New York State's Federal-State Health Reform Partnership Phase Out Plan

New York State's Federal-State Health Reform Partnership (F-SHRP) Medicaid Section1115 Demonstration (11-W-00234/2) is due to expire on March 31, 2014. This document is the Phase Out Plan for the F-SHRP as required by Special Terms and Conditions (STC) Number 8, explaining the disposition of the populations remaining in the F-SHRP, the Designated State Health Programs (DSHPs), the 12-month continuous eligibility groups, and the closeout costs associated with terminating the demonstration.

The current populations in the F-SHRP consist of Mandatory Mainstream Managed Care (MMMC) and Managed Long Term Care (MLTC) recipients. These populations will be transitioned into the New York State's Partnership Plan Medicaid Section 1115 Demonstration (11-W-00114/2). Once transitioned, the eligibility and benefits for these populations will be equal to those afforded them while under the F-SHRP Demonstration.

The current DSHPs consist of Health Care Reform Act programs, State Office on Aging programs, Office of Children and Family Services-Committees on Special Education direct care programs, and State Department of Health-Early Intervention Program Services. Transitioning the DSHPs to support new Partnership Plan programs is under discussion with CMS.

The Department has recently submitted an amendment to request that all modified adjusted gross income (MAGI) eligibility groups be eligible to receive 12-month continuous coverage. The remaining eligibility groups in the waiver will be transitioned into new MAGI eligibility groups and folded into the Partnership Plan. Discussions with CMS regarding 12-month continuous coverage are ongoing.

In the near future, the Department will be submitting an application for extension to the Centers for Medicare and Medicaid Services (CMS) to request an extension of the Partnership Plan. This request will be to extend the authority to continue existing programs and to incorporate new health care reform initiatives as negotiated with CMS.

Overview of F-SHRP

This waiver program had its origins in the Partnership Plan, which sought to improve the economy, efficiency and quality of care, by requiring families and children to enroll in managed care entities to receive services. In 2004, the state was presented with significant reform opportunities including the aging of New York's population, the continued shift in care from institutional to outpatient settings, and the quality and efficiency advantages that are available through health information technology. The state created the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) capital grant program to invest an anticipated one billion dollars over a four-year period, to effectively reform and reconfigure New York's health care delivery system. In 2005, the state asked the federal government to partner with its HEAL NY initiative to implement reform projects that would improve the quality of care and result in long term savings for both the state and federal governments. The F-SHRP was then approved for an initial five year period beginning in 2006 with a termination date of September 30, 2011. On April 29, 2011 CMS approved an extension of the F-SHRP for an additional two and a half years, setting a termination date of March 31, 2014.

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In 2012, New York added an initiative to the Demonstration to improve service delivery and coordination of long-term care services and supports for individuals through a managed care model. Under the Managed Long Term Care Program (MLTC), eligible individuals in need of more than 120 days of community-based long term care services are enrolled with managed care providers to receive long term services and supports, as well as other ancillary services.

In 2013 New York had two amendments approved. The first amendment was a continuation of the state's goal for transitioning more Medicaid beneficiaries into managed care. Under this amendment the Long Term Home Health Care Program (LTHHCP) participants will be transitioned from New York's 1915(c) Waiver into the 1115 Demonstration and into managed care. The second amendment eliminated the exclusions from Mainstream Medicaid Managed Care (MMMC) for both foster care children placed by local social service agencies and individuals participating in the Medicaid buy-in program for the working disabled.

Populations Affected

The Mandatory Managed Care Program operated by New York State provides Medicaid state plan benefits through comprehensive managed care organizations to those recipients eligible under the state plan as noted below.

A. Mandatory Mainstream Managed Care (MMMC)

Under this Demonstration, beneficiaries residing in Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington, and Yates counties who meet the criteria listed in Table 1 are required to enroll in managed care plans.

Table 1. Eligibility Groups Affected by County-Specific MMMC Enrollment

State Plan Mandatory and Optional Groups	Eligibility Criteria
Pregnant women and children under age 1 (demonstration population 1 and demonstration population 2)	Income up to 200% of the federal poverty level (FPL)
Children ages 1 through 5 (demonstration population 1)	Income up to 133% FPL
Children ages 6 through 18 (demonstration population 1)	Income up to 133% FPL
Children ages 19 through 20 (demonstration population 1)	Income at or below the monthly income standard (determined annually)

Parents and caretaker relatives (demonstration population 2)	Income at or below the monthly income standard (determined annually)
Foster children age 0 through 20 (VI-E Foster Children and non IV-E Foster Care)	Disregard all income, categorically Medicaid eligible
Age l6 through 64 Medicaid buy-in for working people with disabilities	Income up to 250% FPL

The state also has authority to expand mandatory enrollment into MMMC to all individuals identified in Table 2 except those otherwise excluded or exempted (refer to **Attachment 1**: Exclusions and Exemptions from MMMC).

Table 2. Eligibility Groups Affected by New MMMC Enrollment Requirement

State Plan Mandatory and Optional Groups	Eligibility Criteria
Adults and children (age 0 through 64) receiving Supplemental Security Income (SSI) payments or otherwise disabled (demonstration population 3 and demonstration population 4)	Income at or below the monthly income standard
Adults (age 65 and above) (demonstration population 5 and demonstration population 6)	Income at or below the monthly income standard

B. Managed Long Term Care (MLTC)

MLTC provides a limited set of Medicaid state plan benefits, including long-term services and supports through a managed care delivery system, to individuals eligible through the state plan who require more than 120 days of community based long term care services.

The state has authority to expand mandatory enrollment into MLTC to all individuals identified in Table 3, except those otherwise excluded or exempted as outlined in **Attachment 2:** Exclusions and Exemptions from MLTC.

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Table 3: Managed Long Term Care Program

State Plan Mandatory and Optional groups	FPL and/or other qualifying criteria	Expenditure and Eligibility group reporting
Adults age 65 and above (demonstration population 8)	Income at or below SSI level	Demonstration population 8/MLTC
Adults/children ages 18 through 64 (demonstration population 7)	Income at or below SSI level	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Adults age 65 and above (demonstration population 8)	Income at or below the monthly income standard, or with spend-down to monthly income standard	Demonstration population 8/MLTC adults 65 and above – Non-Duals
Adults/children ages 18 through 64 blind and disabled (demonstration population 7)	Income at or below the monthly income standard, or with spend- down to monthly income standard	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Ages 16 through 64 Medicaid Buy-In for Working People with Disabilities (demonstration population 7)	Income up to 250% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Parents and caretaker relatives 21 through 64 (demonstration population 7)	Income at or below the monthly income standard, or with spend- down to monthly income standard	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Children ages 18 through 20 (demonstration population 7)	Income at or below the monthly income standard or with spend- down	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Pregnant Women (demonstration population 7)	Income up to 200% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Poverty Level Children ages 18 through 20 (demonstration population 7)	Income up to 133% of FPL	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals

Foster Children ages 18 through 20 (demonstration population 7)	In foster care on the date of eighteenth birthday	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals
Demonstration Eligible Groups	**FPL and/or other qualifying criteria**	
Community Long Term Services and Supports Population	Income based on higher income standard to community settings for long-term services and supports pursuant to STC 17	Demonstration population 7/MLTC adults 18 through 64 – Non-Duals Demonstration population 8/MLTC adults 65 and above – Non-Duals

Transition of Mainstream Managed Care (MMC) Populations from the F-SHRP to the Partnership Plan

The Department is proposing to transition the MMC populations and counties in the F-SHRP Demonstration into the Partnership Plan Demonstration. This transition simplifies the review process and management of the waivers while maintaining all current requirements. Whenever changes have been made to the managed care program by the State and/or CMS, the State had to include the same Standard Terms and Conditions into both waivers, which was tedious and time consuming. The delivery of services to the enrolled populations is the same in both waivers. The populations or approved benefit packages do not change and all terms and conditions pertaining to the provision of services for the enrolled populations are the same. There will be no disruption to the enrolled populations as the transition will be seamless. As a result, transitioning the enrolled populations into the Partnership Plan upon the termination of the F-SHRP is appropriate, efficient and logical. This was the original intention once the initial F-SHRP expired.

New York State has been operating a Mandatory Managed Care program since 1997. The State began the program with the Mainstream Mandatory Managed Care program in five upstate counties in October 1997. Mandatory enrollment began in New York City in 1999 and has now been effectively implemented in all counties of the State. The State continues, with CMS approval, to enroll more vulnerable and high-need populations into MMC and to create more synergies for the provision of services.

New York State is identified by NCQA as the second highest ranked State on health plan performance, only second to Massachusetts. The Medicaid managed care plans exceed the national benchmark for several measures and have developed systems that are responsive to the needs of the enrolled populations. Many of the Medicaid performance rates are at the same level or higher than the commercial populations, which is a vast improvement over the last 15 years. The State began the Partnership Plan with approximately 650,000 enrollees in 1997, with a current enrollment greater than four million. We have worked diligently with stakeholders and

providers to improve performance and expand access to needed services over the life of the waiver. The initial objectives of the program were to:

- improve access to health care for the Medicaid population;
- improve the quality of health care services delivered; and
- expand coverage to additional low income New Yorkers with resources generated through managed care efficiencies.

The State has achieved extraordinary success in meeting the above goals. Most recently the State has initiated Medicaid Redesign, which will continue to expand upon the strengths of the Medicaid managed care program to reach the triple aim of bending the cost curve, improving quality and experience, and improving health. Many of the strategies rely on integrating the health care delivery system by implementing Care Management for All. The 1115 Waiver will be instrumental in allowing the State to continue to focus on improvements and efficiencies, aligning the delivery system to control costs, while continuing to improve health outcomes. This is evident in the initiatives to transition the nursing home benefit into MMC and to integrate the behavioral health benefit and populations into managed care.

Transition of Managed Long Term Care (MLTC) Populations from the F-SHRP to the Partnership Plan

The Department is proposing to transition the MLTC populations and counties in the F-SHRP Demonstration into the Partnership Plan Demonstration. This transition will also simplify management of the waivers while maintaining all current requirements. Delivery of services to the enrolled MLTC populations is the same in both waivers and as with MMMC, populations and approved benefit packages remain the same. All terms and conditions to the provision of services for the enrolled populations are the same as those in the Partnership Plan. As with the MMMC population, the transition will be seamless and there will be no disruption to the enrolled populations. Transitioning the enrolled populations into the Partnership Plan once F-SHRP expired was the original intention of the waiver.

New York State has been operating a Mandatory Managed Long term Care program since 2011. This was a key part of the Medicaid Redesign Team effort. The State, however, had an existing voluntary MLTC program since 1997. Mandatory enrollment began in New York City in 2011 and has now been effectively implemented in additional counties. These counties are Nassau, Suffolk and Westchester. The State continues, with the approval of CMS, to enroll more populations and counties into the mandatory MLTC program.

Currently in New York State, Managed Long Term Care plans are conducting all assessments as well as enrollment processes for potential enrollees. As part of recent amendments to the STCs, and to assure consumers appropriate access to community based long term care, New York State proposes to develop an independent entity to conduct the distinct clinical assessment that is currently part of the MLTC plans' enrollment and assessment life cycles.

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Designated State Health Plans (DSHPs)

As part of the currently pending MRT Waiver Amendment to the Partnership Plan, New York may transition DSHPs currently under the F-SHRP Demonstration to support new Partnership Plan programs. This will be determined through ongoing discussions with CMS.

Continuous Eligibility Period

The Department has submitted to CMS an amendment proposal to the 1115 Partnership Plan Waiver requesting revisions to the 12-month continuous coverage eligibility policy. New York is seeking to remove authority from both the F-SHRP and Partnership Plan Waivers to provide continuous eligibility for all non-MAGI populations; and subsequently seeking authority to align the 12-month continuous eligibility policy with MAGI eligibility groups only. Pending CMS approval, all MAGI eligibility groups would be eligible to receive 12-month continuous coverage. The expected implementation date is January 1, 2014.

The remaining eligibility groups in the waiver will be revised into new MAGI eligibility groups and transitioned to the Partnership Plan:

12-month continuous eligibility groups
• Pregnant women • Children <19 or 20, if full time student • Children 19 & 20 living with parents • Parents/Caretaker relatives • Adult group (not pregnant, age 19-64, no Medicare, not a caretaker relative)

Once these populations transition into the Partnership Plan Waiver, the authority to provide continuous coverage should transition as well for the following counties: Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.

Closeout Costs

To Be Determined

Process Used to Notify Public

1. **Notices to Beneficiaries**

   Notification to the beneficiaries is not necessary since the transition from the F-SHRP to the Partnership Plan is seamless. There will be no change in eligibility or scope of benefits.

2. **Tribal Notification**

In accordance with SMDL #01-024 dated July 17, 2001, the Department issued a tribal notification (letter dated 9/25/2013) to all Tribal Government Chiefs who maintain primary offices and/or a major population within the state, in addition to Tribal Nation Health Centers. The tribal notification specifies that the Phase Out Plan will be posted on the Department's website to allow for comments **(Attachment 4: Tribal Letter).**

3. Phase-out Plan Published for Public Comment

On October 23, 2013 a draft copy of the Phase Out Plan was posted on the Federal-State Health Reform Partnership website: http://www.health.ny.gov/health_care/managed_care/appextension/federal_state_health_reform_partnership.htm for a 30 day period. Included in this posting are instructions on how consumers and stakeholders can submit comments to the Department **(Attachment 5).**

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Attachment 1: Exclusions and Exemptions from MMMC (STC 18)

Notwithstanding the eligibility criteria in STC 16(b) of the F-SHRP Special Terms and Conditions, certain individuals cannot receive benefits through the MMMC program (i.e. are excluded from participation) while others may request an exemption from receiving benefits through the MMMC program (i.e. may be exempted from participation). Tables 1:1 and 1:2 list those individuals either excluded or exempted from MMMC.

Table 1:1: Individuals Excluded from MMMC

Individuals who become eligible for Medicaid only after spending down a portion of their income
Residents of state psychiatric facilities or residents of state certified or voluntary treatment facilities for children and youth
Patients in residential health care facilities (RHCF) at time of enrollment and residents in an RHCF who are classified as permanent
Participants in capitated long-term care demonstration projects
Medicaid-eligible infants living with incarcerated mothers
Individuals with access to comprehensive private health insurance if cost effective
Foster care children in the placement of a voluntary agency
Certified blind or disabled children living or expected to live separate and apart from their parents for 30 days or more
Individuals expected to be Medicaid eligible for less than six months (except for pregnant women)
Individuals receiving hospice services (at time of enrollment)
Youth in the care and custody of the commissioner of the Office of Family & Children Services
Individuals eligible for the Family Planning Expansion Program
Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a state Office of Mental Health (OMH) facility)
Individuals with a "county of fiscal responsibility" code of 98 (individuals in an Office of People with Developmental Disabilities (OPWDD) facility or treatment center)
Individuals under 65 years of age (screened and requiring treatment) in the Centers for Disease Control and Prevention's (breast, cervical, colorectal, and/or prostate) Early Detection Program, and needing treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage
Individuals eligible for Emergency Medicaid.

Table 1:2: **Individuals Who May Be Exempted from MMMC**

Individuals with chronic medical conditions who have been under active treatment for at least six months with a sub-specialist who is not a network provider for any Medicaid MCO in the service area or whose request has been approved by the New York State Department of Health Medical Director because of unusually severe chronic care needs (exemption is limited to six months)
Individuals designated as participating in OPWDD sponsored programs.
Individuals already scheduled for a major surgical procedure (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area (exemption is limited to six months)
Individuals with a developmental or physical disability receiving services through a Medicaid Home and Community Based Services (HCBS) Waiver authorized under section 1915(c) of the Act.
Residents of alcohol/substance abuse Long Term Residential Treatment Programs.
Native Americans.
Individuals with a "county of fiscal responsibility code of 98" (OPWDD in Medicaid Management Information Systems) in counties where program features are approved by the state and operational at the local district level to permit these individuals to voluntarily enroll.

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Attachment 2: Exclusions and Exemptions from MLTC (STC 19)

Notwithstanding the eligibility criteria in STC 16 of the F-SHRP Special Terms and Conditions, certain individuals cannot receive benefits through the MLTC program (i.e. are excluded from participation), while others may request an exemption from receiving benefits through the MLTC program (i.e. may be exempted from participation). Tables 2:1 and 2:2 lists those individuals either excluded or exempted from MLTC.

Table 2.1: **Individuals Excluded from MLTC**

Residents of psychiatric facilities
Residents of Residential Health Care Facilities (RHCF) at time of enrollment
Individuals expected to be Medicaid eligible for less than six months
Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services
Individuals receiving hospice services (at time of enrollment)
Individuals with a "county of fiscal responsibility" code of 97 (individuals residing in a state Office of Mental Health facility)
Individuals with a "county of fiscal responsibility" code of 98 (individuals in an OPWDD facility or treatment center)
Individuals eligible for the Family Planning Expansion Program
Individuals under 65 years of age who are screened through the Centers for Disease Control and Prevention's Early Detection Program and need treatment for breast, cervical, colorectal, or prostate cancer, and are not otherwise covered under creditable health coverage
Residents of intermediate care facilities for the mentally retarded (ICF/MR)
Individuals who could otherwise reside in an ICF/MR, but choose not to
Residents of alcohol/substance abuse Long Term Residential Treatment Programs
Individuals eligible for Emergency Medicaid
Individuals in the OPWDD HCBS 1915(c) Waiver program
Individuals in the following 1915(c) Waiver programs: Traumatic Brain Injury (TBI), Nursing Home Transition and Diversion (NHTD), and Long-Term Home Health Care Program (LTHHCP) in certain counties. (New York is using a phased in approach to transition LTHHCP individuals into the MLTC program. There are six phases (see **Attachment 3**- "Attachment C of F-SHRP Waiver")
Residents of Assisted Living Programs
Individuals in receipt of Limited Licensed Home Care Services
Individuals in the Foster Family Care Demonstration

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Table 2.2: **Individuals Who May Be Exempted From MLTC**

Individuals aged 18 through 20 who are nursing home certifiable and require more than 120 days of community based long term care services
Native Americans
Individuals who are eligible for the Medicaid Buy-In for the Working Disabled and are nursing home certifiable
Aliessa Court Ordered Individuals

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Attachment 3: "Attachment C" of F-SHRP Waiver

ATTACHMENT
C

Managed Long Term Care Program Enrollment
Plan

Mandatory Managed Long Term Care/Care Coordination Model

(CCM) Mandatory Population: Dual eligibles, age 21 and over, receiving community based long term care services for over 120 days, excluding the following:

- Long-Term Home Health Care Program **(in certain counties, see timeline below)**;
- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Nursing home residents;
- Assisted Living Program participants; and
- Dual eligible that do not require community based long-term care services.

Voluntary Population: Dual eligibles, age 18 through-20, in need of community based long-term care services for over 120 days and assessed as nursing home eligible. Non-dual eligible age 18 and older assessed as nursing home eligible and in need of community based long-term care services for over 120 days.

The following requires CMS approval to initiate and reflects the enrollment of the mandatory population only.

Phase I and II: New York City and the suburbs

July 1, 2012 - Any new dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.

- Enrollment Broker will provide with educational material, a list of plans/CCMs, and answer questions and provide assistance contacting a plan if requested.
- Plan/CCM will conduct assessment to determine if eligible for community-based long-term care.
- Plan/CCM transmits enrollment to Enrollment Broker.

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In addition, the following identifies the enrollment plan for cases already receiving care. Enrollment will be phased in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule.

July 1, 2012: Begin personal care* cases in New York County

August 1, 2012: Continue personal care cases in New York County

September, 2012: Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties

October, 2012: Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County

November, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties

December, 2012: Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties

January, 2013: Continue personal care and consumer directed personal assistance program citywide.

February, 2013 (and until all people in service are enrolled): Personal care, consumer directed personal assistance program, citywide.

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days, citywide

March, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days in Nassau, Suffolk and Westchester counties

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program citywide

April, 2013: Personal care, consumer directed personal assistance program, adult day health care, home health care over 120 days and long-term home health care program in Nassau, Suffolk and Westchester counties

Phase III: Rockland and Orange Counties

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. June 2013

Phase IV: Albany, Erie, Onondaga and Monroe Counties

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. Anticipated Fall 2013

Phase V: Other Counties with capacity:

Dually eligible community based long-term care service recipients in these additional counties as capacity is established. Anticipated Spring 2014

Phase VI:

Previously excluded dual eligible groups contingent upon development of appropriate programs:

- Nursing Home Transition and Diversion waiver participants;
- Traumatic Brain Injury waiver participants;
- Nursing home residents;
- Assisted Living Program participants;
- Dual eligible that do not require community-based long-term care services.

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Attachment 4 – Tribal Letter

September 25, 2013

Dear Colleague:

This letter is to inform you that New York State Department of Health intends to submit a Phase Out Plan for the termination of the Federal-State Health Reform Partnership (F-SHRP) section 1115 Medicaid Demonstration (11-W-00234/2) to the Centers for Medicare and Medicaid Services (CMS) by the end of November, 2013. The waiver was initially approved for a five year period beginning in 2006, with a termination date of September 30, 2011. On April 29, 2011, CMS approved an extension of the F-SHRP waiver for an additional two and a half years, making the termination date March 31, 2014. The initial purpose of the F-SHRP waiver was to facilitate rightsizing the acute care infrastructure, to reform long term care and to improve primary and ambulatory care.

No Medicaid beneficiaries will be adversely affected by the termination of the F-SHRP waiver. Medicaid eligibility and services currently in effect for recipients will continue unchanged under the Partnership Plan section 1115 Medicaid Demonstration (11-W-00114/2).

The Designated State Health Programs (DSHPs) funded under F-SHRP will end as of March 31, 2014. The DSHP health system reform initiatives included programs that: promoted the efficient operation of the state's health care system, consolidated and right sized New York's health system by reducing excess capacity in the acute care system, shifted emphasis in long-term care from institutional-based to community based settings, expanded the use of E-prescribing, electronic records and regional health information organizations and improved the provision of ambulatory and primary care.

The Phase Out Plan will be available on the Department's website: http://www.health.ny.gov/health_care/managed_care/appextension/federal_state_health_reform_partnership.htm.

If you have comments or questions, please forward them to Kim Lance at kal05@notes.health.state.ny.us or Donna Speckert at dxs217@notes.health.state.ny.us and they will be addressed accordingly.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

cc: Michael Melendez
Wendy Stoddart
Marilyn Kacica
Karina Aguilar

New York State's Federal-State Health Reform Partnership Phase Out Plan

Vanetta Harrison

Attachment 5: Public Notice

Public Notice

On October 1, 2006, New York State's Federal-State Health Reform Partnership (F-SHRP) demonstration was approved by the Federal government under Section 1115 of the Social Security Act. The demonstration was approved for an initial five year period to pursue the following reform initiatives: Rightsizing Acute Care Infrastructure, Reforming Long Term Care, and Improvement in Primary/Ambulatory Care. On April 29, 2011, the government approved an extension of F-SHRP for an additional two and a half years, making the termination date March 31, 2014.

The Special Terms and Conditions (STCs) of the F-SHRP demonstration detail the State's obligations to the Centers for Medicare and Medicaid Services (CMS) when a demonstration expires. In accordance with the STCs, the State is preparing a Phase Out Plan to facilitate these obligations.

This plan gives an explanation of the disposition of the beneficiaries remaining in F-SHRP. Upon the expiration of F-SHRP, Medicaid beneficiaries will remain eligible to receive their services under another New York State demonstration, the Partnership Plan, with no loss of benefits.

Additionally, there are Designated State Health Programs (DSHPs) currently funded under F-SHRP. These programs facilitated such initiatives as promoting the efficient operation of the state's health care system and improving the provisions of ambulatory and primary care. The funding for DSHPs will expire, and they will end on March 31, 2014 when F-SHRP expires.

The Phase Out Plan will be available on the Department of Health's website: http://www.health.ny.gov/health_care/managed_care/appextension/federal_state_health_reform_partnership.htm.

Additional information concerning the expiration of the F-SHRP demonstration may be obtained by writing to:

New York State Department of Health
Office of Health Insurance Programs
Corning Tower – Attention: Kim Lance (OCP Suite 720)
Albany, NY 12237

-OR-

Via e-mail: kal05@notes.health.state.ny.us

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

Glossary of Acronyms

DSHP	Designated State Health Program
FMR	Fair Market Rent
FPL	Federal Poverty Level
F-SHRP	Federal-State Health Reform Partnership
HCBS	Home and Community Based Services
HEAL NY	Health Care Efficiency and Affordability Law for New Yorkers
HUD	Housing and Urban Development
ICF/MR	Intermediate Care Facility for the Mentally Retarded
LTHHCP	Long Term Home Health Care Program
MCO	Managed Care Organization
MLTC	Managed Long Term Care
MMMC	Mandatory Medicaid Managed Care
NHTD	Nursing Home Transition and Diversion
OPWDD	Office of People with Developmental Disability
RHCF	Residential Health Care Facility

SSI	Supplemental Security Income
TBI	Traumatic Brain Injury