move to a different State)? Will the Department ignore until the next regularly scheduled redetermination any information received from other sources that may impact recipients' eligibility (e.g., increase in income reported to the State's Income Eligibility Verification System or Food Stamps/SNAP program)? Under what circumstances will eligibility be terminated before the next regularly scheduled redetermination?**

Eligibility will not be terminated for increases in income of which the Department becomes aware, but may be terminated for other reasons, such as moved out of state, death, client request, and the discovery that the original determination or most recent redetermination was in error because the recipient misrepresented facts material to his/her eligibility. Eligibility may be suspended upon incarceration.

17) **Please explain how changes in family size or other eligibility characteristics (e.g. an eligible child no longer lives with a caretaker parent/parent; end of the post partum period for a woman eligible through pregnancy; a child aging out of an eligibility category; end of foster care eligibility for a child) will affect the individual's eligibility under this proposal.**

The Department plans to provide continuous coverage in instances of household size changes and other eligibility changes.

18) **The Partnership Plan demonstration does not include all the individuals eligible for Medicaid in the State. Do the Department and the county social services districts have the capacity to identify those individuals who will NOT be eligible for 12 months continuous enrollment and handle their eligibility redeterminations accordingly?**

Our intent is to provide continuous coverage statewide to individuals living in all 62 counties. We will be able to identify those individuals whom our state statute excluded from continuous coverage, e.g., SSI cash recipients, spend-down clients.

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19) **Please provide the specific expenditure and/or waiver authorities, or special terms and conditions that the Department wishes to have modified to accommodate the various eligibility simplification proposals in the extension request.**

The DOH is currently in the process of identifying all of the specific expenditure and/or waiver authorities and special conditions related to the State's eligibility simplification requests.

Regarding 12 months continuous eligibility, the Department proposes to add the following to the Special Terms and Conditions:

Individuals enrolled in the Family Health Plus program and individuals in the following Medicaid categories will be eligible for a total of twelve months of continuous coverage from the initial determination of eligibility and from the date of any subsequent determination of eligibility (this does not apply to individuals who have available monthly income in excess of the medically needy income level and spend down to become eligible for Medicaid):

- Single individuals and childless couples in Medicaid;
- ADC-related children (aged 19 - 21);
- Parents and caretaker relatives living with dependent children under age 21; and
- Qualified pregnant women.

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

20) **Would the Department be amenable to limiting the change in FHPlus eligibility to employees of county or municipal governments or school districts?**

State statute allowing public employees to enroll in FHPlus does not differentiate between types of public employees.

Section 3.5 - Expanding Mandatory Managed Care (MMC)

21) **If an amendment was no longer required to expand MMC to additional counties, how will the Department inform CMS of such an undertaking, including phase-in plans and outcomes?**

Counties newly eligible for mandatory Medicaid managed care enrollment will follow the same process that the State used to roll out mandatory managed care in the early days of the waiver. Before commencing any readiness activities with a particular county, the Department will inform CMS of its intent to expand mandatory managed care into that county and provide a proposed implementation plan and a timeline. OHIP's Bureau of

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Program Planning and Implementation will initiate extensive readiness activities in each county implementing mandatory enrollment. Prior to implementation, the Bureau will conduct an on-site readiness review using an assessment tool created by CMS and updated for the implementation of mandatory managed care enrollment of the SSI population.

22) **The Department submitted an amendment request on November 4, 2008 to require persons living with HIV/AIDS (PLWHAs) to enroll in managed care. However, a request for additional information was not sent to the Department for response. Therefore, we request that the Department provide written responses to the following questions:**

a) How will the boroughs in New York City be phased-in? Please provide more detail.

Prior to implementing mandatory managed care enrollment for people with HIV/AIDS, the Department will send a general mailing to all Medicaid individuals who are known to have an exemption for HIV/AIDS alerting them that they may be required to enroll in managed care. The mailing will not explicitly identify the person as having HIV/AIDS, but will inform them that managed care enrollment is mandatory and a letter that specifies a choice date will be forthcoming. Following this general mailing, a mandatory enrollment notice which will include details on exemption criteria will be mailed by borough, with no more than 2,500 mailings per month. The order of the phase-in by borough is Brooklyn, Bronx, and Manhattan followed by Queens and Staten Island, which will be grouped together. Staggering by borough will provide ample time for the Department to communicate with providers, advocates, and other stakeholders in the local community to ensure that outreach activities are targeted to the areas receiving the mailings.

b) Please provide the rationale for giving PLWHAs 60 days to make an affirmative selection of a health plan, rather than the 90 days afforded to disabled individuals.

Individuals who are SSI or SSI-related will still get 90 days just as with all other SSI cases; non-SSI individuals will be given 60 days. The Department does not believe it is advisable or necessary to provide a different timeframe for those with HIV/AIDS since there is an element of disclosure in doing so. The existing enrollment materials will be revised to emphasize the choices for people with HIV/AIDS. The experience with the SSI enrollment shows that most people who do make a plan choice do so early in the choice period, well within the 60 days, and there is minimal added value to the 30 extra days. By taking advantage of the significant infrastructure that exists in the HIV/AIDS community, we anticipate that enhanced outreach will lead to higher voluntary choice rates.

c) The Department cites "confidentiality concerns" as the reason for not auto-assigning to an HIV SNP those PLWHAs who do not affirmatively select a MCO. Please expand upon those concerns.

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Auto-assignment to an HIV SNP may cause unanticipated disclosure or fear of disclosure for beneficiaries who wish to keep their HIV status confidential from family and friends. Once enrolled in an HIV SNP, plans are required to conduct aggressive outreach (including a home visit if other contact fails) to new members to assess care needs and arrange for coordinating ongoing care in the plan. If auto-assigned to a SNP, this specific group of new members may be concerned about additional disclosure as a result of plan contact. During mandatory planning discussions, the outreach goal for people living with HIV/AIDS (PLWHAs) was to limit auto-assignment. Beneficiaries who get auto-assigned to a mainstream plan can transfer to an HIV SNP and exercise that choice at any time. This flexibility allows SNP access to beneficiaries who may have been auto-assigned to mainstream but who would benefit from the enhanced services offered by a SNP.

d) How will the Department monitor and ensure that auto-assignments rates for PLWHA is consistent with the auto-assignment rates which resulted from the mandatory managed care enrollment of SSI-eligible individuals in New York City?

We believe that continued outreach to the HIV/AIDS community including providers, advocates, and consumers will lead to voluntary choice rates that are higher than the rates for SSI-eligible individuals. This outreach will encourage providers, state and local agencies, advocates, health plans, and others to work with consumers who must choose a plan. The Department will review the mailing schedules and track the voluntary choice rates as the program is implemented.

e) Some PLWHA will be exempt from mandatory managed care enrollment due to other circumstances, and may request an exemption through the enrollment broker in NYC. Please provide the most recent managed care exemption form being used in NYC.

Since all other exemptions remain in place, a person who has other circumstances that meet the exemption criteria will continue to be exempt and can apply to be exempt from mandatory enrollment. The current exemption form is included as Attachment 3.

f) CMS has heard concerns from multiple advocacy groups about the capacity of the mainstream MCOs to provide appropriate care to PLWHAs; however, those concerns are belied by the data showing that those PLWHAs who choose to enroll in managed care overwhelmingly select a mainstream plan. Please provide the data that demonstrates adequate network capacity (e.g. Designated AIDS Centers) in the mainstream plans.

Mainstream managed care plans are contractually obligated to include Designated AIDS Center (DACs) hospitals in their networks and all New York City plans contract with multiple AIDS Centers. Plans are also required to include Ryan White funded programs

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in their network. The table below shows how many contracts each plan in New York City has with a DAC hospital or other HIV specialty hospital or clinic. In addition, health plans are required to provide quarterly as part of the provider network submission information that identifies physicians who are HIV-experienced.

Provider Network Data - 4th Quarter 2008

Count of New York City AIDS Services Providers

	Ancillary Services	
Plan Name	**Designated AIDS Centers**	**AIDS Clinics**
Affinity Health Plan	14	3
Amerigroup	12	1
GHI HMO Select	20	2
Health Insurance Plan	32	21
Health Plus	10	11
Healthfirst PHSP	9	2
Metroplus Health Plan	16	2
Neighborhood Health Providers	16	19
New York State Catholic Health Plan	22	3
Unitedhealthcare Of New York	8	0
Wellcare	13	0

Also, a recent amendment to the model contract requires mainstream plans to identify HIV specialists (defined as having 20+ patients or are accredited by one of several bodies) within their network in their provider directories. This will enable newly-enrolled recipients to identify experienced physicians if they do not currently have one.

g) **When the Partnership Plan was first approved, it was projected that HIV SNPs would enroll as many as 100,000 PLWHAs. However, as of April 2009, approximately 5,000 PLWHAs were enrolled with a HIV SNP. If a clear majority of PLWHAs are "voting with their feet" in choosing a mainstream plan over an HIV SNP, what unique value do HIV SNPs offer to the NY managed care program? Has the Department discussed these concerns with the HIV SNPs to identify the reasons for low enrollment**?

Using 2007 beneficiary enrollment data, the New York City HIV+ Medicaid population was revised to 51,500, with an estimated 36,805 beneficiaries eligible to enroll in managed care. Some individuals were already enrolled in managed care at time of diagnosis and remained in the plan. To date, there are 5,800 SNP members. While the majority of new enrollment each month comes from FFS beneficiaries, enrollment also comes from those who disenroll from mainstream programs.

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HIV SNPs are a valuable component of New York's managed care program and offer another care options for persons living with HIV. In these plans, members have HIV-experienced providers as PCPs and a care coordination that is specialized to meet the needs of HIV+ members. SNP programs address preventive health and have links to supportive community services that address members' psychosocial needs in specifically targeted ways. The Department has discussed enrollment with the SNP plans and has seen progress in SNP growth as a result. In part this growth is attributable to the SNPs expansion of provider networks, especially large DAC providers. On-going outreach and education about Medicaid managed care in the community by the Department has led to positive conversations between HIV providers and SNPs.

h) The Program Evaluation cites a unique "live and work" rule for PLWHAs living on Staten Island, which does not have a SNP or Designated AIDS Center. How does this rule facilitate access to services for PLWHAs? Will it be continued once managed care enrollment is required?

None of the SNPs include Staten Island (SI) as part of their service area at this time and the DACs located in SI closed in June, 2008. Because medical care and specifically HIV care is limited on Staten Island the expansion of the "live and work" rule gives HIV+ beneficiaries the same SNP choices as others in the remaining four NYC boroughs. SNPs are able to establish limited networks of providers in SI and SNP members would also have access to a broader SNP network of medical services than is available on SI. Because care coordination is a required SNP benefit, SNPs are able to help members get access to services they have difficulty finding on their own. The "live and work" rule will continue once managed care enrollment is required. A phased-in schedule described above has Staten Island in later part of phase-in to allow for more network development by the plans.

i) The Department created an e-mailbox last fall to accept comments from advocacy groups and others about this proposal. Please summarize the comments received from this mailbox.

The Department received one set of comments on the waiver amendment request from Medicaid Matters (Attachment 4). In their May 5, 2009 letter, Medicaid Matters expressed strong support for the proposal to provide twelve months of continuous coverage for certain adults, saying that it will reduce gaps in coverage. The balance of comments focused on the proposal to mandatorily enroll people living with HIV/AIDS, as follows:

- Member satisfaction surveys do not necessarily reflect the specific experiences of disabled individuals.
- Plan networks may not include enough HIV specialists.

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- Any one plan may not include all of an enrollee's providers, requiring enrollees to choose among their providers.
- To avoid high auto-assignment rates, New York Medicaid Choice call center capacity should be increased and NYC managed care staff should receive training regarding the needs of people living with HIV/AIDS.
- A comprehensive outreach campaign for beneficiaries, providers and health plans should be undertaken to ensure enrollment efforts reach the HIV/AIDS population, including alternative forms of outreach for the unstably housed, instructions on responding to enrollment letters, what enrollment will mean to these individuals and how to avoid interruptions in services.
- A longer choice window and a shorter lock-in period should be afforded this population.
- The program should be evaluated after the first 2,500 enrollments and enrollment halted if auto-assignment rates are high.
- Potential enrollees should be pre-coded for automatic exclusions and exemptions based on utilization data.
- Since individuals who fail to choose a plan will be auto-assigned to a mainstream plan, the same standards of care that apply to HIV SNPs should apply to mainstream plans with respect to service coordination, case management and community services linkage requirements.
- The mandatory enrollment program does not address systemic problems faced by people living with HIV/AIDS, including poor communication and lack of respect from health care practitioners, inadequate transportation, financial distress, lack of integration of services, continuity of care and inadequate follow-up after hospital discharge.
- The health screening form should include questions about the need for reasonable accommodations and plans should provide data to the Department regarding accommodations requested and granted.
- To ensure continuity of care, health screening forms should be promptly completed and shared with case managers; the Department should monitor compliance with transitional care requirements.
- Outreach, education and case management efforts should be initiated to assist enrollees in navigating a "bifurcated" delivery system in which some benefits are provided by the plan and others are carved out.
- Procedures are needed to ensure plan compliance with due process requirements to ensure enrollees do not lose access to critical services.

These comments as well as input received from providers and community organizations throughout the implementation process have and will continue to be taken into account as we develop policies related to enrollment, case management requirements, choice period, outreach and education.

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

23) **Please provide additional detail on the history of this eligibility policy and why it cannot be addressed within the context of the State's home and community based services waiver (Long-Term Home Health Care Program or LTHHCP).**

On October 30, 2008, CMS advised the Department that it cannot apply spousal impoverishment post-eligibility rules to medically needy individuals. Furthermore, CMS advised that Section 1924(h) of the Social Security Act only permits a participant in a home and community-based waiver program to be considered an institutionalized spouse if s/he "is described in section 1902(a)(10)(A)(ii)(VI) of the Act." To determine income eligibility for this group (a group that New York State does not cover), states use a special income standard of 300 percent of the federal SSI community payment. If the applicant's income is over this amount (incurred medical bills cannot be used to spenddown to the income level), the individual is ineligible.

New York State has not elected to cover the group described in Section 1902(a)(10)(A)(ii)(VI) of the Act because the State covers institutionalized individuals under its medically-needy program; thus, providing Medicaid coverage to individuals who have income that is over the income limit but insufficient to cover the cost of their institutional care. Furthermore, election of the group described in Section 1902(a)(10)(A)(ii)(VI) of the Act would not be limited to determining eligibility for participants in a home and community-based waiver program, but would affect all eligibility determinations for institutionalized individuals.

24) **The State was previously advised that individuals whose eligibility is determined under the 1115 demonstration could not be served under a 1915(c) waiver. Individuals served under a 1915(c) waiver must be eligible through the Medicaid State plan. How will the State address this issue?**

This will require further follow-up discussion with CMS.

25) **Subsequent to the submission of the application, the State further refined this population. Please explain the difference between "those who would otherwise have an income spenddown if community budgeting rules were used to determine eligibility" (the population definition in the application) and "those where the change in budgeting (i.e. no post eligibility treatment of income deduction) would increase the individual's spend-down (the population definition provided to CMS on April 6).**

Under the LTHHCP 1915(c) waiver, the State requested waiver of Section 1902(a)(10)(C)(i)(III) of the Act to use institutional income and resource rules for the medically needy. The definition change for the target population clarifies that these individuals would have an increased spenddown if institutional income and resource rules are used for the medically needy with no post-eligibility deduction for a community spouse allowance. Since the State currently uses institutional rules,

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instead of community rules, for the target population, reference to community budgeting rules was deleted.

We have identified a group of spousal cases (LTHHCP waiver recipients with a spouse) who will have less income that can be retained by the household, if the post-eligibility deduction of the community spouse income allowance is eliminated. In these cases the amount which is currently retained by the household would have to be applied to the waiver recipient's cost of care. This would occur when the community spouse's income is below the minimum monthly maintenance needs allowance and the waiver recipient's income is over the Medicaid income level for one.

26) **How many individuals in the LTHHCP will be affected by this provision?**

Based on 2006 Welfare Management System (WMS) data, an estimated 1200 LTHHCP waiver participants may be affected by this provision.

27) **What is the total cost of the HCB services these individuals received in the most recent year that data is available?**

Based on 2007 claims data, the most recent available, the cost of service for these recipients is estimated at $34.3 million. Please note, however, that as described in an April 2, 2009 letter to Mr. Clarke Cagey, the State has proposed to include in the Partnership Plan waiver only the cost of the total annual spenddown amount that would be available toward the cost of care if spousal eligibility but no post-eligibility rules had been used. This is estimated at $8 million annually.

28) **How does the State intend to treat unmarried individuals who are currently being served under the LTHHCP waiver?**

Unmarried recipients participating in the waiver will retain income up to the Medicaid income level for a household of one (or higher if living with dependent child/children). Excess income will be applied to the cost of medical care.

29) **How does the State intend to treat unmarried applicants for the LTHHCP?**

Unmarried applicants for the LTHHCP will be allowed to retain income up to the Medicaid income level for a household of one (or higher if living with dependent child/children). Excess income will be applied to the cost of medical care.

30) **How does the State intend to treat medically needy individuals without a spenddown under the LTHHCP waiver**?

If a married medically needy individual has no excess income, using the institutional income and resources rules but no post-eligibility, the individual would be eligible for coverage. If a single

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medically needy individual has no excess income, using the Medicaid income level for one, the individual would be eligible for coverage.

31) **Will these provisions be applied to new applicants to the LTHHCP program? If so, please provide an estimate of the number of individuals and the associated costs for the three-year extension program.**

Yes, these provisions will be applied to new LTHHCP applicants. Consistent with LTHHCP 1915(c) waiver application participant enrollment numbers, approximately 40 new applicants annually may use the spousal provisions to apply for LTHHCP participation. During the three-year extension period, the annual Medicaid cost for new participants is estimated at $4 million—significantly less than the cost of nursing home care.

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

32) **Please provide a detailed explanation and history of the Indigent Care Pool, including State appropriations for the pool over the past 10 years.**

The Legislature through the enactment of the New York Health Care Reform Act of 1996 (HCRA) amended Section 2807 of the Public Health Law by adding Section 2807-p to establish authority for the Comprehensive Diagnostic and Treatment Centers Indigent Care Program. Passage of HCRA 2000 resulted in a further continuation of this section as it pertains to diagnostic and treatment centers (D&TCs). The legislation allocated an annual aggregate amount of up to $45 million to be distributed to eligible voluntary, non-profit and publicly sponsored D&TCs.

Also, Section 2807-p and Section 2807-l of the Public Health Law provides for up to $3,000,000 to eligible D&TCs. Comprehensive primary care providers with less than two years of operating experience and comprehensive primary care providers that have received Certification of Need (CON) approval indicating a significant increase in uninsured visits are eligible for consideration of a grant award.

Furthermore, according to PHL 2807-p.4-c, additional payments for uncompensated care shall be made to voluntary non-profit D&TCs that are eligible for indigent care grants for the periods of 6/1/2006-12/31/2006 and 1/1/2007-12/31/2007, in the amount of $7,500,000. However, for periods on and after January 1, 2008, such additional payments shall be distributed to both voluntary, non-profit D&TCs and public D&TCs; for the period 1/1/2008-12/31/2008, in the amounts of $7,500,000, and for the period 1/1/2009~12/31/2009, in the amounts of $7,500,000.

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To be eligible, the facility must: provide a comprehensive range of primary health care services; have provided services to uninsured individuals to account for at least 5% of the total base year threshold visits; be able to demonstrate that it has made reasonable efforts to maintain financial support from community and public funding sources; be able to collect payments from third party insurance payers, governmental payers and self-paying patients; and receive an all- inclusive cost based Medicaid rate in accordance with the Commissioner of Health's Administrative Rules and Regulations Part 86-4.11.

Losses are calculated by applying the current all-inclusive Medicaid rate to the base year eligible visits to establish the cost of providing services to the medically indigent and by offsetting such costs with revenues received from care granted to eligible visits. The base year for the Indigent Care calculation is two years prior to the grant period.

The indigent care allocations of funds for each eligible D&TCs shall be based on the dollar value of the result of the ratio of total funds allocated for distributions for all eligible D&TCs to the total statewide nominal payment amounts for all eligible D&TCs.

A nominal payment amount for the financing of losses associated with the delivery of uncompensated care will be established for each eligible D&TC. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of uncompensated care for percentage increases in the relationship between base year period eligible uninsured care clinic visits and base year period total clinic visits according to the following scale:

% of eligible indigent care clinic visits to total visits	**% of nominal financial loss coverage**
up to 15%	50%
15 ~ 30%	75%
more than 30%	100%

Indigent Care Grant for the last 10 years

Effective Period	Regular Amount	Supplemental Amount	Total
1/1/2009-12/31/2009	$59,450,000	$2,940,000	$62,390,000
1/1/2008-12/31/2008	$51,468,750	$2,931,250	$54,400,000
1/1/2007-12/31/2007	$52,500,000	$3,000,000	$55,500,000
1/1/2006-12/31/2006	$52,500,000	$3,000,000	$55,500,000

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1/1/2005-12/31/2005	$45,000,000	$3,000,000	$48,000,000
1/1/2004-12/31/2004	$45,000,000	$3,000,000	$48,000,000
1/1/2003-12/31/2003	$45,000,000	$3,000,000	$48,000,000
10/1/2002-9/30/2003	$45,000,000	$3,000,000	$48,000,000
10/1/2001-9/30/2002	$45,000,000	$3,000,000	$48,000,000
10/1/2000-9/30/2001	$45,000,000	$3,000,000	$48,000,000

33) **Is the Indigent Care Pool currently (for F-SHRP) or potentially (for the Partnership Plan) a designated State health program? If so, please clarify how the State would get Federal match in two different ways.**

The clinic indigent care program is not a DSHP under F-SHRP.

34) **How does the State's DSH allotment factor into this request?**

The State seeks to secure a federal match to existing State funds dedicated to the clinic indigent care program. The State is amenable to counting the resultant Gross Medicaid payments against statewide FFY DSH allocations, if required.

Section 3.8 - Advancing the Health Care Improvement Act of 2009

35) **Please provide a detailed explanation of the "partnership" the State is requesting access new Federal matching funds for state health reform efforts, including dollar amounts per year and anticipated outcomes.**

DOH will respond under separate cover after discussion with CMS.

Section 4 – Program Evaluation

36) **On page 3-17 of the Interim Evaluation Report, concerning Objective 5: HIV Special Needs Plan, Delmarva indicates that the low enrollment (contrary to initial expectations) in HIV SNPs reflects "the voluntary nature of the program and the non-participation of several large HIV care providers." Does the Department agree with this assertion? If so, the Department has never advised CMS that there were large providers missing from the**

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SNP networks. Please provide the names of these providers, and advise whether they are also not participating with the mainstream plans.

Yes, the Department agrees with both observations. In 2005, Fidelis and HealthFirst SNPs ceased enrollment. The HIV PCP networks of these plans included the large Designated AIDS Centers (DACs) listed below. These DACs did not overlap with the PCP networks of the three remaining SNPs at the time these plans closed. Fidelis and HealthFirst also have mainstream programs that include these HIV programs as specialty providers. All of the larger hospital institutions listed below participate in the mainstream program for all their members. In contracting with plans, the hospitals include the AIDS Centers as participating providers. These DACs are now contracted with at least one of the three NYC SNPs.

Previously Contracted with the Fidelis SNP network
St. Vincent Catholic Medical Centers
Catholic Medical Centers
Bronx-Lebanon Hospital Center

Previously Contracted with the Healthfirst SNP network
Beth Israel Medical Center
Bronx-Lebanon Hospital
Interfaith Medical Center
Montefiore Medical Center
St Luke's Roosevelt Hospital Center
University Hospital of Brooklyn

37) **On page 2-7 of the Interim Evaluation Report, Delmarva recommends that the Department explore an improvement in access to specialists. Since this issue continues to be a concern, particularly in more rural counties, please provide more information on initiatives from the MCOs to not only increase the number of specialists and subspecialists, but also the availability of appointments with those physicians.**

We routinely monitor plan networks for adequacy. Where there is an inadequate number of providers, including specialists, the plan is notified. The notification includes the number of specialists contracting with other MCOs in the county. If the plan cannot secure a contract, the Department requires that the plan permit members to receive services from either an out-of-network provider or an in-network provider in another county (but only if the member agrees to go out of county) and that the plan continues contract negotiations.

If the Department's complaint process reveals that network providers are not available to members, we require the plan to contact the provider. If the problem cannot be remedied, we instruct the plan that it must arrange for care even if it is out of network or with a provider in another county if that is more convenient for the member.

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38) **Does the Department intend to undertake another satisfaction survey of disabled individuals enrolled in managed care, now that the phase-in process across the State is substantially complete? If so, please advise how concerns about accessibility and accommodations will be addressed.**

The Department intends to repeat the SSI Experience of Care survey upstate and Long Island counties in the fall of 2009.

Section 5.1 - Program Monitoring

39) **Please provide a description of the Department's oversight and monitoring of its Facilitated Enrollment (FE) program, including any corrective action undertaken in the past three years.**

Effective January 1, 2007, health plan facilitated enrollers were required to submit a facilitated enrollment integrity compliance plan to the Department for approval. These plans included the following components: information on how applications are being reviewed for quality and completeness; telephone verification on a sample of applications to ensure that information is accurate and secret shopping of facilitated enrollment staff to ensure appropriate behavior. Health plans are required to submit quarterly reports detailing these activities to the Department.

Health plans must also report any instances when their compliance activities reveal inappropriate behavior on behalf of a facilitated enroller. Since the compliance program was implemented, several health plan facilitated enrollers have been removed from their duties when inappropriate, potentially fraudulent, activity was found. In those instances, health plans are required to review that facilitated enroller's prior applications to ensure there was no evidence of fraudulent activity. Appropriate action is taken if the individual was inappropriately enrolled as a result of the facilitated enroller's actions.

Additionally, the Department conducts onsite reviews of the facilitated enrollment compliance activities as part of its annual Child Health Plus audit process. This consists of reviewing the health plan's compliance with their plan and conducting an audit of a sample of applications completed by their facilitated enrollers. After completion of the audit, the Department makes recommendations for corrective action, as necessary.

40) **Please confirm that the Department is seeking to continue the FE program for the extension period.**

Yes, the Department is seeking to continue to fund the FE program for the extension period.

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41) **Please provide an update on the Department's ongoing monitoring of high auto-assignment rates for SSI eligibles in certain upstate counties, and progress in bringing those rates into line with the rest of the State.**

On a monthly basis, the Bureau of Program Planning and Implementation reviews the auto-assignment (AA) rates for the Medicaid managed care population, including the SSI population. After the expansion of MMC to the SSI population in upstate counties, analysis of initial data on the AA rates for this population revealed higher than acceptable rates in a number of upstate counties. In response, the Department initiated a policy that suspends AA in counties with rates above 30%. Once suspended, the county must submit a corrective action plan. AA is not reinstated until the county shows significant improvement in the plan selection rate of their SSI beneficiaries. For counties with an AA rate between 20% and 30%, county staff must submit a work plan outlining their strategies for reducing those rates.

In March, 2009, AA was suspended in four counties -- Monroe, Erie, Oswego, and Chautauqua. SSI persons who would have been auto-assigned to a health plan were placed on an exception report rather than the auto-assignment being effectuated for May and June. Since the Department took this action two of the four counties -- Chautauqua and Oswego -- have improved their AA rates. Discussions with Erie and Monroe counties (whose rates have decreased slightly) are on-going to ascertain whether there are additional strategies can be undertaken to reduce further the rate.

The Department continues to monitor and work closely with all counties in implementing strategies for lowering SSI AA rates and keeping them as low as possible. Strategies that were implemented by counties and the State include but are not limited to:

- In counties where AA is suspended, the Division of Managed Care sends an additional letter to persons targeted for AA as a "heads up" enrollment reminder. The letter was designed to include a graphic of the Medicaid card to get the attention of the reader and the outside envelope was stamped "URGENT."

- Some counties are sending additional mailings with a colored postcard.

- All counties are including the interim step of coding the client with a 90 (Exclusion) if mail is returned to avoid auto-assigning someone with an incorrect address. Once a correct address is ascertained and confirmed, mailings begin again.

- Both counties and the Department are outreaching to providers including case managers and pharmacies, asking them to encourage their SSI patients to contact their county's Medicaid managed care office. A statewide mailing to providers with large numbers of SSI patients that highlights the program and urges them to assist clients in choosing a plan was sent out in July.

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- Managed Care staff is encouraged to engage staff in other parts of their agencies such as front desk staff and workers in adult services who may act as representative payees for SSI individuals, HEAP, Homeless, Food Stamp and Temporary Assistance workers. The staff is asked to refer individuals back to the Medicaid managed care office for an enrollment discussion. Counties can also screen individuals from lists for involvement in other LDSS cases (i.e., Food Stamps, HEAP) for more current addresses, phone numbers, and possibly family enrollment in managed care so individuals can be processed as case additions (as in the case of a child on SSI).

Section 5.2 – Financing Mechanisms

42) **Please provide a summary of the Department's experience after the first year of moving to risk-adjusted capitation rates for the MCOs. How has this approach affected the determination of actuarial soundness of the rates?**

New York State implemented a risk adjusted rate methodology in 2008 based on Clinical Risk Groups (CRGs). All plans in a region receive the same rate, adjusted for each plan's relative risk score. This regional risk methodology is being phased in over a four year period. For the initial rate period, April 2008 through March 2009, plans received a rate that was 25% based on the regional risk rating method and 75% based on each plan's own previously negotiated rate trended forward. For April 2009 through March 2010, 50% of the plans' rate was based on the regional risk method and 50% based on the plan's previously negotiated rate trended forward. For April 2010 through March 2011, the rate will be 75% regional risk adjusted and 25% individual plan rate, and by April 2011, rates will be completely phased in to regional risk.

The State's actuarial consultant, Mercer Health and Benefit, LLC, was involved in both the development and testing of the CRG rate methodology. Mercer determined that the CRG software was a viable alternative to other available risk software models, based on a comparison of CRGs to the two most common risk software approaches. Mercer also ensured that the capitation rates were developed in accordance with rate-setting guidelines established by CMS.

Plans have reacted favorably to the model. Currently, plan risk scores are determined once annually, although information about all plans risk scores is calculated on a rolling quarterly basis and provided to the plans during the year. It is possible that more frequent updates to the relative risk scores could be incorporated into the model in the future.

Mercer also determines actuarial soundness for the Medicaid and FHP rates on an annual basis. Mercer develops rate ranges utilizing base data and adjustments specified in the CMS Capitated Rate-Setting Checklist. Due to the blended rate phase-in, Mercer calculated a set of

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rate ranges to apply to each of the two rate components. Mercer's actuarial certifications for SFY 2009 and 2010 have been included as Attachment 5 to this response.

43) **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 percent of the payments for services rendered or coverage provided.**

The requested information will be submitted under separate cover.

- **a) Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?**
- **b) Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?**
- **c) If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

44) **Section 1902(a)(2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.**

The requested information will be submitted under separate cover.

- **a) Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.**
- **b) Please describe whether the NFS comes from appropriations by the State Legislature, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.**

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c) Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

d) If any of the NFS is being provided by local funds using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

e) If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

f) For any payment funded by CPEs or IGTs, please provide the following:

i) a complete list of the names of entities transferring or certifying funds;

ii) the operational nature of the entity (state, county, city, other);

iii) the total amounts transferred or certified by each entity;

iv) clarify whether the certifying or transferring entity has general taxing authority; and

v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

45) **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

The requested information will be submitted under separate cover.

46) **Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).**

The requested information will be submitted under separate cover.

47) **Does any public provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that, in the aggregate, exceed its reasonable costs of providing services?**

The requested information will be submitted under separate cover.

a) In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

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b) If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?
c) If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Section 6.2 - Budget Neutrality Summary

48) **Has the Department factored into the projected budget neutrality agreement for the extension period all the program expansions it is requesting? If so, that information is not readily apparent. The Department must provide a separate estimate of the impact on the budget neutrality agreement for each of the new program expansions requested in the application. Specifically, please provide for <u>each</u> of the three years in the extension request, estimates both for increased expenditures (in the "with waiver" calculations) as well as increased member months and enrollment (where appropriate) for each of the following expansions:**
a) Increasing Family Health Plus eligibility to 200% of FPL
b) Spousal budget provision
c) Indigent Care Pool support
d) Health Care Improvement Act of 2009

Include assumptions for enrollment and expenditure growth trends, as well as the impact of the enhanced FMAP (through the Recovery Act) the State will be receiving in DY 12 and the first quarter of DY 13.

The requested information will be submitted under separate cover.

49) **Please clarify the narrative on p. 31, which discusses the Department's assumption about the PMPM figures and trend factors for the extension. Is the Department proposing to keep the trend rates that were negotiated for the current extension period in 2006? Why are the F-SHRP PMPMs referenced in this application?**

Yes, the Department is proposing to keep the trend rates that were negotiated for the current extension period in 2006. The F-SHRP PMPMs were referenced since demonstration groups 1 and 2 are the same as in the FSHRP waiver (but for different counties) and it would be appropriate to use the same PMPMs that were already approved by CMS.

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Attachment 5 - Public Notice

50) **Please provide a copy of the actual notice that appeared on February 27/ 28 in any of the newspapers referenced in the application.**

Attachment 6 includes copies of the actual notices that appeared in newspapers referenced in the application.

51) **Please provide copies of any comments received from tribes or tribal organizations regarding the application.**

Pursuant to CMS guidelines, the Department advised the seven federally-recognized Tribal Nations in the State of our intent to request an extension of the Partnership Plan waiver. See Attachment 7 for a sample letter to the Tribal Nations. The Department did not receive any comments from the tribes or tribal organizations regarding the application.

52) **Please provide copies of any public comments received about the application, and note where, if at all, the application was modified in response to those comments.**

The Department received comments on the waiver application from Medicaid Matters on May 18, 2009. A summary of the comments are below while a copy is attached as Attachment 8. As the comments were received after the application was submitted to CMS, the waiver extension request was not modified in response to the comments.

- A formal process should be developed to solicit public input into any waiver amendments that may be proposed to incorporate Partnership for Coverage initiatives.
- Medicaid Matters strongly supports expansion of Family Health Plus (FHPlus) eligibility but cautions against approaches that result in different rules in different parts of the State.
- Medicaid Matters strongly supports amending the waiver to reflect efforts to simplify eligibility requirements for public programs.
- Medicaid Matters supports the State's request to extend FHPlus eligibility to low-wage government workers.
- Medicaid Matters would like additional information concerning the counties and/or populations that would be subject to expansion of mandatory enrollment.
- Expansion of mandatory enrollment to additional counties should be monitored closely, specifically with respect to auto-assignment rates; transition and exemption policies should be in place from the start; and, county resources should be supplemented when auto-assignment rates exceed 20 percent.
- Medicaid Matters supports the Long Term Home Health Care Program spousal impoverishment demonstration and urges its expansion to include the Traumatic Brain Injury and Nursing Home Transition and Diversion Waiver programs.
- Quality improvement efforts should focus on markers relevant to the specific population mandated to enroll.

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- The State should use the Medicaid Managed Care Advisory Review Panel (MMCARP) for exploring questions and soliciting input on preventing serious disruptions in care.
- Medicaid Matters requests clarification on the process and time frames for public comment and suggests the State consider soliciting public input prior to submitting proposals to CMS.

Family Planning Benefit Program

53) **Since the extension application makes no mention of this program, please confirm that the Department intends to continue operating the FPBP.**

Yes, the Department intends to continue operating the FPBP.

54) **Does the Department have any updates to the family planning code list included as Attachment C in the current STCs? If so, please provide them in electronic format to Camille.dobson@cms.hhs.gov.**

The Department would like to add two new CPT-4 codes to the 1115 Family Planning Benefit Program Waiver, Attachment C.

99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service

New York State has converted the Medicaid clinic payment system from a solely rate based reimbursement to reimbursement based on Ambulatory Patient Groups (APGs). Implementation of this payment methodology began with hospital outpatient clinics on 12/1/08. Implementation for diagnostic and treatment centers will begin when CMS approves the methodology which is forthcoming.

As part of the new payment methodology, New York State implemented several primary care enhancements. These CPT-4 codes are one of the enhancements that were assigned to all Article 28 clinics to provide additional reimbursement to primary care providers when they provide office services during the evenings, weekends, or holidays in addition to their regularly scheduled hours. We are requesting that Family Planning Benefit Program providers be allowed to bill for these payment enhancements when appropriate.

Attachment 1:
CAHPS ACTION PLANS FOR 2005 MEASUREMENT YEAR
NEW YORK CITY MEDICAID

GETTING CARE NEEDED

Barrier	Action Plan
Current provider directory being used by customer service center is not up to date making it difficult for members to access the PCP or nurse they would like.	Update provider directory to include accurate list of providers in the plan's network. This will be done by a private outside vendor who will verify not only participation in the network but all information that is currently in the directory. Changes will be made to the systems based on this initiative. Due to the size of the provider directory the cost to send the directory to all members is prohibitive. The customer service center is the primary means by which a member can get provider directory information.
Plan network of specialists is deficient in certain areas causing problems for members to access specialists.	The plan will review the HPN complaints, and the provider Access and Availability Surveys to identify specialty network deficiencies. That information will be forwarded to the new VP of Network Operations at the health plan. She will work with United Health Networks to build the network in those specialty areas. Also, the hiring of 8 network managers was approved and is in progress. They will be devoted to handling Medicaid business and building the network in this area.
Operational deficiencies in the authorization process for care are causing members to not be able to get the care, tests or treatment they need.	Improve the process by which providers request and get approved for specialized medical services for their members. This is known as the UM approval and appeals process. The following actions will take place to improve the process: • Auditing of the UM Approval and Appeal process to identify issues which need improvement • Education of the provider community on the UM approval and appeal rules, which will in turn reduce the number of denials for care. • Automation of various pieces of the UM Appeals process including the letter generation process to providers thereby reducing the possibility of human error. Clinical training of all UM staff including the physician advisors to ensure they are following the UM P&Ps.
Monitoring systems were not consistently in place to catch areas for improvement	Establish a monthly system to monitor calls of members calling the customer service center. The Plan's member outreach staff will listen in on the calls on a monthly basis and review the calls for accuracy. Any inconsistencies will be documented and sent to the manager of the customer service center for quality improvement purposes.
Customer service center staff, who were dedicated to the NY plan, started serving other plans across the country.	A new dedicated NY team of customer service center reps was created. This team will only take calls from the NY plans only. A training outline was created by the plan for the customer service center; the training outline highlighted the most important training needs which need attention. An exhaustive training of the staff will begin in April 2007.
Providers didn't have access to real time provider directory information.	Continue to encourage providers to contact the Plan for assistance. Make available real-time provider network information on the web.
Contracting with non-par specialty provider is rate- driven. The process of negotiations can be perceived as delays when members are seeking services from Out of network providers.	Continue to work with specialty providers in the community to negotiate feasible contracts. Reinforce with members the utilization requirements and the importance of seeking care within the network via the member newsletter.
Members perceive that all delays are caused by the Plan.	Provide educational reminders regarding the utilization and

Barrier	Action Plan
	referral process to members via the member newsletter. Conduct an internal member satisfaction survey and target members assigned to high volume providers to ascertain the in-depth root cause and develop and implement provider specific quality initiatives. Distribute outcomes of the survey along with recommendations to providers.
Lack of easily accessible reference guidelines for use by plans representatives, enrollees and providers.	Reinforce utilization guidelines, member responsibility and available programs and assistance offered through the Health Services department via the member newsletter. Create an easily accessible provider reference guide (i.e. poster, pocket guide) for use by plan representatives, enrollees and providers.
Poor member relationship with PCP	Review and analyze ER usage separately for Commercial and Medicaid populations. Review monthly report identifying members with 3 or more ER visits. Contact member. Assist with PCP identification, and making necessary appointments.
Some members use the ER for routine care.	Contact frequent ER users to assess care needs, and assist with PCP relationship and provide education regarding access of routine services. Assess member for additional care needs and provide case management support as indicated.
Prior authorization process needs review	Review prior authorization process to determine if current list of services needing prior auth needs adjustment
PCP network may not be adequate. Members' choices may be limited. Quarterly reports are produced showing network capacity to standards	Review capacity reports more thoroughly. Identify areas of inadequacy. Once identified, increase recruiting efforts to inform members about enhanced choices.
Appointment Availability	Provider Alert to be sent to network providers reiterating the plan's standards.
Appointment Availability	Targeted education to large provider groups/clinic sites that have exhibited issues with appointment availability and lack of eligibility checks
Member Understanding	Member survey to elicit information as to the members' understanding of the appropriate time to obtain appointments. This same opportunity will be utilized to provide education for same.
Member Understanding	Member Newsletter reiterating the appointment availability standards and reminding members to make their appointments early for such services as school and camp physicals.
Member Understanding	Personalized orientation for new members including the appointment availability standards and expectations on obtaining appointments

CUSTOMER SERVICE

Barrier	Action Plan
Review of abandonment rate for 2005 was 2.5%. Although this was better than the corporate goal of 4% the customer service QI Committee (CSQIC) focused on reducing the abandonment rate.	Hire additional Customer Service Representatives (CSRs) to improve abandonment rate
Automated Response Unit (ARU) was time consuming and difficult to navigate.	A plan will be formulated to simplify the prompts within the Automated Response Unit (ARU) to allow members easier navigation and access to CSRs
Website information was difficult to navigate and understand.	Redesign the website to make it easier to navigate.
New member packet is comprehensive. Medicaid new member packet needs to be reviewed to determine if materials are user friendly	Review new member packet Include question in Focus Group Survey to capture members' satisfaction with new member packet.
Customer Service not able to address member inquiries regarding new enrollment or recertification due to inability to view member enrollment information for new enrollees or members submitting documentation for recertification.	System to be upgraded to add scanning capacity for all documentation received in Enrollment. Process to be modified to allow viewing of scanned documentation by Customer Services while member in on the phone so that members' inquires can be immediately addressed. Training for Customer Service to be provided by Enrollment Department Manager.
Customer Service not able to address member inquiries regarding premium billing due to inability to view member documentation online.	Customer Services to be given access to Premium Billing module and provided with training on how to use the Premium Billing module so that members' inquires can be immediately addressed while member is on the phone.
Members speak languages other than English, Spanish and Chinese and Customer Service not staffed to accommodate other languages like Indian languages (Hindi, Urdu, Bengali, Punjabi, Gujrati, etc.).	Customer Service uses the AT&T Language Bank for languages other than English, Spanish and Chinese. Six percent (6%) of plan members speak an Indian Language (i.e., Hindi, Urdu, Bengali, Punjabi, Gujrati, etc.). Customer Service to add a staff person that speaks the Indian languages.

State of New York
Department of Health/Insurance Department
PARTNERSHIP FOR COVERAGE

Report of the Commissioner of Health and Insurance Superintendent to Governor David A. Paterson on the Partnership for Coverage Initiative on the Release of the Urban Institute Report

REFORMS TO ACHIEVE QUALITY, AFFORDABLE COVERAGE FOR ALL NEW YORKERS

July 17, 2009

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***** Indicates revisions made on 7/30/09 to correct a computation error. See page 6 of the narrative and the chart on page 15 entitled Total Annual Expenditures Per Insured New Yorker.

Achieving Quality, Affordable Coverage for All New Yorkers

In 2007, New York State initiated the Partnership for Coverage to examine options for ensuring access to affordable, quality health insurance coverage for all New Yorkers. Today, nearly 2.7 million New Yorkers are uninsured.[1] New Yorkers are struggling. Rising health care costs burden New York's weakening economy and consume an ever growing share of the State budget. Reform is needed. Health reform in New York State requires a comprehensive strategy focused on solving the problems in New York's health care system while building on its strengths. This report describes New York's achievements to date and summarizes the Urban Institute's analysis of four distinct health reform proposals to expand coverage to all non-elderly New Yorkers.

I. Background

New York has demonstrated a strong, ongoing commitment to health insurance coverage. New York's public health insurance programs provide comprehensive coverage to 3.7 million people or 21.4% of all non-elderly New Yorkers.[2] As a result, the rate of low-income New Yorkers without insurance is more than 6% below the national average. However, almost one half of the uninsured are eligible for, but not enrolled in, one of New York's existing public health insurance programs. And many New Yorkers have incomes too high to qualify for public coverage, but too low to afford private health insurance.

As the only state in the nation with open enrollment and pure community rating, New York is also a leader in guaranteeing access to private health insurance coverage. In New York, insurers must offer coverage to all individuals and small employers and premiums must be based on broad community pools, without differences due to age, sex, health status or occupation. New York's standardized individual health insurance market ensures that a comprehensive level of benefits is available to all. However, while New York guarantees the availability of private health insurance, affordability is an obstacle to coverage.

Almost 16% of all New Yorkers are currently uninsured. Those without coverage face worse health outcomes, as the uninsured delay getting more cost-effective primary care. And the uninsured face large bills, which are a major contributor to personal bankruptcy. At the same time, many New Yorkers who do have health insurance are either inadequately insured or at risk of losing their coverage due to high costs that consistently increase faster than inflation. Rising health care costs are destabilizing businesses, and New Yorkers buying coverage directly face single premiums averaging $970 per month. New York has an 8.2% unemployment rate that will likely worsen with the economic downturn, causing a further decrease in coverage.

Despite 2.7 million uninsured, overall health care spending by government, employers and individuals in New York totals $83.9 billion annually.[3] New York spends $28.5 billion on public health insurance programs for non-elderly low-income residents.[4] Health care costs per capita are higher in New York than in all but two other states and the District of Columbia.

II. Partnership for Coverage Overview

Under the Governor's Partnership for Coverage initiative, the New York State Departments of Health and Insurance (the Departments) were charged with developing, evaluating and recommending proposals for achieving affordable, quality health insurance coverage for all New Yorkers using a building block approach. The State has made important progress towards understanding and overcoming the obstacles to health insurance coverage and paving the way to improved efficiency and better health outcomes.

Beginning in Fall 2007, the Departments broadly sought input on problems related to health care access, quality, affordability and costs as well as recommendations on health reform. The Departments held eight public hearings across New York State and convened in-depth and ongoing discussions with many stakeholder groups including providers, consumers, businesses, insurers, labor organizations, health policy experts and other states involved in health reform initiatives. A Web site, www.partnership4coverage.gov, was created to share progress and information.

As authorized by the New York State Executive Budget for fiscal year 2007/2008, the Departments issued a request for proposals (RFP) and contracted with the Urban Institute to conduct in-depth micro-simulation modeling to determine the cost and coverage implications of four health reform proposals in New York. The four proposals include: (1) a single payer public health insurance option; (2) Assembly Member Gottfried's New York Health Plus proposal, that provides an option for all New Yorkers to enroll in Family Health Plus (FHPlus); (3) a public-private partnership option that simplifies and expands existing public programs and reforms private health insurance; and (4) a market-based option that relies on regulatory flexibility and tax credits. These proposals were developed based on statutory criteria and extensive public input.[5]

While engaging in in-depth analysis of the State's health care delivery system, New York advanced the goals of the Partnership for Coverage by expanding access to coverage and investing more wisely in the health care delivery system to improve quality and control costs.

III. Progress to Date - Achieving Partnership for Coverage Goals

New York has greatly simplified and expanded its public programs, which now reach children up to 400% of the federal poverty level (FPL) and adults up to 200% FPL pending federal approval and financial participation. New York has also undertaken groundbreaking Medicaid reimbursement reform and enhanced protections for consumers purchasing private coverage.

A. Public Expansions

In September 2008, the State expanded eligibility in its Child Health Plus (CHPlus) program from 250% to 400% FPL to provide nearly every uninsured child with access to affordable, comprehensive coverage. In addition, the FHPlus Premium Assistance program and FHPlus

Buy-In program were introduced to make comprehensive cost-efficient coverage available to employers and employees. Pending federal approval, eligibility for FHPlus will be expanded up to 200% FPL to cover over 400,000 additional adults. Today, FHPlus covers parents with incomes up to 150% FPL and single adults up to 100% FPL.

B. Public Program Simplifications

To reach the 1.2 million New Yorkers who are currently eligible for public programs but not enrolled, New York adopted reforms to streamline public program eligibility and renewal.[6] These reforms include permitting self-attestation of income and residency at renewal, repealing the face-to-face interview at initial application, eliminating the resource test for community Medicaid and FHPlus, ending the vestiges of welfare eligibility rules including alcohol and drug screening and finger imaging, establishing a single eligibility level for single adults and childless couples, replacing the county-specific levels, eliminating age-based eligibility distinctions for children, shifting to a gross income test for Medicaid, permitting presumptive eligibility for children in Medicaid, and allowing children aging out of foster care to keep Medicaid to age 21. A Statewide Enrollment Center will soon centralize some public program renewals. Pending federal approval, the State will adopt a gross income standard of 160% FPL for FHPlus and provide 12 month continuous coverage for adults in FHPlus and certain adults covered by Medicaid.

C. Cost Containment and Quality Improvement

Accounting for almost one out of every three dollars spent on health care in the State, Medicaid has the leverage to change the delivery of health care for all New Yorkers. New York has advanced groundbreaking reimbursement reforms to reward quality and efficiency and ensure greater value for patients and taxpayers. In 2008, the State reduced inpatient hospital rates by $224 million to approximate costs and reformed the flawed outpatient reimbursement methodology. New York invested $300 million in reimbursement rates for hospital clinics, community health centers and physicians. In 2009, inpatient rates were reduced further and an additional $300 million was invested in outpatient services. In addition, a new inpatient rate methodology was authorized that will recognize appropriate differences in hospitals and more effectively match payment to patient complexity and quality. One of the most far reaching developments is the implementation of a program to incentivize patient-centered medical homes in December 2009. In the Adirondack region of the State, Medicaid will participate in a multi-payer medical home pilot which emphasizes primary and preventive care and improved coordination of care. The Doctors Across NY program was implemented to support new physicians in medically underserved communities.

D. Private Insurance Reforms

New York guarantees individuals and small groups access to health insurance at premium rates that reflect the risks of the community at large, rather than the risks of each policyholder. Individuals who purchase health insurance directly are guaranteed access to comprehensive coverage necessary for those most in need of health care. Healthy NY provides eligible New Yorkers with incomes up to 250% FPL and eligible small businesses with access to a

streamlined, but more affordable, coverage option. The State has extended reinsurance to help mitigate high premiums in the individual and Healthy NY markets. In addition, New York has recently simplified and increased funding for its risk adjustment mechanism to more broadly spread risk.

New York's extensive consumer protections include grievance and utilization review standards, the right to an external appeal, numerous benefit mandates and extensive notice and disclosure requirements. Recently enacted reforms benefit consumers by limiting health plans' ability to deny care that the plan had already pre-authorized, extending external appeal rights to out-of-network care and introducing provider contracting protections. Additionally, the Governor is currently advancing several legislative proposals to improve or increase access to health insurance coverage. These include extending a COBRA option to 36 months, expanding coverage for dependents through age 29, and reinstating prior approval of premium rate increases. The Governor has also proposed a managed care reform bill that expands grievance and appeal rights to more consumers and providers and extends certain rights to access specialty care to more consumers.

IV. Urban Institute Modeling of Four Health Reform Proposals

As the State tackled necessary reforms, the Departments also worked closely with the Urban Institute to obtain a clear picture of the cost and coverage implications of broad health system reform proposals. The reform proposals and the Urban Institute's analysis are summarized below and in the attached charts and are more fully detailed in the Urban Institute's attached report. To allow for effective comparison, the cost and coverage effects for all proposals are shown in the third year of implementation. New government costs are presented as total federal and State spending since federal share of government costs post-reform is uncertain.

A. Public Health Insurance for All

Summary. The Public Health Insurance for All proposal envisions a state-run public health insurance program to cover all New Yorkers not eligible for an existing public program. The State is responsible for setting provider payment rates, establishing global budgets for institutions, administering payments, enrolling New Yorkers and handling consumer disputes. Private insurers have no role.

Cost and Coverage Effects. Complete coverage is achieved by the Public Health Insurance for All proposal. Employer and individual spending is wholly eliminated, and government spending increases by $57.7 billion to total $86.3 billion. Of the proposals simulated, this reform achieves complete coverage with the greatest redistribution of health care spending, the lowest aggregate change in health care spending of $2.4 billion and the greatest cost to government per newly insured of $21,287 annually. Providing insurance coverage to all without cost-sharing increases the demand for health care services to a level that the delivery system is unable to initially absorb, largely due to physician shortage. This unmet demand of $402 million in health care services would reduce the proposal's cost, but leave some without some of the medical care they would obtain if there were no constraints in supply.

B. New York Health Plus

Summary. Under New York Health Plus, all New Yorkers can participate in the existing FHPlus program offered through managed care plans. A competing publicly run fee-for-service option, like traditional Medicare, is also available. Private and supplemental health insurance coverage remains. All employers and workers are subject to a payroll tax totaling 10% of all wages (not capped). Those who purchase private coverage in lieu of participating in New York Health Plus are eligible for a tax credit to offset their payroll tax liability. Physicians can organize and collectively negotiate with health plans. Full mental health parity is extended to FHPlus.

Cost and Coverage Effects. New York Health Plus achieves complete coverage. Gross government costs increase by $47.5 billion, offset by $13.6 billion in newly generated payroll taxes. Employer sponsored insurance declines by almost 60%, as employers drop coverage in favor of employee enrollment in New York Health Plus. Even with the 10% payroll tax, employers save $9.9 billion. Individuals would no longer choose to purchase coverage in the individual market. Individuals save $17.9 billion, with the greatest savings accruing to those with incomes above 400% FPL. The aggregate change in health care spending totals $6.1 billion. Of the proposals modeled, New York Health Plus has the second highest cost to government per newly insured of $17,512 annually, with a net government cost (post payroll tax) of $12,508 per newly insured. Unmet demand for health services due to provider constraints is valued at $1 billion.

C. Public-Private Partnership

Summary. The Public-Private Partnership proposal is a building block approach to reform that layers five key components: (1) simplification and expansion of public health insurance programs to 200% FPL for adults and 400% FPL for children; (2) merger of New York's individual and small group health insurance markets; (3) sliding scale subsidies for those with incomes up to 400% FPL who purchase coverage through a new purchasing pool or insurance exchange; (4) assessments on employers with 10 or more employees, offset by the amount employers contribute to health insurance; and (5) a mandate that requires individuals to buy health insurance once affordable options are available. The benefit design and cost sharing for private coverage mirrors a typical employer product. This proposal is modeled with and without the introduction of a competing public option.

Cost and Coverage Effects. The Public-Private Partnership proposal achieves complete coverage upon full implementation of the reform components. The merger of New York's individual and small group markets reduces the cost of individual health insurance by 56%. Because the merger is combined with a public program expansion, small group single premiums decline slightly and small group family premiums remain fairly constant. Sliding scale premium subsidies ensure affordability across income levels. An assessment upon employers that do not offer health insurance and an individual requirement to purchase health insurance retains and expands private investment in coverage. Coverage in the individual market increases by one million. Employer coverage drops slightly. Of all the proposals, the Public-Private Partnership reforms result in the least redistribution of health system financing and the lowest annual

government cost per newly insured of $2,959 gross and $2,663 net (post assessment). The proposal adds $7.2 billion in government costs, while decreasing employer spending by $1.2 billion and individual spending by $50 million. Aggregate new health care spending totals $6 billion. This reform does not result in unmet demand for health care services.

Impact of Public Option. Introducing a competing state-run public option does not change the coverage effects of the Public-Private Partnership proposal significantly, but yields savings due to downward pressure on premiums. With a public option, overall net costs to government fall from $7.2 to $7.1 billion. The annual net cost to government per newly insured (post assessment) drops from $2,663 to $2,630*. There is also a slight reduction in employer and individual spending. These results show the third year of implementation and reflect one-third of the full savings estimated to be realized in year ten.

D. The Freedom Plan

Summary. The Freedom Plan decreases private insurance market regulation and relies on tax credits and government funded stop loss to increase coverage. The proposal permits insurers to sell high deductible health insurance policies exempt from benefit mandates in New York's individual market. Community rating rules are modified to permit premiums to be set based upon smaller, segregated risk pools. A 50% tax credit for individuals and small businesses purchasing health insurance is phased in over ten years. Government funded stop loss subsidies are increased in New York's individual and Healthy NY markets.[7]

Cost and Coverage Effects. The Freedom Plan does not achieve complete coverage. The number of uninsured New Yorkers drops from 2.7 million to 2.3 million, with most of the reduction attributable to the recent expansion of CHPlus. The individual market is impacted by risk selection due to the new high deductible health plans, compromising the viability of comprehensive individual products. With the tax credit partially phased in, total government spending per newly insured is $6,605 annually, largely due to the credit.[8] Total government costs increase by $2.75 billion. Employer spending decreases by $2.1 billion. Individual spending increases by $1.2 billion with the greatest costs accruing to those between 201% and 299% FPL. Aggregate health care spending increases by $1.9 billion. This proposal does not result in unmet demand for health services.

V. Comparison of Proposals

Currently 15.8% of New Yorkers lack health insurance. Three of the four proposals modeled cover all New Yorkers and drop the State's uninsured rate to zero. The Freedom Plan leaves 13.3% of New Yorkers uninsured. Several measures related to post-reform sources of coverage and spending are presented below and illustrated in the attached charts and table.

A. Post Reform Sources of Coverage

Post Reform Employer and Individual Coverage. Employers currently provide 61.1% of health insurance coverage for insured New Yorkers. There is minimal change in employer-based

coverage under the Public-Private Partnership and the Freedom Plan proposals, 60.1% and 60.9%, respectively. Under New York Health Plus, employer coverage drops to 25.3% and under Public Health Insurance for All, employer coverage ends altogether. The individual market ceases to exist under the Public Health Insurance for All and the New York Health Plus proposals. Individual coverage increases from 1.4% to 7.2% under the Public-Private proposal and to 3.7% under the Freedom Plan.

Public Programs Post Reform. Public health insurance programs, which currently cover 21.4% of the population, would continue to serve significant numbers of New Yorkers under all four proposals, ranging from 100% under Public Health Insurance for All to 21.7% under the Freedom Plan. Three in four New Yorkers (74.4%) would be publicly covered under New York Health Plus. The Public-Private Partnership proposal raises public program enrollment to 32.4%.

B. Post Reform Spending

Total Government Spending Post Reform. Government spending on health care for the non-elderly currently accounts for $28.5 billion of the $83.9 billion spent on health care spending in New York. Under each of the four proposals, government spending increases -- by 202% under the Public Health Insurance for All proposal (total $86.3 billion); 119% under New York Health Plus (total $62.5 billion); 25.3% under the Public-Private Partnership model (total $35.8 billion); and 9.6% under the Freedom Plan (total $31.3 billion).

Post Reform Government Cost per Newly Insured. The "total cost per newly insured" gauges the amount of government investment required under each proposal per capita, per newly insured. Annually, gross government costs per newly insured vary from $2,959 for the Public-Private Partnership proposal to $21,287 for Public Health Insurance for All. The gross cost per newly insured for New York Health Plus is $17,512, and the Freedom Plan is $6,605. Net government costs per newly insured (post assessment) are $2,663 for the Public-Private Partnership proposal and $12,508 for New York Health Plus.

Employer and Individual Spending Post Reform. Post-reform expenditures by employers and individuals also vary widely. Under Public Health Insurance for All, employer and individual spending is eliminated. New York Health Plus produces a considerable shift in spending patterns, reducing individual spending by 81.3% and small employer spending by 29.8%. Individual spending remains constant under the Public-Private Partnership proposal while small employer spending drops 3.5%. The Freedom Plan raises individual spending 5.4%, but reduces small employer spending by 6.2%.

Total Spending. Aggregate health care spending is the amount of new spending across the health care delivery system by all payers including government, employers and individuals. New York Health Plus would cause the largest annual increase in aggregate spending at $6.1 billion followed by the Public-Private Partnership proposal at $6.0 billion. The Public Health Insurance for All proposal has the lowest aggregate increase in health care spending of all proposals that achieve full coverage at $2.4 billion and the Freedom Plan results in the lowest increase in aggregate spending of $1.9 billion.

VI. Considerations and Next Steps

New York has one of the most expensive health care systems in the United States, which has the most expensive health care system in the world. For both New York and the nation, health care is often fragmented, costly, inefficient and unavailable to a large number of residents. Costs are growing at an unsustainable rate that outpaces inflation. As the economy continues its sharp downturn and costs continue to rise, the number of uninsured will likely increase and those with coverage will face more limitations and higher costs.

Current times present significant challenges. However, challenging times bring opportunities and highlight the need for comprehensive reform. At the State or federal levels, effective health reform will require financial support, difficult political choices and shared responsibility.

The three proposals modeled by the Urban Institute which extend health insurance coverage to all New Yorkers – Public Health Insurance for All, New York Health Plus, and the Public-Private Partnership – require substantial government investment. Current State budget constraints make federal support essential to State health reform efforts. New York must partner with the federal government to ensure the needs of New Yorkers are addressed.

National health reform discussions are active and multiple proposals are emerging. Many key components of the health reform proposals currently being advanced by President Obama and Congress closely parallel reforms already undertaken in New York State as well as reforms modeled by the Urban Institute in the Public-Private Partnership proposal. New York's experiences and the Urban Institute's modeling of the Public-Private Partnership proposal offer valuable insight as to how such reforms might play out in a large state like New York.

The Urban Institute's modeling of the Public-Private Partnership proposal shows that public program expansions will cover the lowest income families as well as the most chronically ill and disabled. Public program simplifications will maximize enrollment and assure continued coverage. Private insurance markets must operate efficiently to ensure coverage is available and affordable. Subsidies offered through an insurance exchange make coverage accessible to low income residents and broaden participation in risk pools. Once affordable options are in place, an individual responsibility requirement dramatically increases coverage and decreases costs per newly insured. Adding an employer assessment leads to shared responsibility among government, employers, and individuals. Introducing an option for individuals to choose a public insurance plan through an insurance exchange further lowers cost for government, employers and individuals.

New York has taken important steps to implement the foundations of reform, placing New York ahead of most states. Through public program expansions, nearly every child in New York State has access to comprehensive coverage. And, with federal approval, the same will be true for adults up to 200% FPL. New York has also greatly streamlined public program eligibility and introduced sweeping public program reimbursement reforms that encourage the right care in the right setting. New York is the only State in the nation to guarantee access to private health insurance on a pure community rated basis. New York also has extensive consumer protections

in place for those with private health insurance. These reforms exemplify New York's commitment to quality, affordable health insurance coverage for all residents.

New York's experiences are highly relevant and can be useful to federal policymakers as they consider options for health reform. Additionally, the Urban Institute's modeling provides a road map with numerous options for consideration, one of which closely parallels many of the predominant proposals being debated at the federal level. New York's report from the Urban Institute provides significant insight for State and federal policymakers as they grapple with the hard and timely questions of improving the health care system.

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[1] The data and methodology used by the Urban Institute are described in Appendix 1 of their report. The data sources for the number of uninsured are the March 2005 CPS for New York and the Northeast Region of the United States. The March 2005 CPS provides data on insurance coverage in 2004. The Urban Institute public enrollment data are adjusted for the shortfall in the number of Medicaid and CHPlus enrollees reported in the Current Population Survey (CPS) as compared with the number of enrollees reported by State administrative data for 2006 and weighted to reflect the population in New York in 2009. This simulation results in an estimated 2.7 million uninsured in New York. The Department of Health reports the most recent CPS available with no adjustments (March 2008), which currently shows 2.5 million uninsured New Yorkers in 2007.

[2] The Department of Health reports that actual enrollment (including both elderly and non-elderly) in Medicaid, FHPlus and CHPlus was 4.6 million as of February, 2009. The Urban Institute public enrollment data is based on the CPS adjusted as described in footnote 1and inflated to simulate 2009 values.

[3] The Urban Institutes' calculation of base government spending includes acute care of the non-elderly population. Employer and individual spending is largely for the non-elderly population but includes some costs for the working, privately insured population over 64. Uncompensated care costs are not reported.

[4] The Urban Institute's $28.5 billion dollar public program spending estimate includes CHPlus spending, reflects growth to 2009, and excludes Medicaid spending on the aged and long term care.

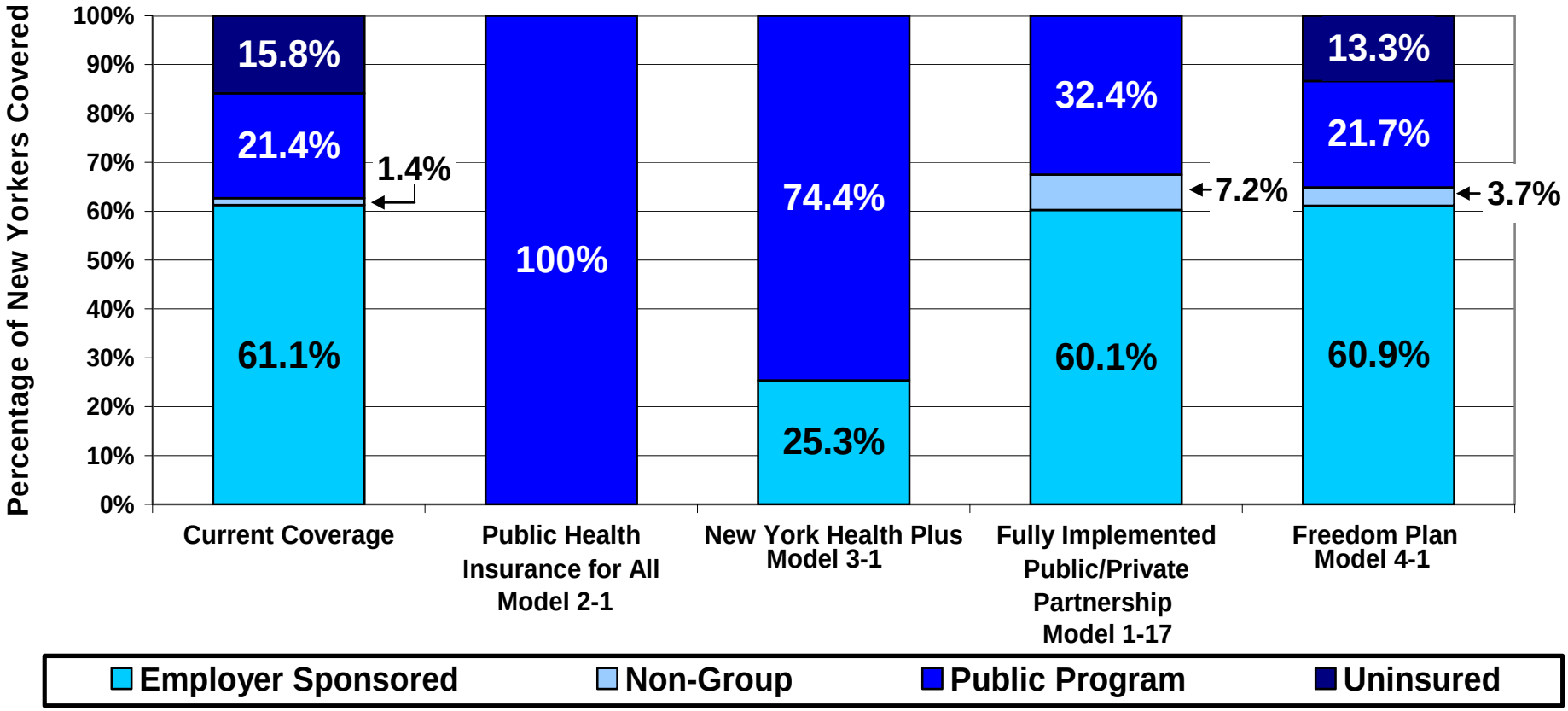
[5] Specifically, the Commissioner and Superintendent were directed in 2007/2008 New York State Executive Budget to consider the extent to which proposals: (1) rapidly provide universal health coverage to the people of New York; (2) control the cost of health insurance and health care; (3) fairly and 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.

[6] The Department of Health estimates that 1.2 million uninsured New Yorkers are eligible for public programs. The difference from the Urban Institute estimate may be explained by the use of different years of the CPS, the inclusion of the regional data, higher eligibility levels in public programs since 1996, or differences in how eligibility units were created for simulation.

[7] The Freedom Plan proposal, which was introduced in multiple legislative sessions including 2009, also expanded eligibility for the Healthy NY program from 250% FPL to 300% FPL and permit a Healthy NY "buy-in" at higher income levels. Please note that the Urban Institute was unable to model the impact of such an expansion at this time.

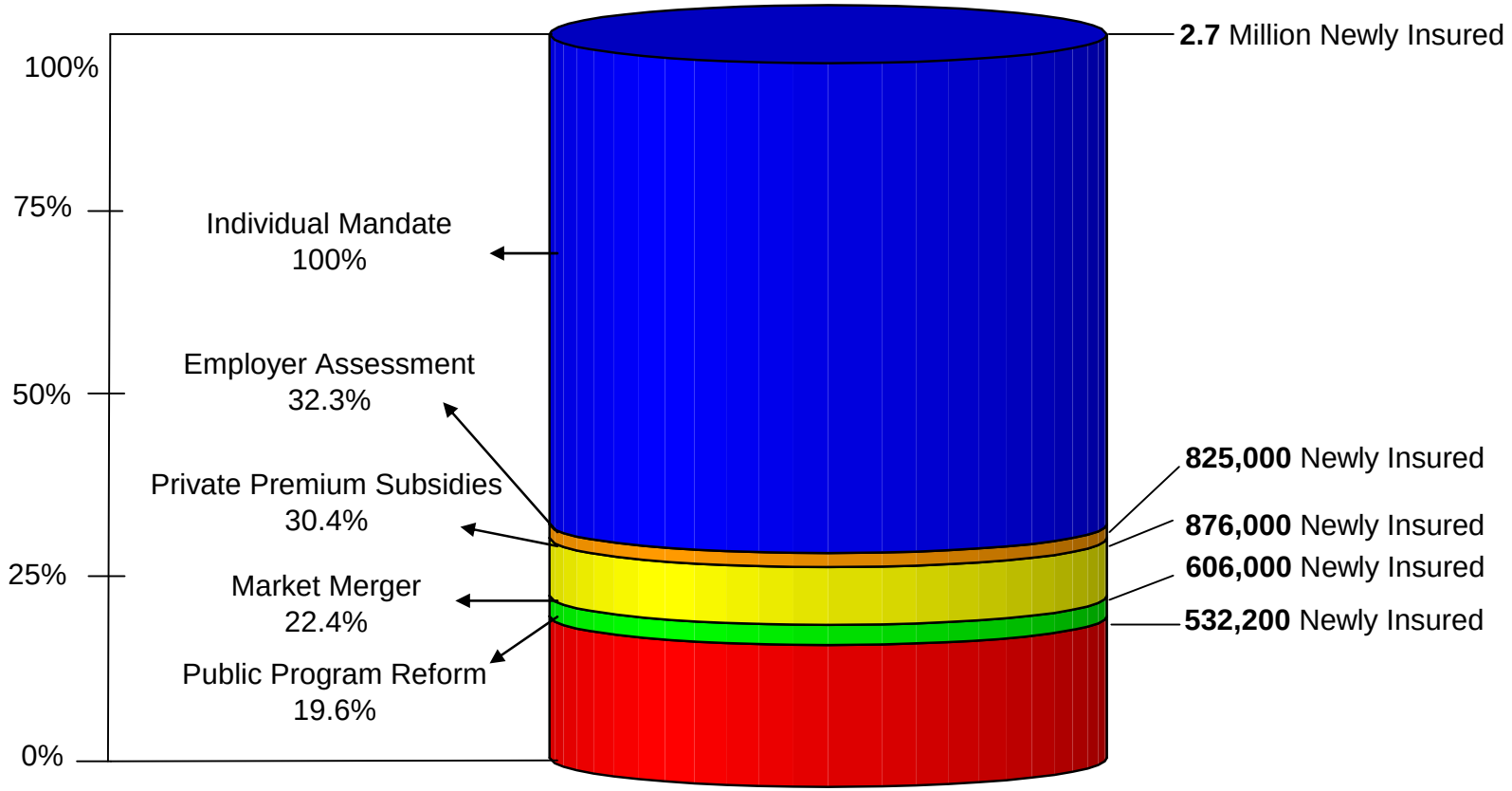
[8] Costs were calculated as if the 50% tax credit that is phased in over 10 years was in its third year of implementation. Overall costs to government and costs to government per newly insured would increase in future years with full phase in of the tax credit.

Sources of Coverage



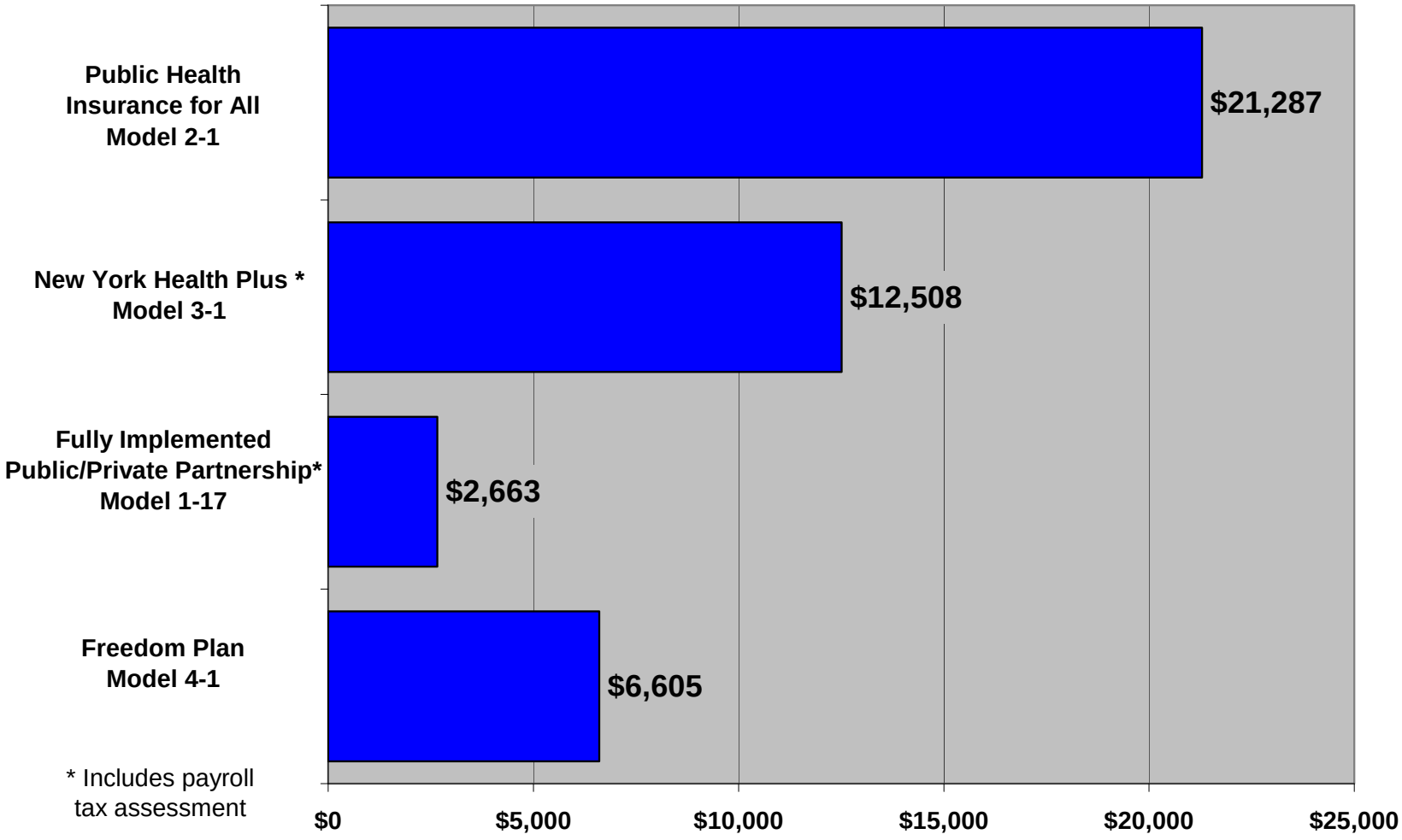
Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options,* Appendix 1 (July 2009). The Urban Institute estimated the number of uninsured and public program enrollment based on March 2005 CPS for New York and the Northeast Region, which provides data on 2004 coverages. The data was adjusted to account for underreporting of public program enrollment in the CPS as compared to 2006 State administrative data and weighted to reflect the 2009 New York population. This simulation resulted in an estimated 2.7 million uninsured New Yorkers and 3.7 million non-elderly public program enrollees. The Department of Health reports the most recent CPS available with no adjustments (March 2008), which currently shows 2.5 million uninsured New Yorkers in 2007. The Department of Health's actual combined elderly and non-elderly enrollment in public programs was 4.6 million as of February 2009.

Reaching New York's Uninsured Through the Public/Private Partnership Model (Model 1-17)



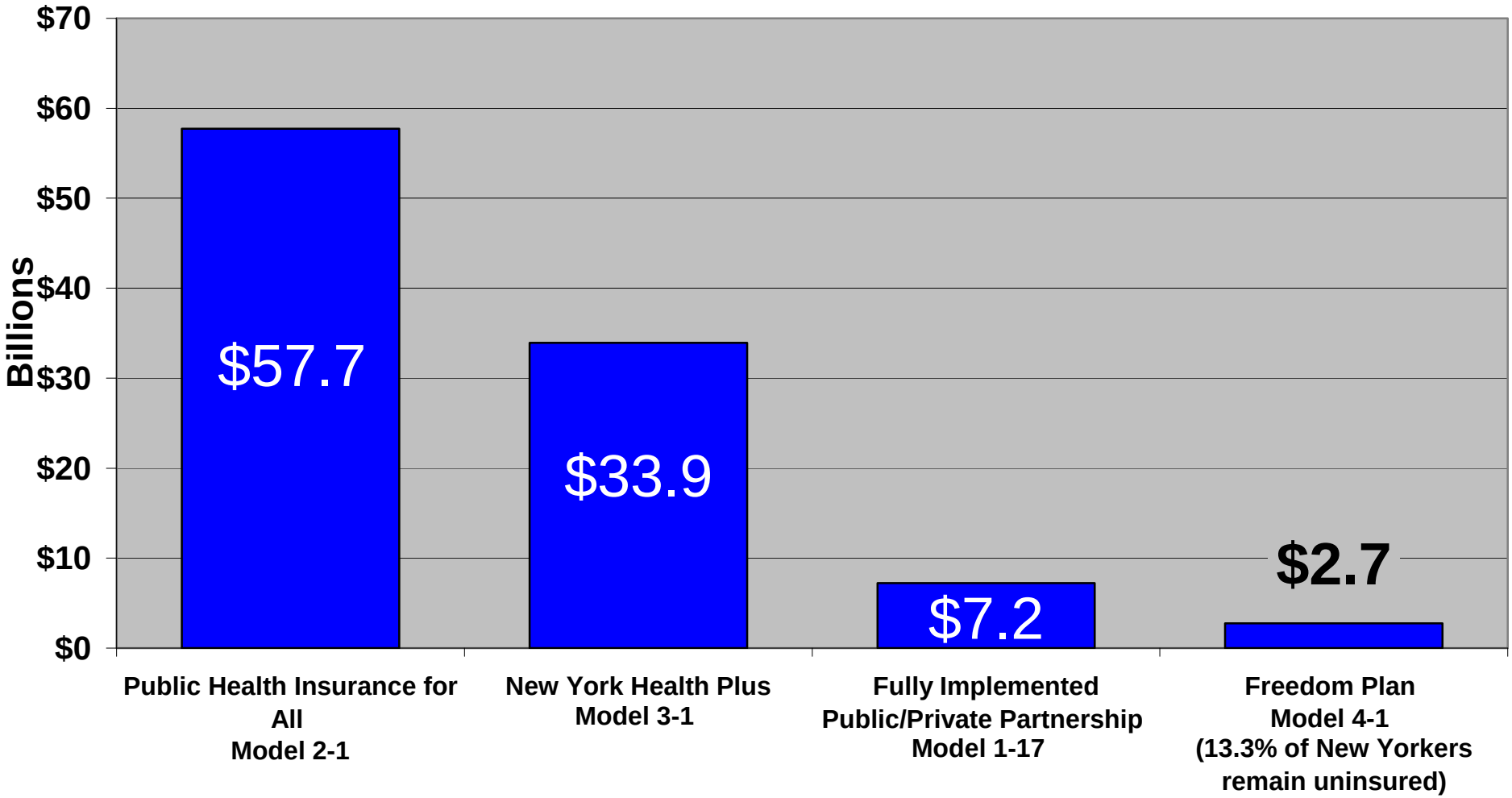
Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options,* Appendix 1 (July 2009). The Urban Institute used data and methods to estimate the number of uninsured and public program enrollment based on March 2005 CPS for New York and the Northeast Region which provides data on 2004. Data was adjusted for undercounting of public program enrollment and weighted to reflect the 2009 population.

Annual Net Government Spending Per Newly Insured



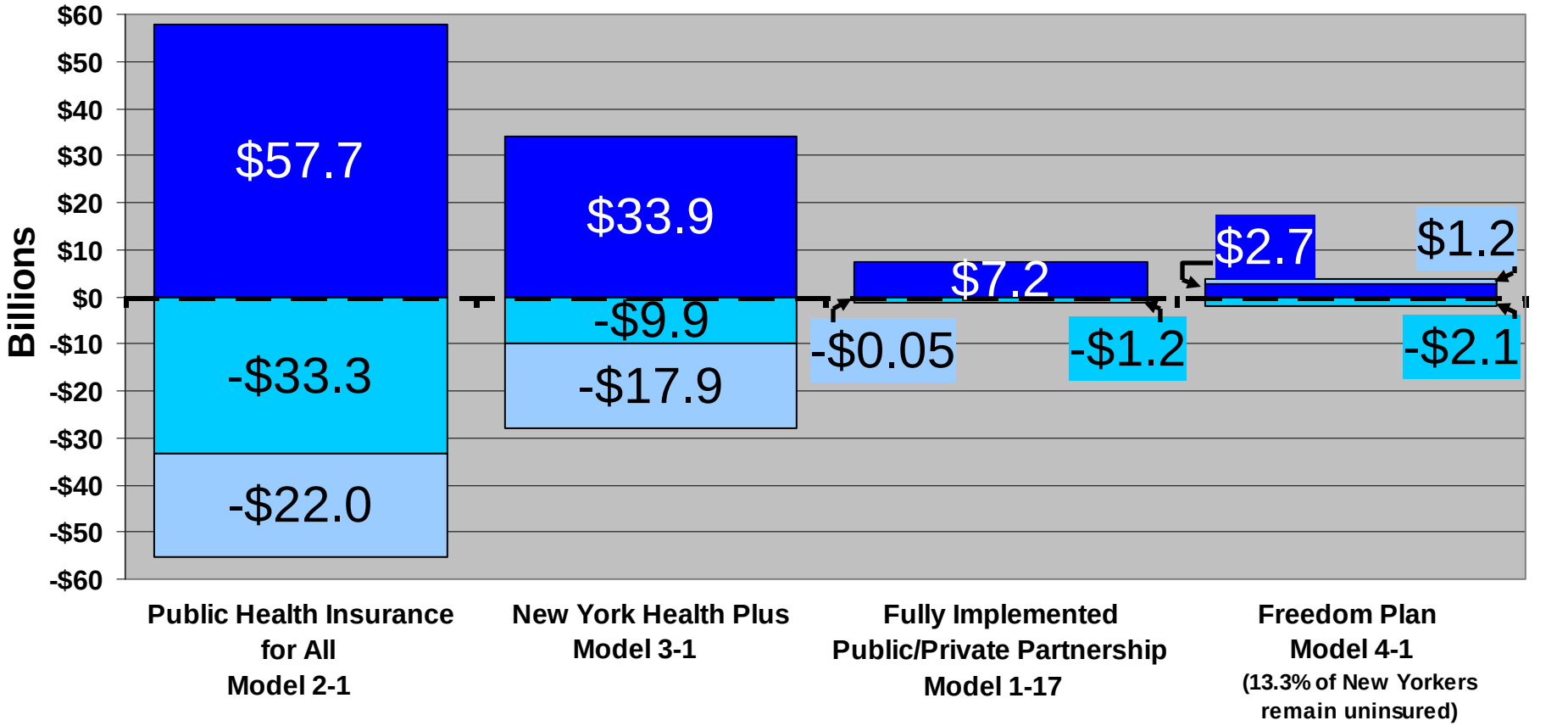
Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options* (July 2009). Government spending is reflected as the total of Federal and State spending.

Aggregate Change in Government Spending



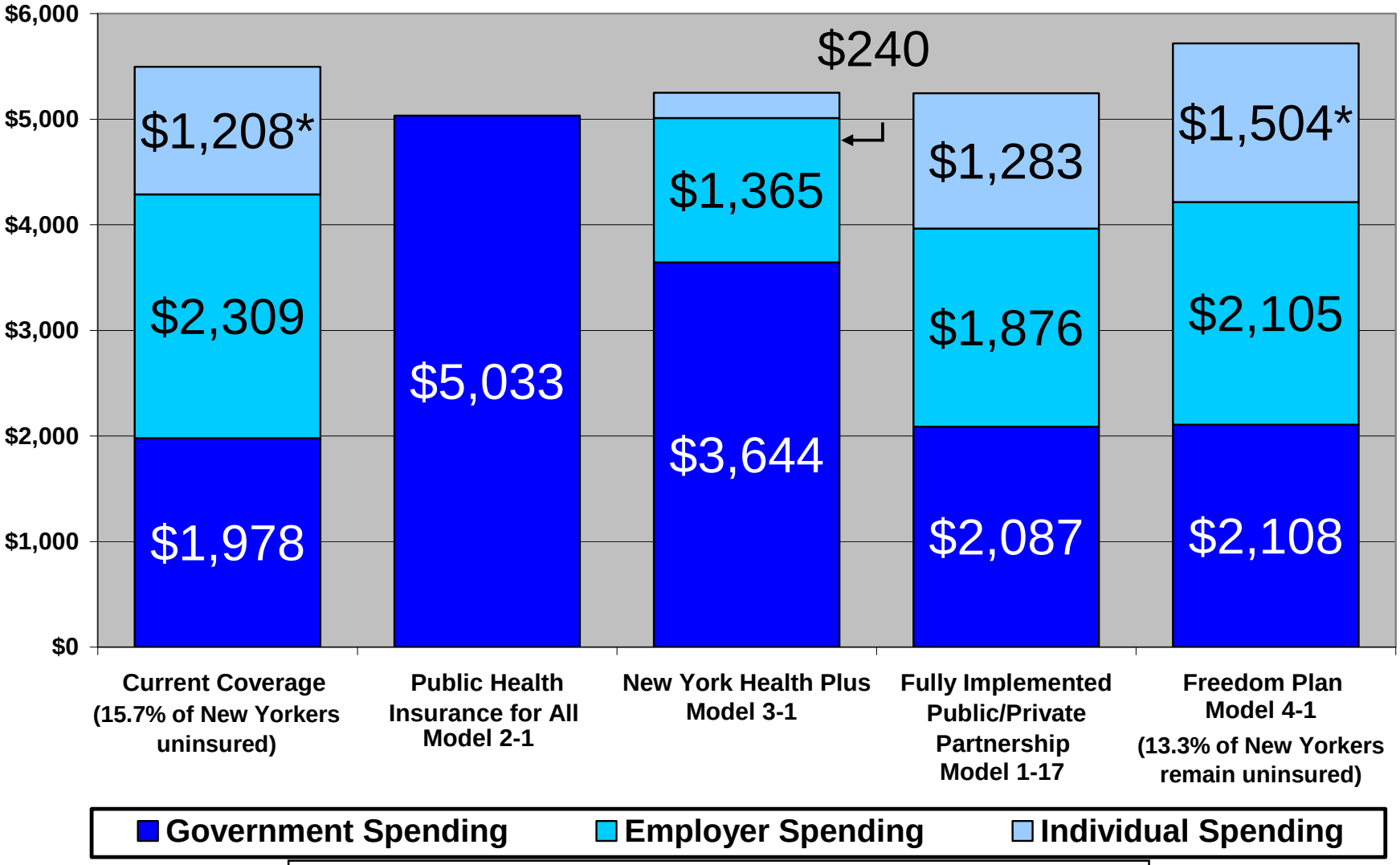
Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options* (July 2009). Government spending is reflected as the total of Federal and State spending.

Aggregate Changes in Spending by Payer



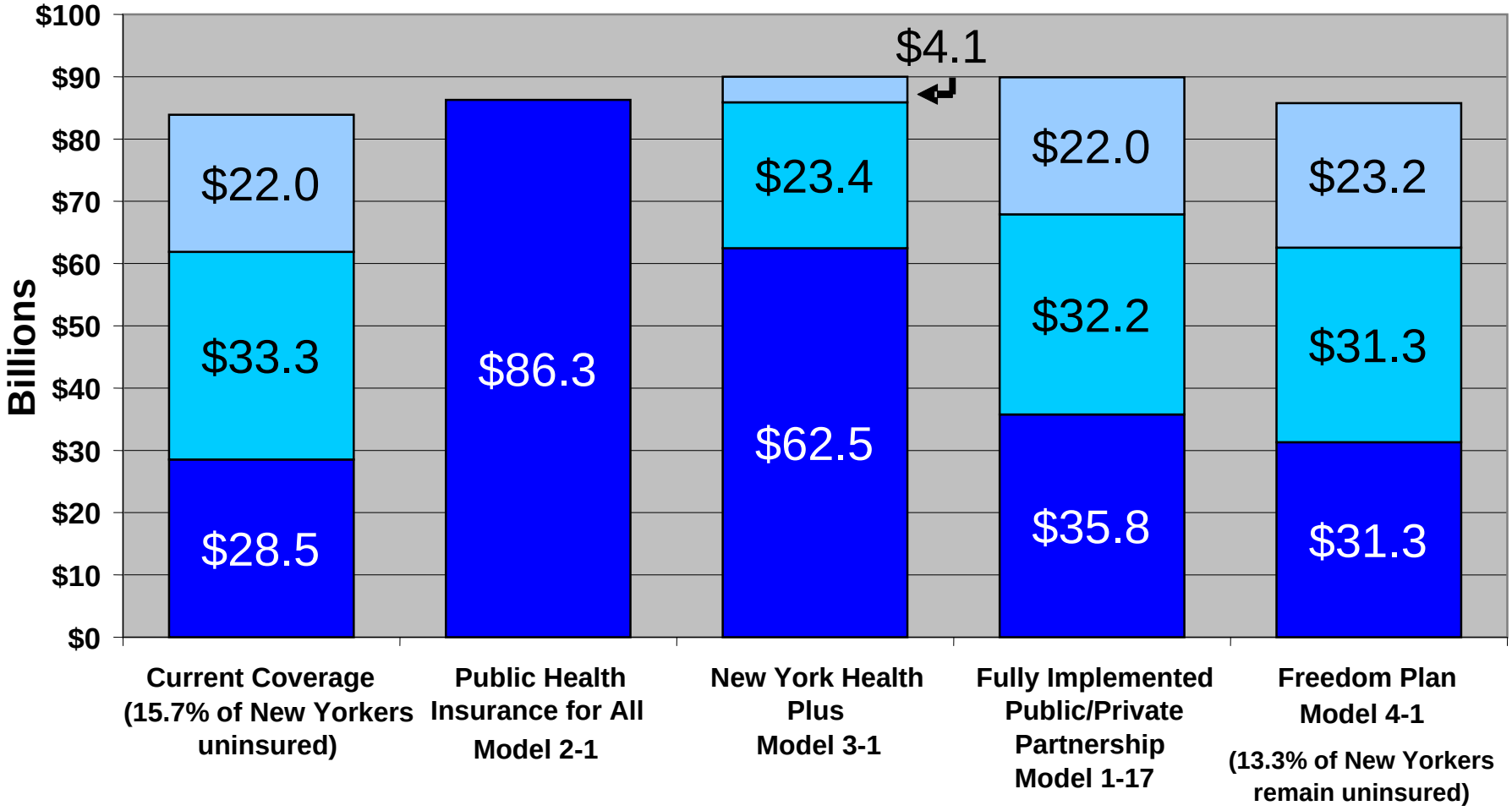
Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options* (July 2009). New government spending is reflected as the total of Federal and State spending.

Total Annual Expenditures Per Insured New Yorker



Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options* (July 2009). Government spending is reflected as the total of Federal and State spending. These numbers were calculated from The Urban Institute's modeling for purposes of effective comparison.

Total Annual Spending Across All Categories



Source Data: The Urban Institute, *Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options* (July 2009). Government spending is reflected as the total of Federal and State spending.

Partnership For Coverage- Modeled Proposals Comparison

Government Spending	Reduction in Uninsured	Change in Government Spending	%	Per Capita Government spending per newly insured	Total Government Expenditures	Total Government Expenditures per covered life
Public Health Insurance for All	-100.0%	$57,720,000,000	202.2%	$21,287	$86,265,000,000	$5,033
New York Health Plus	-100.0%	$33,915,000,000	118.8%	$12,508	$62,460,000,000	$3,644
Fully Implemented Public/Private Partnership	-100.0%	$7,220,000,000	25.3%	$2,663	$35,765,000,000	$2,087
Freedom Plan	-15.4%	$2,749,000,000	9.6%	$6,605	$31,294,000,000	$2,108

Employer Spending		Change in Employer Spending	%	Per Captia Employer Spending per newly insured	Total Employer Expenditures	Total Employer Expenditures per covered life
Public Health Insurance for All	-100.0%	-$33,321,000,000	-100.0%	$0	$0	$0
New York Health Plus	-100.0%	-$9,920,000,000	-29.8%	$0	$23,402,000,000	$1,365
Fully Implemented Public/Private Partnership	-100.0%	-$1,169,000,000	-3.5%	$0	$32,152,000,000	$1,876
Freedom Plan	-15.4%	-$2,071,000,000	-6.2%	$0	$31,250,000,000	$2,105

Individual Spending		Change in Individual Spending Spending	%	Per Capita Individual Spending per newly insured	Total Individual Expenditures	Total Individual Expenditures per covered life
Public Health Insurance for All	-100.0%	-$22,033,000,000	-100.0%	$0	$0	$0
New York Health Plus	-100.0%	-$17,924,000,000	-81.3%	$0	$4,109,000,000	$240
Fully Implemented Public/Private Partnership	-100.0%	-$50,000,000	-0.2%	$0	$21,983,000,000	$1,283
Freedom Plan	-15.4%	$1,187,000,000	5.4%	$2,853	$23,220,000,000	$1,504

Total Spending		Total Change in Spending	%	Total expense across all categories per newly insured	Total expense across all categories	Total expense per covered life
Public Health Insurance for All	-100.0%	$2,366,000,000	2.8%	$21,287	$86,265,000,000	$5,033.26
New York Health Plus	-100.0%	$6,071,000,000	7.2%	$12,508	$89,971,000,000	$5,249.49
Fully Implemented Public/Private Partnership	-100.0%	$6,001,000,000	7.1%	$2,663	$89,900,000,000	$5,245.35
Freedom Plan	-15.4%	$1,865,000,000	2.2%	$9,458	$85,764,000,000	$5,717.69

REQUEST FOR EXEMPTION

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

☐ Section E Language

What is your Language?: _____

☐ I cannot speak about my medical needs in English.

☐ I cannot find any Medicaid health plan doctor whom I can speak with about my medical needs in my language.

Other family members who have a language reason not to join a health plan:

Name: ID #: *(NYS Benefit Card)* Name: ID #: *(NYS Benefit Card)*

Name: ID #: *(NYS Benefit Card)* Name: ID #: *(NYS Benefit Card)*

☐ I need more space to list my family members. *(New York Medicaid CHOICE will contact you for the names.)*

I hereby certify that I speak the applicant's primary language, which is other than English, or that I ha e a staff pers n capable f translating medical terminology in the applicant's language, which is other than English.

I further certify that I am a fee-for-service provider in the Medicaid program. I do not participate in any f the managed care plans under contract with the Medicaid program.

Health Care Provider: Complete and sign.

Date: (mm/dd/yy) Provider/Physician*: License #:

Specialty: MMIS Pro ider ID #:

Office/Clinic Address:

City: ip C de: Ph ne: ( ) Fax: (

Signature:

** **Must be signed by an Attending Physician.***
Informati n pr ided in this f rm is subject t erification by the New Y rk State Department f Health; HR , the LDSS, or New York Medicaid CHOICE.

☐ Section F Living Outside Your C unty f r a Sh rt Time Only

Y u must send s me official paper sh ving that y u are temporarily living outside the County where you recei e Medicaid. For example, y u can send a letter from your child's school saying that y ur child is a student there.

Your current temporary (short term) address:

ip C de: How long you will be at this address:

ther family members h are temporarily living outside the County with you:

Name: ID #: *(NYS Benefit Card)* Name: ID #: *(NYS Benefit Card)*

Name: ID #: *(NYS Benefit Card)* Name: ID #: *(NYS Benefit Card)*

☐ I need more space to list my family members. *(New York Medicaid CHOICE will contact you for the names.)*

☐ Section G Native Americans

Please provide a copy of official documentation of your Native American status and other family members who are Native Americans living with you who do not want to join a health plan.

See Instructions Sheet for more details.

If the information disclosed involves the release of HIV/AIDS diagnosis then the **New York Medicaid CHOICE** staff should please note the following: This information has been disclosed to you from confidential records information, with specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure. The information provided is also subject to the confidentiality requirements of applicable federal and state laws including New York Mental Hygiene Law §§ 33.13 and 33.16.

Section A *Everyone Must Fill And Sign This Section*

I understand the following:

- I am asking for an exemption from the New York Medicaid CHOICE pr gram. I do not want to join a health plan.
- I know that to ask for the exemption, I may need t gi e inf rmati n about my medical condition. I give my Provider permi i n t gi e New York Medicaid CHOICE all needed medical information only if it i rele ant t my reque t for the exemption. This may include mental health, HI , alc h l r sub tance abu e, or di ability informati n, if it is needed for this exemption request.
- I know that if I am n in a Medicaid health plan and I am appr ed f r an e empti n, I will be disenr lled fr m that health plan.

Name (Please Print):

Signature: **Date:**
(Head of Household must sign for person under 18)

Home Teleph ne # (Area Code) **Cell Phone #** (Area Code)

Fill out any of the following Sections that apply to you.

☐ Section B No Medicaid Health Plan Doctor Near Your Home

There are no Medicaid health plan doctors within 30 minutes or 30 miles of your home.

The names of the 2 streets that cross each other nearest you: and

Address of your current doctor (or clinic):

☐ I need space to list my family members (New York Medicaid CHOICE will contact you).

☐ Section C Foster Care Children

Does not apply to all counties (Call the HelpLine to learn if this exemption applies to your county).

You must sign and return this form along with a letter from the foster care agency.

☐ Section D **Medical/Health**

Health Care Provider/Professional: Complete 1, 2, 3 or 4, as applicable. You must also complete and sign Box 9. By completing and signing this form you are attesting that you do not participate with any of the Medicaid managed care plans but you do participate with fee-for-service Medicaid.

1. I provide prenatal care to this patient and ***I do not participate*** in a Medicaid health plan.

Date (mm/dd/yy) of patient's last visit: _____ Due date (mm/dd/yy) (EDC): _____

2. I provide medical care to this patient who is scheduled for surgery within 30 days after managed care enrollment and ***I do not participate*** in a Medicaid health plan.

Date (mm/dd/yy) of patient's last visit : _____ Surgery date (mm/dd/yy): _____

Patient's condition(s) / diagnosis(es): _____

Surgery to be performed: _____

3. ☐ I have been this patient's **primary care provider** for at least one year and ***I do not participate*** in a Medicaid health plan. **Note:** PCP must check box and complete #9.

4. I am a **specialist** practicing one or more of the medical specialties listed below and providing care to this patient for at least six months and ***I do not participate*** in a Medicaid health plan.

Patient's condition(s) / diagnosis(es): _____

I have been providing care since Date (mm/dd/yy): _____ Patient's last visit Date (mm/dd/yy): _____ Completion of treatment if applicable, Estimated Date (mm/dd/yy): _____

List of Medical Specialties

- Allergy and Immunology
- Cardiology
- Endocrinology
- ENT Surgery
- Gastroenterology
- Hematology
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Psychiatry
- Physiatry (Rehabilitative Medicine)
- Plastic Surgery (non-cosmetic)
- Pulmonology
- Rheumatology
- Other *(as approved by NYSDOH)*

☐ Section D **Medical/Health** (continued)

Health Care Provider/Professional: Complete 5, 6, 7 or 8, as applicable. You must also complete and sign Box 9.

5. I provide medical care to the person requesting an exemption and my patient has *(check one)*:

- ☐ End-stage renal disease (ESRD)
- ☐ HIV/AIDS *(**Note:** Doctors and providers should call 1-888-9EXEMPT to learn if this exemption reason applies to your patient).*

6. The patient needs care in the home or in the community as the result of a physical or developmental disability. (A developmental disability occurs before age 22 and has substantial lifelong functional impairments.) The patient receives coordinated care/services intended to address health care needs, severe behavior problems and/or adaptive behavior deficits. **Note:** A physician, or in the case of developmental disabilities, a Qualified Mental Retardation Professional must check box and complete #9.

☐ My patient's care meets ALL of the following criteria:

- The patient requires extensive and/or complex care in their home or community for at least 120 days; and
- This care allows the patient to stay in their home or in the community in lieu of being in an institutional setting (such as a permanent or long-term placement in a nursing home, intermediate care facility, hospital or skilled nursing facility); and
- A physician and/or qualified health professional has ordered these services

7. My patient is a resident of *(name facility)* _____

☐ an intermediate care facility for the mentally retarded and is expected to stay from: _____ (Date (mm/dd/yy)) until: _____ (Date (mm/dd/yy))

8. I am a psychiatrist, psychologist or LCSW. My patient is an adult who is seriously and persistently mentally ill, or a child who is seriously emotionally disturbed. She/he does not have SSI, nor is certified blind or disabled. My patient has utilized the services that I have checked below during the last 12 months.

- ☐ Ten or more encounters, including visits to a mental health clinic, psychiatrist or psychologist, and inpatient hospital days relating to a psychiatric diagnosis; **or**
- ☐ One or more specialty mental health visits (i.e., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of OMH licensed community residents and family based treatment; and mental health clinics for seriously emotionally disturbed children).

9. Provider Information/Signature (Must be completed)

Date: _____ (mm/dd/yy) Provider/Physician*: _____ (Please Print) License #: _____

Specialty: _____ MMIS Provider ID #: _____

Name of (Clinic/Facility): _____

Address: _____

City: _____ Zip Code: _____ Phone: ( ) _____ Fax: ( ) _____

Signature: _____

**** Must be signed by an Attending Physician, or by a Qualified Mental Retardation Professional for Section D.6.***

Information provided in this form is subject to verification by the New York State Department of Health; HRA, the LDSS, or New York Medicaid CHOICE.

Section F Living outside your County for a short time only.

You do not have to join a health plan if you are living outside of your county right now.

1. Sign section **A** of the form.
2. Check the box at the top of section **F** .
3. Fill out section **F** of the form.
4. Get a letter of proof written on letterhead from an institution such as your child's school saying that your child is a student there. You may also include the names of other family members who are temporarily living outside of your county with you.

Section G Native Americans

You do not have to join a health plan if you are a Native American.

1. Sign section **A** of the form.
2. Check the box at the top of section **G**.
3. Get a copy of one of the following documents: Bureau of Indian Affairs, Tribal Health, Resolution, Long House or Canadian Department of Indian Affairs identification cards; documentation of roll or band number, documentation of parents' or grandparents' roll or band number together with birth certificate(s) or baptismal record indicating descendance from the parents or grandparents; or a notarized letter from a federal or state recognized American Indian/Alaska Native/Tribe Village Office stating heritage or a birth certificate indicating heritage.
4. You may also include the names of other family members who are Native Americans living with you who do not want to join a health plan.

Ask to talk to an Exemption Counselor.
This call is free and confidential.

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

UN-EX-CVR-E-0609

EXEMPTION APPLICATION

Reasons You Can Apply For An Exemption

- **No Medicaid health plan doctor near your home:** Sign section A and fill out section B.
- **Foster Care Children** *(does not apply to all counties):* Sign section A and fill out section C and provide documentation.
- **Primary Care Provider does not accept Medicaid health plans.** Sign section A and ask your doctor to fill out section D.
- **Medical/Health:** Sign section A and ask your doctor to fill out section D.
- **Language:** Sign section A, fill out top and check box at section E and ask your doctor to fill out section E.
- **Living outside your County for a short time only:** Sign section A and fill out section F and provide documentation.
- **Native Americans:** Sign section A and follow the instructions in section G.
- **Physical or Developmental disabilities with extensive needs similar to people in Medicaid Home and Community Based Services waiver programs or Intermediate Care Facilities.** Sign section A and ask your doctor to fill out section D.6.
- **Homeless and/or living in a shelter** Sign section H and fill out section I.
- **Long Term Alcohol and Substance Abuse Program** Sign section H and fill out section J.

Mail this form and papers, (if required) **to:**

New York Medicaid CHOICE
P. O. Box 5009
New York, New York 10274-5009

Use the envelope provided.
You do not need a stamp.

New York Medicaid CHOICE will send you a letter about your exemption request.

Need help?

New York Medicaid CHOICE
1-800-505-5678
TTY/TDD: 1-888-329-1541

Instructions

More **Instructions**

Section A Everyone MUST sign section A.

Section B No Medicaid health plan doctor near your home.

You do not have to join a health plan if you cannot find a doctor in a Medicaid health plan within 30 minutes or 30 miles of your home.

1. Sign section **A** of the form.
2. Check the box at the top of section **B**.
3. Fill out section **B** of the form.

Section C **Foster Care Children.** Does not apply to all Counties.

Children in foster care do not have to join a health plan.
Call the HelpLine to find out if this exemption applies to the area where you live.

1. Sign section **A** of the form and check the box at the top of Section **C**.
2. Fill out Section **C**.
3. Get a letter from the foster care agency on letterhead saying that the child (children) are in foster care.

Section D Medical/Health

You do not need to join a health plan if any of the reasons below applies to you.

- You are **pregnant** and you are already getting prenatal care from a medical provider who is not in a Medicaid health plan.
- You are scheduled for major **surgery** and your doctor is not in a Medicaid health plan.
- You have been going for at least one year to a **primary care provider** who is not in a Medicaid health plan.
- You have a **disability or a chronic condition,** and you have been going for 6 months or more to a specialist who is not in a Medicaid health plan
- You have a **diagnosis of HIV+ or AIDS.**
  (Note: Doctors and providers should call 1-888-9EXEMPT to learn if this exemption reason applies to your patient.)
- You have **kidney disease** and you are on dialysis.
- You have a **physical or developmental disability** and you are receiving extensive care in the home or in the community similar to people in Medicaid Home and Community Based Services waiver programs.
- You are a resident of an **intermediate care facility for the mentally retarded** or have similar needs.
- You are an adult who is **seriously and persistently mentally ill** or you are a child who is **seriously emotionally disturbed** and have received treatment within the last 12 months.
  (This exemption does not apply to patients who have SSI or who are certified blind or disabled.)

1. Sign section **A** of the form.
2. Check the box at the top of section **D**.
3. Ask your doctor, specialist or medical professional to fill out section **D**. This section can only be filled out for one person.

Section E Language

If you cannot find a doctor (or staff person) in a Medicaid health plan who speaks your language, then you can apply for an exemption.

1. Sign section **A** of the form.
2. Check the box and complete the top of section **E**.
3. You may include the names of other family members who live with you and who do not understand English.
4. Ask your doctor to fill out the Provider's part of section **E**.

Medicaid Matters New York

May 5, 2009

Via U.S. Mail and Electronic Transmission:

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

Dear Sir or Madam:

We write to comment on the New York State Medicaid waiver amendment requests submitted to the Centers for Medicare and Medicaid Services (CMS). Our comments address New York State's efforts to implement twelve months of continuous coverage for Medicaid and Family Health Plus eligibles and to extend mandatory managed care to Medicaid recipients living with HIV/AIDS. Public notice of the submission of the requested amendment was posted on the Department's website in March of 2009.[1]

Twelve Months Continuous Coverage:

First, we want to emphasize our strong support and appreciation of the State Department of Health's (SDOH) streamlining and simplification efforts in the application and renewal procedures for Medicaid and Family Health Plus. Studies by both the United Hospital Fund and the New York State Health Foundation have found that large numbers of New York State Medicaid and Family Health Plus recipients experience gaps in coverage even though they remain eligible for coverage.[2] Providing 12 months of continuous coverage to adults will eliminate some of these gaps and furthers the State's commitment to covering all eligible individuals.

HIV/AIDS Enrollment:

[1] New York State Department of Health, Waiver Amendment Request, *available at*: http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm#summary_partnership.
[2] Manatt Health Solutions, "Streamlining Renewal in Medicaid and SCHIP: Strategies from Other States and Lessons for New York," United Hospital Fund, 2008, *available at* http://www.uhfnyc.org/usr_doc/Streamlining_Renewal.pdf; Lake Research Partners, "Reducing Enrollee Churning in Medicaid, Child Health Plus, and Family Health Plus," NYS Health Foundation, February 2009, *available at* http://www.nyshealthfoundation.org/userfiles/file/LakeResearch_2_2009.pdf.

While we appreciate the cost constraints that our State is operating under and its commitment to increased access to health insurance coverage for uninsured New Yorkers, we have serious concerns about mandating enrollment of additional vulnerable populations into Medicaid managed care. These concerns are largely based on the experiences of mandatory enrollment of the SSI population which began in November 2005. As discussed below, we believe that SDOH must improve upon and exercise its planning and oversight authority before mandatory enrollment is extended. We fear that if issues regarding outreach, education, and plan access and capacity are not appropriately addressed before the amendment is approved, Medicaid recipients living with HIV/AIDS will experience dangerous interruptions in critical health care services.

We therefore urge the Department to consider the recommendations we address below as it continues its efforts to seek CMS approval of this amendment request.

Rationale and Description of Key Program Features

The summary waiver amendment description states that quality of care in the Medicaid Managed Care program is repeatedly evaluated and member satisfaction routinely assessed.[3] However, the description fails to provide citations for any of the reports or studies referenced.

We are aware of a member satisfaction survey for mandatory enrollees on SSI that was publicly reported by the Department in July of 2008. This survey was not specifically designed to yield high responses from visually, developmentally or cognitively impaired enrollees. Additionally, it did not address utilization and treatment differences or transitional care upon enrollment.

Similarly, in the member satisfaction survey completed by IPRO, no effort was made to ensure that the survey methodology was appropriate to the SSI population (i.e. by including reasonable accommodations for disabled persons) or that participants reflected disabilities prevalent within the population.[4] Survey findings describing care as "the same as" or "better" were grouped and reported together as if they indicated the same response.[5] No questions were asked about accommodations or accessibility.

Network Capacity

The summary waiver amendment description indicates that there are approximately 30,000 HIV+ Medicaid beneficiaries in New York City (NYC) who would be enrolled under this mandate.[6] The summary does not include any detail in its description of how an additional 30,000 Medicaid beneficiaries will be managed by the existing Medicaid managed care plans.

[3] NYS Department of Health, "Description of Program Changes to the Partnership Plan 1115 Demonstration Waiver (Project Number 11-W00114/2) and the Federal-State Health Reform Partnership (F-SHRP) (Project Number 11-W-00234/2)," [hereinafter "Description of Program Changes"],p.2, posted March 2009, *available at* http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm#summary_partnership.
[4] IPRO, "SSI Survey, New York City, Medicaid Managed Care Members," New York State Department of Health, Office of Health Insurance Programs, July 2008.
[5] *Id.* at 53-55.
[6] "Description of Program Changes," p. 1.

The Department states that it determined managed care plan network capacity for each county before implementing mandatory enrollment in the past and plans to do so in the future. The summary description states that the "AIDS Institute recently met with HIV SNPs to discuss operational issues related to expanding enrollment such as expanding network capacity."[7] SDOH has not disclosed the conclusions reached in this meeting nor how network capacity will be expanded. Further, the Partnership Plan Special Terms and Conditions requires that network capacity be evaluated prior to enrollment of disabled populations.[8] SDOH has published no such evaluations..

The advocacy community remains concerned that New York's Medicaid managed care program does not have enough providers who specialize in HIV to accommodate all new enrollees. Although a larger number of specialists participate in Medicaid managed care than fee-for-service Medicaid, not all providers participate in the same plans. Therefore, enrollees with multiple conditions will likely be forced to choose among their current providers.

Though the Department has provided health plans with a list of providers who serve the HIV/AIDS population, they have not required plans to make use of this information by augmenting their provider networks. A plan's enrollment of people living with HIV/AIDS should be considered a commitment by the plan that it has the capacity to effectively serve these individuals.

Outreach & Training

According to the summary, outreach and enrollment to the 30,000 plus new HIV/AIDS enrollees is to be phased in to 2,500 beneficiaries each month.[9] The summary does not describe what efforts, if any, will be made to increase New York Medicaid Choice (NYMC) call center capacity or what training, if any, will be given to NYMC staff regarding the needs of people living with HIV/AIDS.

The Department has recently released auto-assignment data for the SSI population which points to a failure of outreach during mandatory enrollment of this population. The data reveals auto-assignment rates that are much higher than in the general Medicaid population.[10] During the rollout of mandatory enrollment for the SSI population, we found that many individuals were auto-assigned into plans that their providers did not accept. Often, these individuals did not learn that they had been enrolled in a plan until they were suddenly unable to access medical care. Given an auto-assignment rate of 21.6% for the SSI population in New York City,[11] we believe that there is a significant risk that large numbers of HIV+ individuals will also be auto-assigned and experience gaps in health coverage as a result.

[7] *Id.* at 3.
[8] Center for Medicare and Medicaid Services, Special Terms and Conditions, The Partnership Plan, Dec. 15, 2004, p. 54.
[9] *Id.*
[10] New York State Department of Health, Medicaid Managed Care Auto Assignment Rates.
[11] *Id.*

The summary waiver amendment description states that the Department is working with NYMC to revise the enrollment materials that will be sent to Medicaid recipients living with HIV/AIDS. Yet, to our knowledge, the Department has not solicited the input of people with disabilities and people living with HIV/AIDS or their advocates to help inform this process. We fear that without adequate training and staff increases at NYMC, HIV+ enrollees will face a similar auto-enrollment rate as the SSI population and consequent barriers to receiving timely and appropriate care.

We urge the Department to consider the barriers to enrollment for SSI recipients prior to rolling out the auto-assignment process for individuals with HIV/AIDS. Many individuals living with HIV/AIDS suffer from co-morbidities such as mental illness and may be less likely than other populations to respond to mandatory enrollment letters. In addition, many people living with HIV/AIDS are unstably housed or homeless, presenting additional challenges in reaching them through the mail.

A comprehensive outreach campaign for the education and training of beneficiaries, providers, and health plans is essential to ensure that enrollment efforts reach the HIV/AIDS population. This campaign should incorporate alternative forms of outreach for the unstably housed, specific information on how to respond to enrollment letters, what it means to be enrolled in a managed care plan, and most importantly, how to avoid interruptions in vital services which could present grave health care risks for this population.

Any successful outreach program must be given time to function effectively. Therefore, we recommend that the auto-assignment timeline of 60 days be extended for the HIV/AIDS population (as it was for the SSI population) so that beneficiaries, their advocates and their providers have time to learn about managed care and make educated decisions about plan enrollment. In addition, we recommend that the time in which enrollees can switch plans be lengthened and the "lock-in" period for new enrollees be shortened for the HIV/AIDS population. We further recommend that the enrollment experience of the initial enrollment cohort of 2,500 individuals be evaluated prior to rolling out mandatory enrollment to additional recipients with HIV/AIDS. This evaluation should include an analysis of the auto-assignment rate for the group, and SDOH should halt further enrollment in the event of a high auto-assignment rate for the initial cohort.

To date, Department trainings have resulted in confusion and hysteria in the HIV/AIDS community regarding the timing and the logistics of the mandatory enrollment process. In fact, many believe mandatory enrollment has already begun and that having HIV/AIDS is no longer a basis to be exempt from Medicaid managed care. Adding to the confusion, providers and HIV/AIDS advocates have not been properly trained to help recipients choose a health plan that best meets their needs or to help recipients apply for other exemptions or exclusions to which they may be entitled.[12] The confusion, stress and anxiety this misinformation has caused recipients with HIV/AIDS could lead to significant health issues since stress often exacerbates symptoms for this population. It has also caused recipients to prematurely lose access to care and to the providers with whom they have existing relationships. These problems could be avoided with proper outreach and training.

[12] Comments made at HIV Care Network Meetings Citywide from October 2008 through February 2009.

Enrollment

We continue to urge the Department to consider "intelligent enrollment" instead of random auto-enrollment for individuals who do not select a plan in order to ease problems with transitional care and limit interruption of services. This could help to ensure that even those who are auto-assigned are more likely to be enrolled in a plan that more of their providers accept.

In addition, SDOH should consider using systems already in place to target vulnerable populations and prevent their enrollment into Medicaid managed care. We recommend that the Department use data it already has to pre-code enrollees for automatic exemptions and exclusions. The amendment request states that SDOH will enroll Medicaid beneficiaries whose "only known exemption" from mandatory enrollment is their HIV/AIDS status.[13] However, we believe that recipient utilization data and other agency data could be used by the Department to determine other exemptions for which people living with HIV/AIDS may be eligible.

For example, the New York City Department of Homeless Services has records of those who live in their shelter system and are therefore exempt. SDOH has records of who is receiving primary care treatment or treatment for a chronic condition with a provider who does not accept any Medicaid managed care plan. Similarly, SDOH records could confirm if a Medicaid recipient with HIV/AIDS is receiving nursing home level of care.

Standards of Care

The SDOH AIDS Institute has designed specific standards of care for HIV SNPs. However, the Department has indicated that when people living with HIV/AIDS are auto-enrolled into plans, they will be enrolled in mainstream managed care plans rather than SNPs[14]. Given this procedure, we believe that it is essential that the Department demand of these plans the same standards of care for HIV/AIDS that SNPs are required to provide. The main differences in the two types of plans are the provisions for service coordination, case management requirements and community services linkages[15]. We urge the Department to require Medicaid managed care plans to conform to SNP standards in these areas.

The State's proposed approach to enrollment of the HIV/AIDS population in mainstream managed care does not appear to reflect the most up-to-date analysis of managing the care of "high cost" or "high need" individuals. A recent study of care for this population suggests that these individuals often have multiple chronic conditions and acute illnesses, including psychiatric disabilities and substance abuse conditions.[16] Many high need individuals are also homeless, unstably housed, socially isolated, lack family and community supports or struggle

[13] "Description of Program Changes," p. 1.
[14] "Description of Program Changes," p. 4.
[15] Medicaid Managed Care for People with HIV and AIDS Frequently Asked Questions, revised March 2009, *available at* http://www.health.state.ny.us/health_care/managed_care/living_with_hiv/questions_and_answers.htm
[16] Birnbaum, Michael and Deborah E. Halper, "Rethinking Service Delivery for High-Cost Medicaid Patients," United Hospital Fund, 2009, *available at* http://www.uhfnyc.org/usr_doc/Rethinking_Service_Delivery_Medicaid_Patients_.pdf, p. 8.

with abusive relationships.[17] This population experiences poor communication and lack of respect from health care practitioners, struggles with inadequate transportation, and experiences constant financial distress. The report indicates that problems such as the unmet need for integration of services across settings, lack of continuity of care, and inadequate follow-up after discharge exacerbates these conditions.[18] It also describes the need for a coordinated multidisciplinary approach to care and connection to community-based organizations able to assist with community supports.[19] The plan to auto-enroll HIV+ individuals in mainstream managed care plans does not consider how these issues will be addressed if this vulnerable population is enrolled.

ADA Compliance

Many individuals with HIV/AIDS have disabilities resulting from the disease process or co-morbid conditions. These may include difficulty with walking, climbing stairs, vision problems, cognitive limitations, and psychiatric disabilities[20]. In addition, the 2008 amendments to the Americans with Disabilities Act (ADA) expanded the scope of disability covered by the law. More HIV+ individuals will likely be covered by the ADA, as "the operation of a major bodily function, including…functions of the immune system," is considered a major life activity for purposes of the definition of disability.[21]

Current SDOH processes do not capture the information required for managed care plans and providers to reasonably accommodate individuals with disabilities to ensure their full and equal access to care. This is because health plan "health screening forms" do not routinely include this type of beneficiary information.[22] As a result, plans often do not learn about accommodations needed by new enrollees, and accommodations are thus not supplied by the plans and providers. These omissions in the health screening process must be rectified by adding questions to the health screens about reasonable accommodations required. Further, SDOH should track this information by requesting data regarding accommodations requested and granted within the Medicaid managed care plan.

Even the health plans' ADA compliance plans that currently exist rarely take into account accommodation of people with cognitive or psychiatric disabilities (such as reading and explaining materials to individuals who require that assistance). This will have an impact on people with HIV/AIDS who have cognitive and psychiatric limitations related to their conditions.

Health plans rely on self-audit by practitioners of ADA compliance, a notoriously inaccurate process. As there is no common instrument for analysis, the plans' results are essentially meaningless. In addition, there is no verification of the results. Therefore, there is virtually no useful information available on ADA compliance with regard to accommodations in areas such

[17] *Id.* at 9.
[18] *Id.* at 4, 9.
[19] *Id.* at 16.
[20] Prevalence of Psychiatric Disorders Much Higher Among HIV Patients, Psychiatric News, October 19, 2001, Volume 36, Number 20, 2001. American Psychiatric Association, p.19.
[21] Americans with Disabilities Act, 42 U.S.C. § 12102(2)(B).
[22] Review of health plan materials received pursuant to a FOIL request.

as changing rooms, examination tables, bathrooms, assistance with dressing and undressing, large print materials or audio versions of written materials, and ASL interpretation.

Continuity of Care

Previously mandatorily enrolled populations have experienced termination of existing long term and specialty care services for chronically ill individuals. Even with mechanisms in place to address this issue, including providing plans with Medicaid utilization data for new enrollees, many new enrollees with chronic illness have lost access to critical health services. With 63% of the 30,000 proposed new enrollees with HIV/AIDS on regular medication regimens, access to care is critical as loss of providers means loss of access to prescription drugs.[23] This can lead to lowered resistance and increased emergency room usage. Plans must be monitored and held accountable by the Department when they fail to ensure continuity of care. Plan requirements for continuity of care should include prompt completion and transmission of health screening forms to health plans and case managers. The waiver amendment proposal must ensure oversight of the transitional care requirements in the New York State Public Health Law (N.Y. Pub. Health L.§ 4403(6)(f)).

We also urge the Department to evaluate past treatment of enrollees who face a bifurcated service delivery system. The carving out of services such as prescription drugs, COBRA case management, HIV adult day treatment and certain substance abuse services creates an unusually complex system for both enrollees and providers for which neither have been appropriately educated. This is especially critical considering that 44% of the proposed 30,000 new HIV/AIDS enrollees are SSI recipients who will be subject to the bifurcated system.[24] We urge the Department to acknowledge the difficulties faced by enrollees who must access care through two entirely different systems, and to design outreach and education efforts specifically around this issue. Enrollees with a bifurcated delivery system must receive case management and assistance with plan navigation and coordination of benefits in this area.

Enrollee Rights and Plan Oversight

Medicaid recipients newly enrolled in managed care plans have been denied their due process rights when their existing services are terminated without notice and they are not informed of their right to appeal or to receive aid-continuing. We strongly recommend that the Department develop procedures to ensure plans' compliance with due process requirements. These procedures should include an evaluation of utilization data to ensure that chronically ill individuals and/or recipients with disabilities do not lose access to critical services upon enrollment. There should also be a mechanism for monitoring and imposing sanctions for plans that repeatedly violate the Public Health Law, the Social Services Law and regulations and/or contract requirements.

In conclusion, we appreciate New York's commitment to expanding Medicaid coverage through the waiver process. However, we believe that without addressing critical issues related to beneficiary rights and quality of care, the mandatory enrollment of HIV+ Medicaid recipients

[23] SDOH response to Medicaid Matters New York Request for Data Letter, March 16, 2009, p.8.
[24] SDOH response to Medicaid Matters New York Request for Data Letter, March 16, 2009, p.7.

into Medicaid managed care will seriously threaten the well-being of these individuals. We hope to work with the Department to ensure expansion of enrollment in public health insurance programs and a more effective transition to managed care for people living with HIV/AIDS in New York State.

Sincerely,

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October 1, 2008

Ms. Patricia Kutel, Director
New York State Department of Health
Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Medicaid Managed Care Rate Update Letter for April 1, 2008 – March 31, 2009

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, developed actuarially sound capitation rate ranges for the Medicaid program covering the contract period fiscal year 2009 (FY09), April 1, 2008 — March 31, 2009, in a letter dated February 8, 2008.

Since then, the State implemented a one percent budget reduction effective April 1, 2008, through March 31, 2009. However, since the budget reduction became known after April 1, instead of applying a one percent budget cut for twelve months, the State implemented a two percent budget cut for six months.

Mercer reviewed the updated FY09 rates from the State reflecting the two percent budget reduction for the period October 1, 2008 – March 31, 2009. The updated rates effective for FY09 still fall within the FY09 actuarially sound rate ranges.

Sincerely,

Tim Doyle, FSA, MAAA

TD:lgm/Enclosure

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February 8, 2008

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Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Family Health Plus Managed Care Rate Range Certification Letter for Contract Period April 1, 2008 – March 31, 2009

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has developed actuarially sound capitation rate ranges for the Family Health Plus (FHPlus) program covering the contract period fiscal year 2009 (FY09), April 1, 2008 – March 31, 2009. This letter provides an overview of the analyses and methodology used in the development of the managed care rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Rate Methodology

Overview

Capitation rates for the FHPlus program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). The primary base data used to develop FY09 rates was the Medicaid Managed Care Operating Report (MMCOR).

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS Capitated Rate-Setting Checklist:

- Incurred but not reported (IBNR) claims adjustments
- Trend factors to forecast expenditures and utilization to the appropriate contract period
- Prospective and historic program changes not reflected in the base data
- Administration loading
- Statistical variation for sound ranges
- Risk adjustment

The various steps used in the development of the rate ranges are described in the following paragraphs.

Base Data Development

Mercer utilized MMCOR data from calendar year 2005 (CY05) and CY06 as the primary data source in the rate-setting process. The multiple years of data were blended together to arrive at base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. The MMCOR data reflects the actual medical expenses for the managed care organizations (MCOs) for each of the following three rate cells and the kick payment.

- **FHPlus** – Includes:
  - FHPlus Adults with Child 19 – 64 Male and Female
  - FHPlus Adults without Child 19 – 29 Male and Female
  - FHPlus Adults without Child 30 – 64 Male and Female
- **Maternity Kick Payment**

Mercer reviewed the MMCOR data to ensure it is appropriate to incorporate into the rate development. Specifically, Mercer reviewed remaining liability associated with IBNR claims. Mercer determined that the reported IBNR was sometimes not appropriate for rate development. In these instances, Mercer used the health plan-reported IBNR, total medical expenses, and prior period adjustments to apply an appropriate IBNR percentage to the plan's reported medical expenses. In addition, non-State plan services were removed in the financial data.

Each MCO may elect to cover certain benefits on an optional basis. As a result, the base data was determined separately for the core benefits and optional benefits. The optional

benefits are Dental and Family Planning (FP). In some non-New York City (NYC) regions, there was no data in the base period for one or more optional benefits. To accommodate the potential expansion of available benefit packages, the aggregated Rest of State (ROS) (all regions except NYC Metro) data was used to develop base rates in these instances.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor was necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop trend assumptions. These sources included, but were not limited to:

- Health care economic indices, such as Consumer Price Index for the Northeast region and Global Insight (formerly DRI)
- Trends exhibited in the MMCOR data submitted by FHPlus
- Trends in other state Medicaid expansion programs for similar populations

Mercer developed separate per member per month (PMPM) trends for FHPlus and the Maternity Kick Payment. Mercer also developed separate trends for the core benefits and the two optional benefits. For FHPlus, Mercer developed separate trends by each region and by major category of service (COS). For the Maternity Kick Payment and optional benefits, Mercer developed trends for NYC and ROS by major COS. The following aggregate annual PMPM trend estimates were used for the capitation rate range:

Aid Category	Category of Service	Statewide Annual Midpoint PMPM Trend
FHPlus	Core Benefits (including Rx)	6.1%
	Core Benefits (excluding Rx)	5.5%
	Dental	2.8%
	Family Planning	7.4%
Kick Payment	Maternity Kick	5.0%

Trend was applied for 33 months from the midpoint of the base period (December 31, 2005) to the midpoint of the contract period (September 30, 2008).

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes occurring after the base year.

There are four program changes explicitly incorporated in Mercer's analysis. The State legislature reauthorized the Health Care Reform Act (HCRA) of 2000. This included an increase to the indigent care surcharge for patient service revenue payments made for hospital and certain treatment services provided in the State from 6.47 percent to 6.54 percent. The change was effective in January 2006 and will remain in effect through at least December 2008. At the direction of the State, Mercer has explicitly assumed that the assessment will continue through the end of the SFY09 contract period, and has reflected this increase in the development of the capitation rates appropriately.

The State also elected to implement a co-payment structure for several services covered by the FHPlus program with an effective date of April 1, 2006. Mercer's analysis determined the impact of these co-payments on a PMPM basis. The estimated aggregate value of the co-payments was removed from the base data prior to the application of trend and all other prospective adjustments.

Additionally, the State has implemented a series of increases in the emergency room surgical component. Prior to 2007, this rate was $95. Effective January 1, 2007 it was increased to $125, then again to $140 effective January 1, 2008. This rate will increase further to $150 effective January 1, 2009. These changes affect each plan differently, so the State provided Mercer with the PMPM impact to the ER service line by health plan and region. Mercer analyzed this change, for all applicable plans, on a regional PMPM basis. After removing all outlier plans, the estimated aggregate impact is compared to the base data to determine an ER PMPM adjustment. This adjustment is applied to the overall base data prior to the application of trend and all other prospective adjustments.

Finally, on October 1, 2008, all pharmacy benefits will be carved out of managed care and will be paid by the State on a fee-for-service (FFS) basis. To account for this in the SFY09 rate ranges, all aspects of the rate development process have been adjusted to reflect the removal of pharmacy benefits during the last six months of the contract period.

Administration

The actuarially sound capitation rate ranges developed include a provision for MCO administration. Mercer reviewed MMCOR administrative costs. Mercer also relied upon its professional experience in working with numerous state Medicaid expansion programs, both nationally and locally within the northeast region. The load for administration, which includes profit and margin, was 16.1 percent on a Statewide basis as a percentage of premium.

Rate Ranges

Statistical error and uncertainty are inherent in any rate development process. The final rate ranges represent a "best estimate" of the range of anticipated cost to provide services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received by an MCO provides sufficient margin so that insolvency is not a significant risk for an appropriately managed MCO. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue received by an MCO is not so large that the State is at risk of paying too many taxpayer dollars for the provision of health care to eligible recipients.

The application of rate ranges is complex; the State contracts with 24 different MCOs Statewide. Mercer utilized the first half of CY07 regional enrollment at the premium group level to composite the MCO rates. This eliminated fluctuations due to low plan enrollment and allows for a more direct comparison to the actuarially sound rate ranges, as they were also composited using the first half of CY07 enrollment.

The managed care rate for each MCO by region was compared to the actuarially sound rate range. In certain situations, the regional MCO composite may result in an MCO falling outside the actuarially sound regional rate range. Where this outcome occurs for an individual MCO, the composite in all regions in which the MCO contracts must fall within the Statewide actuarially sound rate range.

Risk-adjusted Rates

Since the State elected to implement risk-adjustment in FY09, Mercer assisted the State in selecting a risk-adjustment model. Models reviewed include Clinical Risk Groups (CRGs), Adjusted Clinical Groups (ACGs), Chronic Illness and Disability Payment System (CDPS)

and Medicaid Rx. Mercer found that CRGs produced similar results to the other models reviewed. This conclusion appears to be consistent with the Society of Actuaries latest paper called "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment" that shows CRGs produced results comparable to the other models tested. CRGs are developed by 3M and utilize diagnosis codes, procedure codes and pharmacy codes to classify individuals into groups for risk adjustment.

Mercer used CY06 encounter data with six months of run-out for the risk assignment period. The data was thoroughly reviewed for completeness and quality. St. Barnabas and Community Premier Plus were excluded from the analysis since they exited the program and their data was not complete.

Once the data was validated, standard prices were developed and used in instances where the plan did not report a payment amount or when the payment amount was deemed an outlier. This process was performed for each service category.

The next step in the risk assignment process was to assign each member to a CRG risk group. CRG grouper version 1.5.1 was used to determine a member's CRG risk group assignment. To compute the CRG weights, a member's CRG assignment was combined with their eligibility information and health care expenditures. This information was used to compute the average PMPM cost for each CRG risk group. CRG weights were computed by dividing the average cost for each CRG risk group by the average cost for all members.

The plan's raw risk score was calculated by averaging the CRG weights for all of the members that were enrolled in the plan during the year, weighted by each member's months of enrollment in the plan. Risk scores were developed for each of the nine regions. Note that optional benefits, as well as the maternity category, are not risk-adjusted. Risk scores were not determined for plans with less than 600 member months in a region due to concerns regarding the credibility of the plan's risk score. In these instances, the plan was given a risk score of 1.0.

The FY09 rates incorporate a blended approach in which 25 percent credibility was applied to the risk-adjusted rate and 75 percent credibility was applied to the rate developed using the prior year methodology.

Certification

Mercer certifies the above rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations.

Mercer has relied on data and various other information provided by the State in the development of these rate ranges. We have reviewed the data and analyses for reasonableness and we believe them to be free of material error and suitable for rate development purposes for the populations and services covered under the managed care contract. However, we have not audited these data and if they are materially incomplete or inaccurate, our conclusions may require revision.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State. Use of these rates for any purpose beyond that stated may not be appropriate.

Please contact me at +1 602 522 6584 with any questions regarding the above.

Sincerely,

Timothy Boyle, FSA, MAAA

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Maria Dominiak, Mercer
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March 20, 2009

Ms. Patricia Kutel
Director
New York State Department of Health
Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Family Health Plus Managed Care Rate Range Certification Letter for Contract Period April 1, 2009 – March 31, 2010

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has developed actuarially sound capitation rate ranges for the Family Health Plus (FHPlus) program covering the contract period fiscal year 2010 (FY10), April 1, 2009 – March 31, 2010. This letter provides an overview of the analyses and methodology used in the development of the managed care rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Rate Methodology

Overview

Capitation rates for the FHPlus program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). The primary base data used to develop FY10 rates was the Medicaid Managed Care Operating Report (MMCOR).

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS Capitated Rate-Setting Checklist:

- Incurred but not reported (IBNR) claims adjustments
- Trend factors to forecast expenditures and utilization to the appropriate contract period
- Prospective and historic program changes not reflected in the base data
- Administration loading
- Statistical variation for sound ranges
- Risk adjustment

The various steps used in the development of the rate ranges are described in the following paragraphs.

Base Data Development

Mercer utilized MMCOR data from calendar year 2006 (CY06) and CY07 as the primary data source in the rate-setting process. The multiple years of data were blended together to arrive at base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. The MMCOR data reflects the actual medical expenses for the managed care organizations (MCOs) for each of the following three rate cells and the kick payment.

- **FHPlus** – includes:
  - FHPlus Adults with Child 19 – 64 Male and Female
  - FHPlus Adults without Child 19 – 29 Male and Female
  - FHPlus Adults without Child 30 – 64 Male and Female
- **Maternity Kick Payment**

Mercer reviewed the MMCOR data to ensure it was appropriate to incorporate into the rate development.

As has been done in previous contract periods, Mercer specifically reviewed each plan's remaining liability associated with IBNR claims. Mercer made adjustments for IBNR for those plans that have historically included a large initial IBNR reserve followed by large write-offs in subsequent reporting periods.

Each MCO may elect to cover certain benefits on an optional basis. As a result, the base data is determined separately for the core benefits and optional benefits. The optional

benefits are Dental and Family Planning (FP). Optional benefit costs were analyzed separately for the New York City Metro (NYC) and Rest of State (ROS) regions to develop base rates.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor was necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop trend assumptions. These sources included, but were not limited to:

- Health care economic indices, such as Consumer Price Index for the Northeast region and Global Insight (formerly DRI)
- Trends exhibited in the MMCOR data submitted by FHPlus
- Trends in other state Medicaid expansion programs for similar populations

Mercer developed separate per member per month (PMPM) trends for FHPlus and the Maternity Kick Payment. Mercer also developed separate trends for the core benefits and the two optional benefits. For FHPlus, Mercer developed separate trends by each region and by major category of service (COS). For the Maternity Kick Payment and optional benefits, Mercer developed trends for NYC and ROS by major COS. The following aggregate annual PMPM trend estimates were used for the capitation rate range:

Aid Category	Category of Service	Statewide Annual Midpoint PMPM Trend
FHPlus	Core Benefits	4.9%
	Dental	3.1%
	Family Planning	7.4%
Kick Payment	Maternity Kick	4.1%

Trend was applied for 33 months from the midpoint of the base period (December 31, 2006) to the midpoint of the contract period (September 30, 2009).

Program Changes

Program change adjustments recognize the impact of benefit or eligibility changes occurring after the base year.

The one program change explicitly incorporated into Mercer's analysis reflects the changes that the State has made to the emergency room surgical component reimbursement between the base period and the contract period. During the base period, the Emergency Room services were reimbursed on a flat fee basis, including capital, of $119 per visit during CY06 and $149 per visit during CY07. Effective January 1, 2009, Emergency Room services will be reimbursed using an Ambulatory Patient Group (APG) methodology. These changes affect each plan differently, so the State provided Mercer with the PMPM impact to the Emergency Room service line by health plan and region. Mercer analyzed this change, for all applicable plans, on a regional PMPM basis. The estimated aggregate impact was compared to the base data to determine an appropriate adjustment. Separate adjustment factors were developed for each region and premium group.

Administration

The actuarially sound capitation rate ranges developed include a provision for MCO administration. Mercer reviewed MMCOR administrative costs. Mercer also relied upon its professional experience in working with numerous state Medicaid expansion programs, both nationally and locally within the northeast region. The load for administration, which includes profit and margin, was 18.8 percent on a Statewide basis as a percentage of premium.

Rate Ranges

Statistical error and uncertainty are inherent in any rate development process. The final rate ranges represent a "best estimate" of the range of anticipated cost to provide services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received by a health plan provides sufficient margin so that insolvency is not a significant risk for an appropriately managed health plan. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue received by a health plan is not so large that the State is at risk of paying too much for the provision of health care for eligible recipients.

The application of rate ranges is complex; the State contracts with 22 different health plans statewide. Mercer utilized the CY07 regional enrollment at the premium group level to composite health plan rates. This eliminated fluctuations due to low plan enrollment and allowed for a more direct comparison to the actuarially sound rate ranges, as they were also composited using CY07 enrollment.

The managed care rate for each health plan was compared to the actuarially sound rate range for each region in which the health plan will operate during FY10. In certain situations, a regional health plan rate may fall outside the actuarially sound regional rate range. Where this outcome occurs, the statewide composite rate for the health plan in question must fall within the statewide composite actuarially sound rate range.

Risk-adjusted Rates

The State implemented a risk-adjustment process in FY09 based on the Clinical Risk Group (CRG) model developed by the 3M. Prior to selecting the CRG model, Mercer evaluated the performance of the CRG model compared to the Adjusted Clinical Groups (ACGs) and Chronic-Illness and Disability Payment System (CDPS) on New York's Medicaid programs. The CRG model produced similar results to the other models.

The application of risk-adjustment will continue into FY10 with a few methodology refinements. The approach used to develop the FY10 risk scores and the resulting capitation rates is described within this section.

CY07 encounter data with six and a half months of run-out was used for the risk assignment period. The data was reviewed for completeness and quality. Managed Health, Inc, Community Premier Plus, and Community Choice Health Plan were excluded from the analysis since they exited the program and their data was not complete.

Once the data was validated, standard prices were developed and used to calculate the price for each service provided by the health plans. This process was performed for each service category.

The next step in the risk assignment process was to assign members with at least three months of managed care enrollment to a CRG risk group. CRG grouper version 1.6.1 was

used to determine a member's CRG risk group assignment. To compute the CRG weights, a member's CRG assignment was combined with their eligibility information and health care expenditures. This information was used to compute the average PMPM cost for each CRG risk group. CRG weights were computed by dividing the average cost for each CRG risk group by the average cost for all members.

The plan's raw risk score was calculated by averaging the CRG weights for all of the members that were enrolled in the plan during the year, weighted by each member's months of enrollment in the plan. Risk scores were developed by region. The plan's raw score in a region was then divided by the overall regional average raw risk score to determine their relative risk score for each region and eligibility group combination. Note that the optional benefits and the kick payments, are not risk-adjusted. Risk scores were not determined for plans with less than 600 member months in a region due to concerns regarding the credibility of the plan's risk score. In these instances, the plan was given a relative risk score of 1.0.

The FY10 rates incorporate a blended approach in which 50 percent credibility was applied to the risk-adjusted rate and 50 percent credibility was applied to the rate developed using the methodology in effect prior to the implementation of risk-adjustment.

Certification

In preparing these rate ranges, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State. The State is responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that these rate ranges were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid-covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates ranges developed by Mercer are actuarial projections of future contingent events. Actual plan costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Health plans are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by health plans for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the FHPlus program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

Please contact Tim Doyle at +1 602 522 6584 or Ron Ogborne at +1 602 522 6595 with any questions regarding the above.

Sincerely,

Timothy Doyle, FSA MAAA

F. Ronald Ogborne III, ASA, MAAA

Copy:
Anthony Soccio, State
Maria Dominiak, Mercer
Justyn Rutter, Merce

Tim Doyle

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Tim.Doyle@Mercer.com
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October 1, 2008

Ms. Patricia Kutel, Director
New York State Department of Health
Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Family Health Plus Managed Care Rate Update Letter for April 1, 2008 – March 31, 2009

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, developed actuarially sound capitation rate ranges for the Family Health Plus program covering the contract period fiscal year 2009 (FY09), April 1, 2008 — March 31, 2009, in a letter dated February 8, 2008.

Since then, the State implemented a one percent budget reduction effective April 1, 2008, through March 31, 2009. However, since the budget reduction became known after April 1, instead of applying a one percent budget cut for twelve months, the State implemented a two percent budget cut for six months.

Mercer reviewed the updated FY09 rates from the State reflecting the two percent budget reduction for the period October 1, 2008 – March 31, 2009. The updated rates effective for FY09 still fall within the FY09 actuarially sound rate ranges.

Sincerely,

Tim Doyle, FSA, MAAA

TD:lgm/Enclosure

Copy:
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Maria Dominiak, Mercer
Ron Ogborne, Mercer
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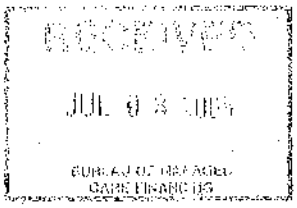
February 8, 2008



Ms. Patricia Kutel
Director
New York State Department of Health
Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Medicaid Managed Care Rate Range Certification Letter for Contract Period April 1, 2008 – March 31, 2009

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has developed actuarially sound capitation rate ranges for the Medicaid program covering the contract period fiscal year 2009 (FY09), April 1, 2008 – March 31, 2009. This letter provides an overview of the analyses and methodology used in the development of the managed care rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Rate Methodology

Overview

Capitation rates for the Medicaid program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). The primary base data used to develop FY09 rates was the Medicaid Managed Care Operating Report (MMCOR).

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS Capitated Rate-Setting Checklist:

- Incurred but not reported (IBNR) claims adjustments
- Trend factors to forecast expenditures and utilization to the appropriate contract period
- Prospective and historic program changes not reflected in the base data
- Administration loading

- Mandatory enrollment for SSI
- Statistical variation for sound ranges
- Risk adjustment

The various steps used in the development of the rate ranges are described in the following paragraphs.

Base Data Development

Mercer utilized MMCOR data from calendar year 2005 (CY05) and CY06 as the primary data source in the rate-setting process. The multiple years of data were blended together to arrive at base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. The MMCOR data reflects the actual medical expenses for the managed care organizations (MCOs) for each of the following ten rate cells and the two kick payments.

- **Temporary Assistance to Needy Families/Safety Net (TANF/SN)** – includes:
  - TANF/SN < 6 Months Male and Female
  - TANF/SN 6 Months – 14 Female
  - TANF/SN 6 Months – 20 Male
  - TANF/SN 15 – 20 Female
  - TANF 21 – 64 Male and Female
  - SN 21 – 29 Male and Female
  - SN 30 – 64 Male and Female
- **SSI** – includes:
  - SSI 6 months – 20 Male and Female
  - SSI 21 – 64 Male and Female
  - SSI 65+ Male and Female
- **Maternity Kick Payments**
- **Newborn Kick Payments**

Mercer reviewed the MMCOR data to ensure it is appropriate to incorporate into the rate development. Specifically, Mercer reviewed remaining liability associated with IBNR claims. Mercer determined that the reported IBNR was sometimes not appropriate for rate

development. Mercer used the health plan-reported IBNR, total medical expenses and prior period adjustments to apply an appropriate IBNR percentage to the plan's reported medical expenses. In addition, non-State plan services were removed in the financial data.

Each MCO may elect to cover certain benefits on an optional basis. As a result, the base data is determined separately for the core benefits and optional benefits. The optional benefits are Dental, Emergent Transportation (EMT), Non-Emergent Transportation (NEMT) and Family Planning (FP). In some non-NYC regions, there was no data in the base period for one or more optional benefits. To accommodate the potential expansion of available benefit packages, the aggregated Rest of State (ROS) (all regions except the NYC Metro area) data was used to develop base rates in these instances.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor was necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop trend assumptions. These sources included, but were not limited to:

- Health care economic indices, such as Consumer Price Index for the northeast region and Global Insight (formerly DRI)
- Trends exhibited in the FFS data for the SSI aid category
- Trends exhibited in the MMCOR data submitted by the MCOs
- Trends in other State Medicaid programs for similar TANF and SSI populations

Mercer developed separate per member per month (PMPM) trends for TANF/SN, SSI, and Maternity/Newborn Kick Payments. Mercer also developed separate trends for the core benefits and the four optional benefits. For TANF/SN, Mercer developed separate trends by each region and by major category of service (COS). For the remaining groups and optional benefits, Mercer developed trends for NYC and ROS by major COS. The following aggregate annual PMPM trend estimates displayed in the table below were used for the capitation rate range.

Aid Category	Category of Service	Statewide Annual Midpoint PMPM Trend
TANF/SN	Core Benefits	5.1%
	Dental	3.2%
	Emergent Transportation	7.1%
	Non-Emergent Transportation	7.9%
	Family Planning	8.7%
SSI	Core Benefits	4.8%
	Dental	3.8%
	Emergent Transportation	5.1%
	Non-Emergent Transportation	5.0%
	Family Planning	5.4%
Kick Payments	Maternity Kick	5.4%
	Newborn Kick	5.4%

Trend was applied for 33 months from the midpoint of the base period (December 31, 2005) to the midpoint of the contract period (September 30, 2008).

Program Changes

Program change adjustments recognized the impact of benefit or eligibility changes occurring after the base year.

There are two program changes explicitly incorporated in Mercer's analysis. The State legislature reauthorized the Health Care Reform Act (HCRA) of 2000. This included an increase to the indigent care surcharge for patient service revenue payments made for hospital and certain treatment services provided in the State from 6.47 percent to 6.54 percent. The change was effective in January 2006 and will remain in effect through at least December 2008. At the direction of the State, Mercer has explicitly assumed that the assessment will continue through the end of the SFY09 contract period, and has reflected this increase in the development of the capitation rates appropriately.

Additionally, the State has implemented a series of rate increases in the emergency room surgical component. Prior to 2007, this rate was $95. Effective January 1, 2007 it was increased to $125, then again to $140 effective January 1, 2008. This rate will increase further to $150 effective January 1, 2009. These changes affect each plan differently, so the State provided Mercer with the PMPM impact to the ER service line by health plan and region. Mercer analyzed this change, for all applicable plans, on a regional PMPM basis. After removing all outlier plans, the estimated aggregate impact was compared to the base data to determine an ER PMPM adjustment. This adjustment was applied to the overall base data prior to the application of trend and all other prospective adjustments.

Administration

The actuarially sound capitation rate ranges developed include a provision for MCO administration. Mercer reviewed MMCOR administrative costs. Mercer also relied upon its professional experience in working with numerous state Medicaid programs, both nationally and locally, within the northeast region. The load for administration, which includes profit, was 16.1 percent on a Statewide basis as a percentage of premium.

Mandatory Enrollment for SSI

Beginning on January 1, 2006, NYC SSI recipients are required to enroll in the managed care program. The other eight regions are anticipating mandatory SSI enrollment by the end of 2008. This enrollment impact is accounted for when developing the actuarially sound rate ranges.

To assess the risk differential between SSI recipients currently enrolled in the managed care program and those currently enrolled in FFS, the State performed an analysis using the Medicaid pharmacy grouper. Mercer reviewed the results of the analysis; these results are incorporated in the actuarially sound rate ranges as a portion of the recipients currently enrolled in FFS that will be enrolling in the managed care program in FY09.

Rate Ranges

Statistical error and uncertainty are inherent in any rate development process. The final rate ranges represent a "best estimate" of the range of anticipated cost to provide services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received by an MCO provides sufficient margin so that insolvency is not a significant risk for an appropriately managed MCO. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue received by an MCO is not so large that the State is at risk of paying too many taxpayer dollars for the provision of health care to eligible recipients.

The application of rate ranges is complex; the State contracts with 23 different MCOs Statewide. Mercer utilized the first half of CY07 regional enrollment at the premium group level to composite the MCO rates. This eliminated fluctuations due to low plan enrollment and allowed for a more direct comparison to the actuarially sound rate ranges, as they were also composited using the first half of CY07 enrollment.

The managed care rate for each MCO by region was compared to the actuarially sound rate range. In certain situations, the regional MCO composite may result in an MCO falling outside the actuarially sound regional rate range. Where this outcome occurs for an individual MCO, the composite in all regions in which the MCO contracts must fall within the Statewide actuarially sound rate range.

Risk-adjusted Rates

Since the State elected to implement risk-adjustment in FY09, Mercer assisted the State in selecting a risk-adjustment model. Models reviewed include Clinical Risk Groups (CRGs), Adjusted Clinical Groups (ACGs), Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx. Mercer found that CRGs produced similar results to the other models reviewed. This conclusion appears to be consistent with the Society of Actuaries latest paper called "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment" that shows CRGs produced results comparable to the other models tested. CRGs are developed by 3M and utilize diagnosis and procedure codes to classify individuals into groups for risk adjustment.

Mercer used CY06 encounter data with six months of run-out for the risk assignment period. The data was thoroughly reviewed for completeness and quality. St. Barnabas and Community Premier Plus were excluded from the analysis since they exited the program and their data was not complete.

Once the data was validated, standard prices were developed and used in instances where the plan did not report a payment amount or when the payment amount was deemed an outlier. This process was performed for each service category.

The next step in the risk assignment process was to assign each member to a CRG risk group. CRG grouper version 1.5.1 was used to determine a member's CRG risk group assignment. To compute the CRG weights, a member's CRG assignment was combined with their eligibility information and health care expenditures. This information was used to compute the average PMPM cost for each CRG risk group for each of the three premium groups (TANF Adult, TANF Child, and SSI). CRG weights were computed by dividing the average cost for each CRG risk group by the average cost for all members within each of the three premium groups.

The plan's raw risk score was calculated by averaging the CRG weights for all of the members that were enrolled in the plan during the year, weighted by each member's months of enrollment in the plan. Risk scores were developed for four premium groups (TANF Child, TANF Adult, SSI Child, and SSI Adult) as well as for each of the nine regions. Note that optional benefits, as well as the maternity and newborn aid categories, are not risk-adjusted. Risk scores were not determined for plans with less than 600 member months in a region due to concerns regarding the credibility of the plan's risk score. In these instances, the plan was given a risk score of 1.0.

The FY09 rates incorporated a blended approach in which 25 percent credibility was applied to the risk-adjusted rate and 75 percent credibility was applied to the rate developed using the prior year methodology.

Certification

Mercer certifies the above rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable law and regulations.

Mercer has relied on data and various other information provided by the State in the development of these rate ranges. We have reviewed the data and analyses for reasonableness and we believe them to be free of material error and suitable for rate development purposes for the populations and services covered under the managed care contract. However, we have not audited these data and if they are materially incomplete or inaccurate, our conclusions may require revision.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rates by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State. Use of these rates for any purpose beyond that stated may not be appropriate.

Please contact Tim Doyle at +1 602 522 6584 or Ron Ogborne at +1 602 522 6595 with any questions regarding the above.

Sincerely,

Timothy Doyle, FSA, MAAA

F. Ronald Ogborne III, ASA, MAAA

cc:
Anthony Soccio, State
Maria Dominiak, Mercer
Justyn Rutter, Mercer

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March 20, 2009

Ms. Patricia Kutel
Director
New York State Department of Health
Office of Managed Care
Bureau of Managed Care Financing
Empire State Plaza
Corning Tower, Room 1970
Albany, NY 12237

Subject: State of New York Medicaid Managed Care Rate Range Certification Letter for Contract Period April 1, 2009 – March 31, 2010

Dear Pat:

In partnership with the New York State Department of Health (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has developed actuarially sound capitation rate ranges for the Medicaid program covering the contract period fiscal year 2010 (FY10), April 1, 2009 – March 31, 2010. This letter provides an overview of the analyses and methodology used in the development of the managed care rate ranges, as well as a certification to the actuarial soundness of the rate ranges presented.

Rate Methodology

Overview

Capitation rates for the Medicaid program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). The primary base data used to develop FY10 rates was the Medicaid Managed Care Operating Report (MMCOR).

Mercer applied the following additional adjustments to the base data, which are consistent with the CMS Capitated Rate-Setting Checklist:

- Incurred but not reported (IBNR) claims adjustments
- Trend factors to forecast expenditures and utilization to the appropriate contract period
- Prospective and historic program changes not reflected in the base data
- Administration loading

- Mandatory enrollment for SSI
- Statistical variation for sound ranges
- Risk adjustment

The various steps used in the development of the rate ranges are described in the following paragraphs.

Base Data Development

Mercer utilized MMCOR data from calendar year 2006 (CY06) and CY07 as the primary data source in the rate-setting process. The multiple years of data were blended together to arrive at base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. The MMCOR data reflects the actual medical expenses for the managed care organizations (MCOs) for each of the following ten rate cells and the two kick payments.

- **Temporary Assistance to Needy Families/Safety Net (TANF/SN)** — includes:
  - TANF/SN < 6 Months Male and Female
  - TANF/SN 6 Months — 14 Female
  - TANF/SN 6 Months — 20 Male
  - TANF/SN 15 — 20 Female
  - TANF 21 — 64 Male and Female
  - SN 21 — 29 Male and Female
  - SN 30 — 64 Male and Female
- **SSI** — includes:
  - SSI 6 months — 20 Male and Female
  - SSI 21 — 64 Male and Female
  - SSI 65+ Male and Female
- **Maternity Kick Payment**
- **Newborn Kick Payment**

Mercer reviewed the MMCOR data to ensure it was appropriate to incorporate into the rate development.

As has been done in previous contract periods, Mercer specifically reviewed each plan's remaining liability associated with IBNR claims. Mercer made adjustments for IBNR for those plans that have historically included a large initial IBNR reserve followed by large write-offs in subsequent reporting periods.

Each MCO may elect to cover certain benefits on an optional basis. As a result, the base data is determined separately for the core benefits and optional benefits. The optional benefits are Dental, Emergent Transportation (EMT), Non-Emergent Transportation (NEMT) and Family Planning (FP). Optional benefit costs were analyzed separately for the New York City Metro (NYC) and Rest of State (ROS) regions to develop base rates.

Trend

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor was necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop trend assumptions. These sources included, but were not limited to:

- Health care economic indices, such as Consumer Price Index for the northeast region and Global Insight (formerly DRI)
- Trends exhibited in the FFS data for the SSI aid category
- Trends exhibited in the MMCOR data submitted by the MCOs
- Trends in other State Medicaid programs for similar TANF and SSI populations

Mercer developed separate per member per month (PMPM) trends for TANF/SN, SSI, and Maternity/Newborn Kick Payments. Mercer also developed separate trends for the core benefits and the four optional benefits. For TANF/SN, Mercer developed separate trends for each region by major category of service (COS). For the SSI, kick payments and optional benefits, Mercer developed trends for NYC and ROS by major COS. The following aggregate annual PMPM trend estimates displayed in the table below were used for the capitation rate range.

Aid Category	Category of Service	Statewide Annual Midpoint PMPM Trend
TANF/SN	Core Benefits	5.6%
	Dental	3.6%
	Emergent Transportation	8.5%
	Non-Emergent Transportation	7.6%
	Family Planning	5.9%
SSI	Core Benefits	4.6%
	Dental	4.3%
	Emergent Transportation	8.0%
	Non-Emergent Transportation	5.7%
	Family Planning	6.0%
Kick Payments	Maternity Kick	4.1%
	Newborn Kick	3.3%

Trend was applied for 33 months from the midpoint of the base period (December 31, 2006) to the midpoint of the contract period (September 30, 2009).

Program Changes

Program change adjustments recognized the impact of benefit or eligibility changes occurring after the base year.

Effective January 1, 2009, the State will no longer provide stoploss coverage for Outpatient Mental Health visits in excess of 20 visits per enrollee per year, making the health plans responsible for all visits. In order to develop an adjustment for this program change, the State supplied Mercer with a summary of the Mental Health Stoploss payments made to each plan by region for claims incurred during CY05 through June 30, 2008. These payments were allocated across the individual premium groups according to the distribution of Outpatient Mental Health expenditures for each plan by region and added to the base data.

Mercer's analysis also reflects the changes that the State has made to the emergency room surgical component reimbursement between the base period and the contract period. During the base period, the Emergency Room services were reimbursed on a flat fee basis, including capital, of $119 per visit during CY06 and $149 per visit during CY07. Effective January 1, 2009, Emergency Room services will be reimbursed using an Ambulatory Patient Group (APG) methodology. These changes affect each plan differently, so the State provided Mercer with the PMPM impact to the Emergency Room service line by health plan and region. Mercer analyzed this change, for all applicable plans, on a regional PMPM basis. The estimated aggregate impact was compared to the base data to determine an appropriate adjustment. Separate adjustment factors were developed for each region and premium group.

Administration

The actuarially sound capitation rate ranges developed include a provision for MCO administration. Mercer reviewed MMCOR administrative costs. Mercer also relied upon its professional experience in working with numerous state Medicaid programs, both nationally and locally, within the northeast region. The load for administration, which includes profit, was 14.3 percent on a Statewide basis as a percentage of premium.

Mandatory Enrollment for SSI

Beginning on January 1, 2006, NYC SSI recipients were required to enroll in the managed care program. Between January 1, 2008 and February 1, 2009, 37 additional counties across the other eight regions also began mandatory SSI enrollment. Mercer made an adjustment to account for the impact of these new enrollees on the overall acuity of the SSI population in each region when developing the actuarially sound rate ranges.

To assess the risk differential between SSI recipients who were enrolled in the managed care program during the base period and those who were enrolled in FFS, the State performed an analysis using the Medicaid pharmacy grouper. Mercer reviewed the results of the analysis; these results were used in conjunction with the projected enrollment in each region during the contract period to determine an appropriate rate-setting adjustment.

Rate Ranges

Statistical error and uncertainty are inherent in any rate development process. The final rate ranges represent a "best estimate" of the range of anticipated cost to provide services during the contract period for the covered populations. The lower end of an actuarially sound rate range attempts to ensure the capitation revenue received by a health plan provides sufficient margin so that insolvency is not a significant risk for an appropriately managed health plan. The upper end of an actuarially sound rate range attempts to ensure the capitation revenue received by a health plan is not so large that the State is at risk of paying too much for the provision of health care for eligible recipients.

The application of rate ranges is complex; the State contracts with 22 different health plans statewide. Mercer utilized the CY07 regional enrollment at the premium group level to composite health plan rates. This eliminated fluctuations due to low plan enrollment and allowed for a more direct comparison to the actuarially sound rate ranges, as they were also composited using CY07 enrollment.

The managed care rate for each health plan was compared to the actuarially sound rate range for each region in which the health plan will operate during FY10. In certain situations, a regional health plan rate may fall outside the actuarially sound regional rate range. Where this outcome occurs, the statewide composite rate for the health plan in question must fall within the statewide composite actuarially sound rate range.

Risk-adjusted Rates

The State implemented a risk-adjustment process in FY09 based on the Clinical Risk Group (CRG) model developed by the 3M. Prior to selecting the CRG model, Mercer evaluated the performance of the CRG model compared to the Adjusted Clinical Groups (ACGs) and Chronic-Illness and Disability Payment System (CDPS) on New York's Medicaid programs. The CRG model produced similar results to the other models.

The application of risk-adjustment will continue into FY10 with a few methodology refinements. The approach used to develop the FY10 risk scores and the resulting capitation rates is described within this section.

CY07 encounter data with six and a half months of run-out was used for the risk assignment period. The data was reviewed for completeness and quality. Managed Health, Inc, Community Premier Plus and Community Choice Health Plan were excluded from the analysis since they exited the program and their data was not complete.

Once the data was validated, standard prices were developed and used to calculate the price for each service provided by the health plans. This process was performed for each service category.

The next step in the risk assignment process was to assign members with at least three months of managed care enrollment to a CRG risk group. CRG grouper version 1.6.1 was used to determine a member's CRG risk group assignment. To compute the CRG weights, a member's CRG assignment was combined with their eligibility information and health care expenditures. This information was used to compute the average PMPM cost for each CRG risk group. CRG weights were computed by dividing the average cost for each CRG risk group by the average cost for all members.

The plan's raw risk score was calculated by averaging the CRG weights for all of the members that were enrolled in the plan during the year, weighted by each member's months of enrollment in the plan. Risk scores were developed by region for each of the following three eligibility groups: (1) TANF/SN Adults (21 years or older); (2) TANF Children (0-20 years); and (3) SSI (adult and children combined). The plan's raw score in a region was then divided by the overall regional average raw risk score to determine their relative risk score for each region and eligibility group combination. Note that the optional benefits and the kick payments, are not risk-adjusted. Risk scores were not determined for plans with less than 600 member months in a region due to concerns regarding the credibility of the plan's risk score. In these instances, the plan was given a relative risk score of 1.0.

The FY10 rates incorporate a blended approach in which 50 percent credibility was applied to the risk-adjusted rate and 50 percent credibility was applied to the rate developed using the methodology in effect prior to the implementation of risk-adjustment.

Certification

In preparing these rate ranges, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by the State. The State is responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that these rate ranges were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid-covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rates ranges developed by Mercer are actuarial projections of future contingent events. Actual plan costs will differ from these projections. Mercer has developed these rate ranges on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

Health plans are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by health plans for any purpose. Mercer recommends that any health plan considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rate ranges before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Medicaid managed care program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

Please contact me at +1 602 522 6584 with any questions regarding the above.

Sincerely,

Timothy Doyle, FSA, MAAA

cc:
Anthony Soccio, State
Maria Dominiak, Mercer
Ron Ogborne, Mercer
Justyn Rutter, Mercer

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

Information is also available to the public on-line at www.health.state.ny.u or www.cms.hhs.gov. Written comments concerning the amendment will be accepted at the above address for a period of thirty (30) days from the date of this notice.

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Order Number: 0003328904
Order Identifier: Public Notice On July

T Dollard / D Hess / D LaCoppla of the city of Albany, being duly sworn, says that he/she is principal Clerk of THE TIMES UNION, a daily newspaper printed in the county of Albany, Town of Colonie, and Published in the County of Albany, Town of Colonie and the city of Albany, aforesaid and that notice of which a printed copy is annexed has been regulary published in the said ALBANY TIMES UNION on the following dates

02-28-2009

Sworn to before me, this Monday, March 02, 2009

Notary Public
Albany County

JODI M. BURICK
Notary Public, State of New York
No. 4898040
Qualified in Albany County
Commission Expires October 19, 2009

Lisa Stephan-Kozlowski

---

of the City of Buffalo, New York, being duly sworn, deposes and says that he/she is Principal Clerk of THE BUFFALO NEWS, DIV. OF BERKSHIRE HATHAWAY, INC., Publisher of the BUFFALO NEWS, a newspaper published in said city, that the notice of which the annexed printed slip taken from said newspaper is a copy, was inserted and published therein 1 time, the insertion being on the 28th day of, February 2009.

Date Ad Ran: 2/28/09

Sworn to before me this 6th day of, March, 2009.

Notary Public, Erie County, New York

LORI A. NIEVES
Notary Public, State of New York
Qualified in Erie County
My Commission Expires 6/5/2011

served.

750 Legal/Public Notices

the design and site plan for the proposed construction and/or rehabilitation to properties located in the City of Buffalo. The hearings will be held at the following times: 8:15 AM renovation for use as the "7th Day Church" with parking at 431 E. FERRY; 8:30 AM construction of a new, low-moderate income single-family home at 235 NORTHAMPTON; and 8:45 AM construction of a three-story mixed-use building with first floor commercial space,

750 Legal/Public Notices

parking, and 12 upper floor apartments at 448 ELMWOOD in Buffalo, New York. The above referenced plans may be examined in Room 901 City Hall weekdays between 8:30 a.m. and 4:00 p.m. and at the hearing. James K. Morrell, Chairman

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 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

Information is also available to the public on-line at www.health.state.ny.us or www.cms.hhs.gov. Written comments concerning the amendment will be accepted at the above address for a period of thirty (30) days from the date of this notice.

Horoscope/ *By Eugenia Last*

Saturday, February 28

CELEBRITIES BORN ON THIS DAY: Eric Lindros, 36; Robert Sean Leonard, 40; John Turturro, 52; Bernadette Peters, 61.

HAPPY BIRTHDAY: You are the grand master of the art of getting what you want this year. You will know how to challenge any situation you face. You are bright and articulate and can win the hearts and favors of people who can help you get ahead. Weigh what it is you really want before you jump in with both feet. Your numbers are 8, 17, 28, 33, 34, 42, 46.

ARIES (March 21-April 19): Don't give in to idle threats brought on by emotions. Taking a loving and understanding approach will help to mellow out the situation and allow you to rectify the problem. Don't let discord escalate.

TAURUS (April 20-May 20): Cooperation, restraint and understanding will be required if you are forced to deal with added responsibilities. Someone older may try to take over.

GEMINI (May 21-June 20): Make special plans for the weekend. Good fortune, good times and good results can all be yours if you take charge. An opportunity will develop if you talk to your boss, a professor or a friend who needs a partner with your skills.

CANCER (June 21-July 22): You cannot count on someone to cover your back. Stress in a relationship will cause you to make a decision you may regret.

LEO (July 23-Aug. 22): Good things are heading your way both personally and professionally. Network with your peers and you will get wind of something that interests you. A move or change in your living conditions is evident.

VIRGO (Aug. 23-Sept. 22): You may have to use a little force to get what you want but, in the end, you will succeed. Pitch in and work hard. A new hobby or activity that takes your mind off your worries will help you in more ways than you realize.

LIBRA (Sept. 23-Oct. 22): Don't sit around waiting for someone to call. You have to initiate activities that you enjoy if you want to connect with interesting people.

SCORPIO (Oct. 23-Nov. 21): You have to put things in proper context if you want to avoid making a personal mistake. Emotional deception is apparent. Change can be good but it must be done with everyone's best interests in mind.

SAGITTARIUS (Nov. 22-Dec. 21): Love is on the rise, so open your doors and your heart to someone you care for. The future looks bright if you reconcile anything from the past that you've left undone. You can then move forward without hesitation.

CAPRICORN (Dec. 22-Jan. 19): Let the past go so you can focus on the here and now. A problem while traveling or discussing family matters will result if you have been wishy-washy about what you can offer.

AQUARIUS (Jan. 20-Feb. 18): Love is within reach — all you have to do is make the first move. You will have greater insight into what you are capable of doing and how far you can go. Consider retraining, additional education or starting your own business.

PISCES (Feb. 19-March 20): It's time to put the past behind you and find new ways to enjoy your life. Any uncertainties from the past will be brought to the surface, giving you a reason to reconnect and make things right.

Birthday Baby: You are a go-getter and a charmer. You can be aggressive, outspoken and a little bit stubborn. You are a born leader.

JUMBLE

Saturday's Jumbles: BASIS USURP POLLEN PIGPEN
Answer: What the school doctor checked during the eye exams — THE PUPILS' PUPILS

Friday's Commuter answer

P	B	S		S	A	D		R	E	G	I	M	E	N
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L	A	D	I	N	G	S		R	O	T		T	O	N

Friday's Sheffer answer

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D	E	N		G	A	L		B	E	E	T	S		

NEWSDAY

AFFIDAVIT OF PUBLICATION

HN MEDIA & MARKETING
275 MADISON AVENUE, 22ND FLOOR
NEW YORK NY 10016-1101

STATE OF NEW YORK) Legal 16066674
:SS.:
COUNTY OF SUFFOLK)
R. Lopes

of Newsday, Inc., Suffolk County, N.Y., being duly sworn, says that such person is, and at the time of publication of the annexed Notice was a duly authorized custodian of records of Newsday, Inc., the publisher of NEWSDAY, a newspaper published in the County of Suffolk, County of Nassau, County of Queens, and elsewhere in the State of New York and other places, and that the Notice of which the annexed is a true copy, was published in the following editions/ counties of said newspaper on the following dates:

SATURDAY FEBRUARY 28 2009 Nassau Suffolk Queens

Sworn To Before Me This
03 day of March , 2009
Notary Public

Guy P. Wasser
Notary Public, State of New York
No. 01WA6045924
Commission Expires 08/07/2010
Qualified in Suffolk County

Legal Notice 16066674

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.

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Albany, New York 12237

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NEWSDAY PROOF

Customer: HN MEDIA & MARKETING Contact: ANNA Phone: 2124901300

Ad Number: 16066674 Start Date:02/28/2009 End Date: 02/28/2009 Times: 1

Price: $747.84 Size: 1 x 99 Section: CL Class: 11100

Printed By: L001 Date: 03/10/2009

Signature of Approval: _____ Date:_____

Zones:

HN MEDIA & MARKETING
275 MADISON AVE FL 22
NEW YORK, NY 100161101

State of New York
County of Monroe
City of Rochester

SUZANNE KIRSTEIN----- being duly sworn, deposes and says that this person is the principal clerk in the office of

Democrat & Chronicle

A daily newspaper published in the City of Rochester, County and State aforesaid, and that a notice of which is annexed is a printed copy, was published in the said paper on the following dates:

TO RUN

02/28/2009

Sworn before me on
02/28/2009

This advertisement is invoiced under
P.O. Public Notice On July 15, 1997, New York
AD # 1010684078
ACCOUNT # 2124901300HNME
Key Code

And published on each of 1 insertion in class CL Legals 4900-4910
And in 107 lines
for charges due and payable to
The Gannett Rochester Newspapers
In the amount of 1,060.00

Signed _____

_____
Notary Public/or Commissioner of Deeds

JOAN M. TRUELL
Commissioner Of Deeds
State Of New York
Monroe County
Commission Expires 2-2-11

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.

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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. CIV-1x

THE POST-STANDARD

PROOF OF PUBLICATION

State of New York, County of Onondaga ss: Diane B. Scaffido, of the City of Syracuse, in said County, being duly sworn, doth depose and says: she is the Principal Clerk in the office of THE POST-STANDARD, a public newspaper, published in the City of Syracuse, Onondaga County, New York and that the notice, of which the annexed is a printed copy cut from said newspaper, was printed and published in the regular edition and issue of said newspaper on the following day(s), viz:

Advertiser: HN MEDIA & MARKETING

Reference #: 70662 PO #:

Product: Post-Standard-Full Run Start Date: 2/28/09 End Date: 2/28/09

Insertions: 1 Run Dates: 2/28/09

Diane B. Scaffido
Principal Clerk

Subscribed and Sworn to before me, on 3/5/2009

NOTARY PUBLIC, ONONDAGA COUNTY, NY

MARGUERITE E. SOUCY
Notary Public in the State of New York
No. 01SO4966679
Qualified in Onondaga County
My Commission Expires May 14, 2010

THE POST-STANDARD

PROOF OF PUBLICATION

State of New York, County of Onondaga ss: Diane B. Scaffido, of the City of Syracuse, in said County, being duly sworn, doth depose and says: she is the Principal Clerk in the office of THE POST-STANDARD, a public newspaper, published in the City of Syracuse, Onondaga County, New York and that the notice, of which the annexed is a printed copy cut from said newspaper, was printed and published in the regular edition and issue of said newspaper on the following day(s), viz:

Advertiser: HN MEDIA & MARKETING

Reference #: 70662 PO #:

Product: Post-Standard-Full Run Start Date: 2/28/09 End Date: 2/28/09

Insertions: 1 Run Dates: 2/28/09

Diane B. Scaffido
Principal Clerk

Subscribed and Sworn to before me, on 3/5/2009

NOTARY PUBLIC, ONONDAGA COUNTY, NY

MARGUERITE E. SOUCY
Notary Public in the State of New York
No. 01SO4966679
Qualified in Onondaga County
My Commission Expires May 14, 2010

The New York Times

620 8TH AVENUE • NEW YORK, NY 10018

SEC A PG. 19

Public Notice

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CERTIFICATION OF PUBLICATION

MAR 12 2009 20____

I, _____, in my capacity as a Principal Clerk of the Publisher of The New York Times a daily newspaper of general circulation printed and published in the City, County and State of New York, hereby certify that the advertisement annexed hereto was published in the editions of The New York Times on the following date or dates, to wit on

_____

FEB 28 2009

_____ 20____

_____

Approved:

_____

THIS CERTIFICATION NOT VALID WITHOUT NYT RAISED SEAL

:TIRES: The Battle to Succeed Morgenthau

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A Powerful Bench

The famous, the powerful, and the children of the famous and powerful have worked for Robert M. Morgenthau.

Cuomo Milgram Vance Fairstein Scoppetta

Eliot Spitzer	Former governor of New York
Andrew M. Cuomo	Attorney general of New York
John F. Kennedy Jr.	Journalist
Christopher P. D'Amato	Son of former Senator Alfonse M. D'Amato
Cyrus R. Vance Jr.	Son of former Secretary of State Cyrus Vance
Robert F. Kennedy Jr.	Environmental lawyer
Nicholas Scoppetta	New York City fire commissioner
Linda Fairstein	Prosecutor, author
Jack T. Litman	Defense lawyer for Robert Chambers
Anne Milgram	New Jersey attorney general
Benjamin Brafman	Defended Sean Combs.
Richard J. Condon	Former New York City deputy police commissioner

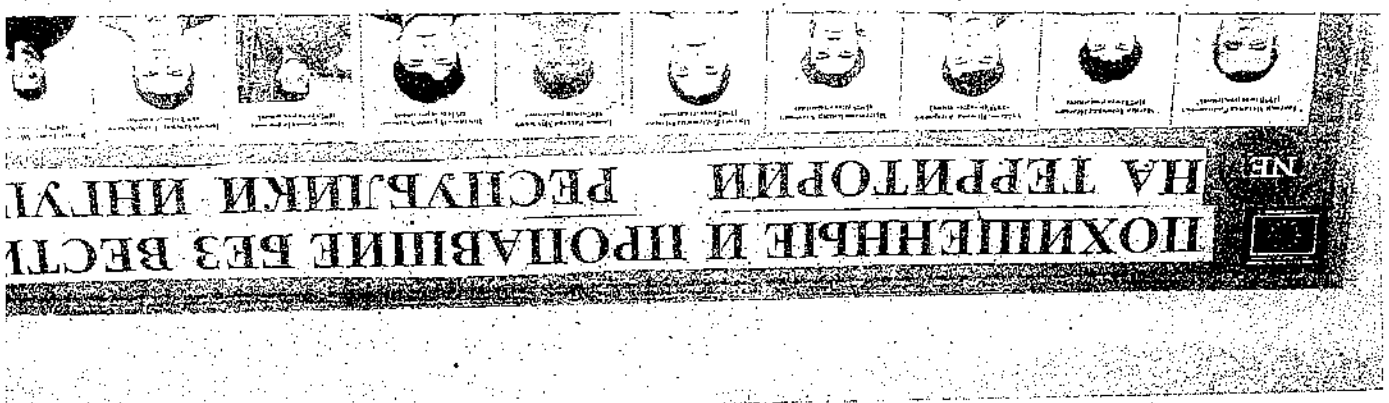
THE NEW YORK TIMES

enough money to [illegible]
soon be leaving his job to campaign full time.

Others mentioned include State Senator Eric T. Schneiderman, who would be able to build on his political base on the Upper West Side; Randy Mastro, a former prosecutor and deputy mayor for Rudolph W. Giuliani; and Rose Gill Hearn, commissioner of the city's Department of Investigation.

Absent so far are any people of color. But Michael Hardy, a lawyer for the Rev. Al Sharpton's National Action Network, said it was a different world from 1985, when C. Vernon Mason, an associate of Mr. Sharpton's who was later disbarred, ran a primary challenge against Mr. Morgenthau and took about a third of the vote.

Mr. Hardy, who said he seriously considered running for district attorney in 1997, said he knew of no people of color who wanted the job now. After all, he said, "There are a lot of good black lawyers who are either president or governors or sitting in a federal office building somewhere."



By ELLEN BARRY

NAZRAN, Russia — Something is changing in Ingushetia, the tiny underbox of a republic that neighbors Chechnya.

The new president, Yunus-Bek Yevkurov, has ordered security barriers removed from most government offices, reasoning that authorities should not need protection from their own people. He rents a modest house from a retired state prosecutor, expressing some discomfort with the gold-domed presidential palace.

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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 James Ransom
St. Regis Mohawk Tribe 412
State Route 37
Hogansurg, NY 13655

Dear Chief Ransom:

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.

Sincefely,

Vallencia Lloyd
Deputy Director
Division of Managed Care

Medicaid Matters New York

May 18, 2009

Via U.S. Mail and Electronic Transmission:

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

RE: Application for Extension of the Partnership Plan
Project No. 11-W-00114/2

Dear Sir or Madam:

We write to comment on New York's Application for Extension of the Section 1115 Demonstration (the Extension Application), as submitted to the Centers for Medicare and Medicaid Services (CMS).[1] Public notice of submission of the extension application was posted on the New York State Health Department (the Department) website on March 31, 2009.

Medicaid Matters New York (MMNY) is solidly in support of the initiatives described in the Extension Application which seek to expand New York's public health insurance programs through eligibility simplifications and income level adjustments. We are also very pleased to see the creative approach to avoiding restrictions in long term care eligibility that are reflected in the Application's proposal for a demonstration project to include participants in the Long Term Home Health Care Program (LTHHCP).

The concerns we have relate primarily to the Department's increased reliance on mandatory managed care as the service delivery model for Medicaid populations that have complex medical needs or reside in rural areas without adequate plan networks. In this area we urge caution, with a special focus on quality monitoring and improvements in enrollment and network capacity prior to continued expansion of mandatory managed care. Finally, we provide comment on the need for clarity regarding applicable special terms and conditions in order to make public notice and comment procedures meaningful.

Our specific comments on the Extension Application follow.

[1] New York State Department of Health, Waiver Amendment Request, *available at*: http://www.health.state.ny.us/health_care/managed_care/appextension/index.htm#summary_partnership.

3.1 Partnership for Coverage

In the extension request, the State outlines the Partnership for Coverage health reform initiative. This "building block" process seeks to achieve health reform that will "ensure access to affordable, high quality medical care for every single New Yorker" at the State level. As described in the request, the State has held a number of public hearings throughout the state. After the hearings, it retained the Urban Institute to model four health reform options. The results of (and assumptions behind) the Urban Institute modeling have not yet been made available to the public for comment. This Extension Request indicates that the Department anticipates that the recommendations from the Urban Institute "may result in New York requesting amendments to the Terms and Conditions of the Partnership Plan." Should the State do so, MMNY urges that the process be open to the public for comments.

MMNY urges the State to develop a formal process for the public and stakeholders to provide comments in conjunction with its request to CMS to allow amendments to the Partnership Plan's Special Terms and Conditions in order to incorporate the Partnership for Coverage recommendations.

3.2 FHP Eligibility Expansion to 200% of FPL

As mentioned in the prior section of our comments, New York's families desperately require access to affordable health coverage. The State's Partnership Plan extension request also seeks to offer the Family Health Plus program to adults with incomes less than 200% of FPL. Currently, there are 1.2 million uninsured adults in New York, or 18% of the adult population. Forty-eight percent of these people live below 200% of FPL.

The State estimates that 400,000 adults will take up FHP if it is offered, at a cost of $680 million. State officials estimate that our Partnership plan has engendered more than $20 billion in federal and state savings in our Medicaid program. New York now seeks to use some of these savings to support expanding our popular FHP program to low-wage workers who are unlikely to receive job-based coverage. MMNY strongly supports this financing mechanism for FHP expansion.

However, the Extension Application also describes a funding mechanism for the FHP expansion that would redirect a portion of the funding historically used to support Upper Payment Limit and/or Disproportionate Share Hospital payments to public hospitals. Under this approach, the expansion would take place on a county by county basis, contingent upon the consent of the local social services district and public hospitals located in the district. MMNY has strong concerns about introducing income eligibility expansions in such a patchwork manner, and opposes this financing mechanism as inconsistent with the State's stated goals of simplifying and streamlining the eligibility rules for Medicaid generally.

MMNY strongly supports expanding FHP income eligibility but cautions against an approach that would create different rules in different parts of the state.

3.3 Simplifying Eligibility

New York, like the rest of the nation, is struggling in these difficult economic times. This past decade, fewer and fewer low-income New Yorkers have meaningful access to coverage for two inter-linked reasons: (1) declining offers of coverage and (2) rising insurance prices. One survey of full-time poor workers in New York (incomes below 100% of FPL) reveals a precipitous decrease in the availability of employer-sponsored coverage (from 52% to 38%) between 2000 and 2008. During this same period, insurance premiums have increased by 81%, while median wages have only increased by 11%.[2] MMNY believes that easing enrollment into public insurance will help low-income individuals and families during the current recession, and has worked closely with DOH officials to support their efforts to streamline public insurance eligibility.

Over the past three years, in an effort to soften the impact that the health crisis has had on poor and moderate-low income New Yorkers, New York State has made a number of improvements to our public insurance programs during our budget making process in the Legislature. MMNY strongly supports all of the following efforts:

The State's 2007-2008 Eligibility Reforms which authorized:

- Self-attestation of income and residency and
- 12 months continuous enrollment for adults.

The State's 2008-2009 Eligibility Reforms, which authorized:

- Permitting children who are aging out of foster care to remain eligible for Medicaid up to the age of 21 years;
- Program alignment measures to simplify income and resource rules across programs (including aligning resource levels for Medicaid and FHPlus);
- Eliminating the alcohol and drug screening for Medicaid applications; and
- Authorization of a Statewide Enrollment Center to accept telephone based renewal and which seeks to reduce the widely varying county retention rates (e.g. ranging from 21% for Schuyler County to 73% for Rockland County Medicaid Managed Care enrollees).

The State's 2009-2010 Eligibility Reforms, which authorized:

- Adoption of a gross income test to further align eligibility for all New York parents and children over the age of one to 160% of FPL; and
- The elimination of an asset test, finger-imaging and a face-to-face interview for public insurance applicants.

MMNY supports the State's efforts to simplify eligibility in public insurance programs listed above and supports its request to amend the Special Terms and Conditions to reflect changes in State law.

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[2] E. Benjamin, A. Garza, "Promoting Equity & Coverage in New York's Public Insurance Programs: Second in a Two-Part Series on Racial and Ethnic Disparities in Health," Community Service Society, May 2009.

3.4 Government Employee Participation in FHP

The State's waiver extension request also seeks to afford government employees the opportunity to participate in FHP, if they are eligible. The vast majority of state and local government employees have health coverage with very little cost-sharing and do not have incomes low enough to qualify for FHPlus. However, there are certain county, municipal and school district employees whose incomes are sufficiently low to quality for FHP and who also face enormous cost-sharing. For these people, opting to participate in their job-based coverage is simply unaffordable. This proposal seeks to allow these workers the opportunity to enroll in the FHPlus Premium Assistance Program, thereby ensuring affordable comprehensive coverage to these low-wage government workers.

MMNY supports the State's request to extend FHP and the FHPlus Premium Assistance Program to low-wage government employees.

3.5 Expanding Mandatory Managed Care to Additional Counties

The Extension Application describes New York's Medicaid managed care program as one of the most successful in the nation. The Application counts recent expansions of the program to counties not previously mandatory, and to the SSI (Supplemental Security Income) related population as successes for New York. Section 2.4 describes the Medicaid Advantage plan as a promising model for coordinating care for dual eligibles (those receiving Medicaid and Medicare).

Section 3.5 announces the Department's intention to expand the mandatory program to additional counties and requests the ability to do so without the need for a state plan amendment. The Application does not specify which counties or which populations would be the subject of expansion efforts. Section 3.5 also references New York's request to mandatorily enroll Medicaid beneficiaries with HIV/AIDS, already pending with CMS (which MMNY has commented on under separate cover (see comment letter dated May 5, 2009).

While we do not wish to diminish the improvements that have been made in many aspects of New York's Medicaid managed care program, we are concerned about the Department's determination to expand the program to additional populations with complex health needs and to additional counties, not all of which have adequate plan options. Many upstate counties are poorly positioned to take on additional administrative duties, such as mandatory enrollment processes, which can be particularly challenging when targeted toward populations already struggling with chronic illness and/or disabilities, such as the SSI-related population and those with HIV/AIDS.

In fact, data released recently on auto-assignment rates of the SSI-related population point to major shortcomings in existing enrollment procedures. The cumulative auto-assignment rates for the SSI population are over 20% in 12 of the mandatory counties outside NYC, which indicates that this population has not been successfully engaged in transitioning from the fee for

service system into Medicaid managed care. Monroe County is experiencing an auto-assignment rate of over 60% -- and no explanation for this break down has yet been made publicly available.

While the Department has maintained that high auto-assignment rates will not disrupt care in upstate counties due to overlapping provider networks among plans, we remain concerned that a disengaged and vulnerable beneficiary population will have difficulty navigating the complex world of Medicaid managed care. While we understand that the Department has required the Social Service Districts with high auto-assignment rates to submit corrective action plans, the steps the Department will take to protect beneficiaries from disruptions in service have not been made publicly available. In a similar situation in Allegany County the Department took commendable action to ensure that each auto-enrolled member was contacted individually. We hope that similar action will be undertaken with these more recent cases of high auto-enrollment.

In New York City, the cumulative auto-assignment rate for the SSI population is also over 20%, and serious disruptions in care during transition resulted before formal transition policies were developed and communicated to providers and advocates in the field. Even now, the form the State will use to process exemptions from mandatory managed care is still under development. The form that was in use earlier did not reflect all available exemptions from managed care. Thus, exemptions have not been available to all qualified Medicaid recipients who would have benefited from preserving existing care networks.

In this climate of uncertainty, we see further moves to expand mandatory Medicaid managed care – both to more upstate counties and to additional persons with complex care needs -- as premature. Similarly, while the dual eligible population can be painted as one that has voluntarily engaged with managed care by signing up for Medicare Advantage, Medicare Advantage plans have been known to engage in aggressive and even misleading marketing practices. Mandating further involvement with the plan by requiring duals to buy into the Medicaid Advantage product will improve care coordination only if the plans are required to provide meaningful assistance to enrollees with complex health care needs.

MMNY would like clarification regarding which counties and populations would be subject to expansion under this Extension Application. We urge the State to roll out further expansion cautiously and engage in vigorous monitoring, in partnership with the counties and stakeholders, each step of the way. Specifically, transition and exemption policies need to be fully operationalized from the outset. Auto-assignment data needs to be produced and analyzed (by new populations, where relevant) immediately following month three of implementation. As soon as rates exceed 20%, steps should be taken to supplement county resources when needed in order to avoid disruptions in care.

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

New York has worked hard to ensure that long term care services in the community are a viable alternative to nursing home care for Medicaid recipients. For twenty years, the State has

made spousal impoverishment protections available to participants in Medicaid waiver programs that provide home care services – the largest of which is the Long Term Home Health Care Program (LTHHCP) or Lombardi. Until recently, spousal impoverishment protections have also been available to participants in New York's Traumatic Brain Injury Program. Spousal impoverishment protections allow waiver participants to make income and resources above the traditional Medicaid levels available to help support spouses and dependent family members.

MMNY has worked with the State to preserve spousal impoverishment protections in these waiver programs, and to make them available in a newer waiver program, the Nursing Home Transition and Diversion Waiver (NHTDW) Program. We are convinced that the waiver options not only align with the care most consumers would choose, but they also save the State money in most cases, given the very high costs associated with institutional care. If the protections are unavailable, Medicaid recipients needing high levels of care will be forced to choose institutional settings, or impoverish their families. Unfortunately, federal requirements have resulted in elimination of spousal impoverishment protections in the TBI and NHTDW programs. A similar change was approved by the state legislature for the Lombardi program in the last legislative session.

The Application seeks approval for a demonstration eligibility group to be defined as participants of the LTHHCP who are married and would be subjected to a spend down without the benefit of spousal impoverishment protections. MMNY strongly supports creation of such a demonstration program, but would urge that it be expanded to include participants of the TBI and NHTDW as well as the LTHHCP. We also request that the demonstration program be open to applicants to these waiver programs as well as participants.

MMNY supports the LTHHCP Spousal Impoverishment demonstration program and urges expansion to include both applicants and participants in the TBI and NHTDW programs, as well at the LTHHCP.

4 & 5 Program Evaluation & Compliance with Special Terms and Conditions

It is not clear at this juncture which pieces of New York's Medicaid managed care program are subject to which Special Terms and Conditions. The State has moved SSI-related Medicaid recipients who reside in 14 of the State's 56 counties from the Partnership Plan to the Federal-State Health Reform waiver F-SHRP. Amendments to allow mandatory enrollment of Medicaid beneficiaries with HIV/AIDS were submitted under a separate request for amendment to both the Partnership Plan and the F-SHRP Waivers. This Extension Application now seeks authority to add mandatory managed care programs in as yet unspecified counties for unspecified populations, presumably under the 1115 waiver.

It would be helpful for the State to clarify the parameters of each waiver and amendment request, by specifying which populations and programs are covered in each and which Special Terms and Conditions apply to each. While the current complexity of which populations are subject to which waivers is in large part due to the design of past Administrations, we would urge attention to simplification and streamlining in future waiver applications, in order to minimize complexity and confusion regarding the rules of the program overall.

In the meantime, our comments are addressed to the terms the State has addressed in Sections 4 & 5 of this Extension Application, Program Evaluation, Monitoring and Financing Mechanisms.

As stated earlier, New York's managed care program has made impressive gains for much of the population it serves. The 1115 Waiver Demonstration Evaluation conducted by the Delmarva Foundation and cited in the Application found a considerably higher ratio of physicians to the eligible population in Medicaid managed care as opposed to the fee for service program. The Evaluation also states that New York's plans out performed national benchmarks on a majority of major quality indicators, and that Quality Improvement incentives have narrowed the gap between quality measures in Medicaid managed care and commercial managed care.

While we do not wish to detract from these successes, it is important to note that there are significant limitations to the State's QARR (Quality Assurance Reporting Requirements) system. First, many of the indicators exclude managed care beneficiaries who experience a high level of "churning," or change of status, moving in and out of insured status or in and out of plan membership – and this group is sizable in New York's program (for example, according to a recent study by the Community Service Society, only 21% of Schuyler County's Medicaid enrollees have had stable coverage over a two year period).

Second, the utility of the QARR system has been questioned for beneficiaries such as the severely and persistently mentally ill, much of whose care is carved out of the managed care benefit package.[3] Finally, although we have been told it is under-development, at this point there is still no QARR or HEDIS data available on quality measures specific to SSI beneficiaries.

Access to specialty care is likely one of the best indirect measures of quality for the SSI-related population. The Delmarva report indicates that only one CAHPS indicator measures access to specialty care services, and that many counties have seen a loss in the participation rates of specialists.[4] The report recommends that New York "further explore whether access to specialists can be improved."[5] Specifically, from 2006 to 2007, 37 counties/boroughs displayed a decrease in OB/GYN participation rates while just 12 counties/boroughs had an increase.

Evaluation of case management services, which is of central importance to populations with disabilities and complex health needs, still awaits clear definition. In the meantime, it is difficult to have any real sense of how well case management programs are working.

Data on plan satisfaction (from CAHPS) as cited by the Extension Application, has limited usefulness, because the 2006 and 2008 data did not survey identical populations. From the data that is available, it appears that ratings for satisfaction with specialists and overall

[3] Sparer, M. 2008. *Medicaid Managed Care Reexamined.* New York: United Hospital Fund.
[4] Delmarva Foundation. March 2009. *New York Department of Health Office of Health Insurance Programs Interim Program Evaluation of Section 1115 Waiver Programs*. p.2-7.
[5] *Id.*

satisfaction with health plans decreased between 2006 and 2008.[6] Without data specific to SSI enrollees, it is unclear whether the increased enrollment of the disabled population contributed to the decreased satisfaction in these areas.

Only one member satisfaction survey has been conducted since mandatory enrollment for SSI beneficiaries began in 2005. Unfortunately, this survey was not designed to accommodate visually, developmentally, or cognitively impaired enrollees. Not surprisingly, the results did not reflect the disabilities prevalent in the SSI population. Nor are the results likely to accurately reflect the experiences of those needing accommodations from their plans and or providers.

Given the lack of evaluation data specific to the populations new to mandatory managed care, monitoring activities take on heightened importance. According to the Extension Application, local districts monitor plan marketing activities, the State surveys plan operations annually, and the State Department of Health routinely conducts program reviews of local districts. MMNY would appreciate more information about monitoring providers and plans regarding required accommodations for persons with physical and other disabilities, such as hearing or vision loss. We urge web-based publication of the schedule of monitoring activities, as well as any documents that are produced in conjunction with these activities.

The Application also describes CMS as playing an active role in assessing New York's compliance with the terms and conditions, and monitoring regular meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP). We would appreciate more information about the role CMS has played historically with MMCARP.

MMNY believes that MMCARP has the potential to provide a valuable venue for advocates and consumers to voice concerns and to learn about the quality improvement and monitoring activities of the State. We would urge more attention to the panel's agenda, with invitations to representatives from CMS and researchers who are well-positioned to speak to MMCARP members about the challenges we face in New York and some of the best practices and new ideas that have surfaced in the area of Medicaid managed care, particularly with regard to patients in rural areas or facing multiple health care needs.

For example, the Medicaid Institute of the United Hospital Fund has released several reports recently that examine New York's managed care program and its ability to reduce hospitalizations and coordinate care for Medicaid beneficiaries with complex care needs. Researchers have posed several relevant questions regarding New York's program:

- As the State strives to expand managed care enrollment among high-risk, medically complex populations and rural communities, what is the appropriate care management system to put in place? In which counties should the State employ a primary care case management option rather than mandatory managed care? Would such an approach make sense for medically complex patients as well?[7]

[6] *Id*, at 3-4.

[7] UHF published a study of "high cost" populations and indicated that the population needed more than medical services to stay connected with care, improve their health and avoid more intensive ER and hospital use. It found a need for connection between health providers and the community agencies that address benefits needs—something

- Is a cap on the number of facilitated enrollers and outreach workers that a plan employs an appropriate strategy for controlling plan marketing behavior? Will such a cap have any effect on Medicare Advantage plans, known for their aggressive, even misleading marketing?

- Could the State utilize contracting strategies more aggressively in order to improve plan (and provider) performance in areas like case management/care coordination and/or transition services for new enrollees, particularly auto-enrolled members?

MMNY urges the Department to dig deeper into existing measures of quality improvement in order to better focus on markers that are relevant to planned expansion of the program. We urge use of MMCARP as a forum for exploring relevant questions about New York's program and soliciting input from consumers and researchers about how to protect vulnerable Medicaid recipients from serious disruptions in care as the program grows.

7 Public Notice Procedures

The Extension Application provides fairly minimal information about the process for public notice and comment, and contains no reference to any opportunity for input prior to the State submitting the Application to CMS. Yet, as CMS has recognized people who may be affected by a demonstration project have a legitimate interest in learning about proposed projects and having input into the decision-making process prior to the time a proposal is submitted.

There are many ways that States can provide for such input. CMS suggests that prior to submitting a section 1115 demonstration proposal to the Department of Health and Human Services (HHS), a State may provide to HHS a written description of the process the State will use for receipt of public input into the proposal prior to its submission. CMS will accept any process, including public hearings, the use of a commission, or formal notice and comment in accordance with the State's administrative procedure act; provided that such notice is given at least 30 days prior to submission.

In the past, waiver applications have at least included a process for making comments to CMS. This Extension Application does not specify such a process, nor does it set out a clear process for making comments to the State, although we were orally advised that our comments should be directed to the State rather than CMS.

The timeline for making comments on this Extension Application is not clear. Section 7.1 references a public notice published in major New York State newspapers on February 27 and 28, 2009, yet this Application Extension was not published until March 31, 2009. Thus the public comment period running 45 days from the published notice would appear to be inapplicable. We have been told orally that the State will accept comments at any time.

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not currently part of the Medicaid managed care model. Birnbaum, M. & Halpern, D. March 2009. *Rethinking Service Delivery for High-Cost Medicaid Patients*. New York: United Hospital Fund.

MMNY requests clarification on the process and timeline the State is using for comment -- both comments that the State wishes to receive directly and comments addressed to CMS. We also urge the State to consider a process for allowing the interested public to submit comment on proposals prior to their submission to CMS.

In the meantime, we appreciate the opportunity to comment on the Application for Extension of New York's 1115 Waiver. We address our comments to the State with a copy to CMS, consistent with oral instruction. Please feel free to contact either of the undersigned members of the MMNY Working Group on Medicaid Managed Care if you have any questions or need clarification on any sections of this letter.

Sincerely,

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