

**NEW YORK FEDERAL-STATE HEALTH REFORM PARTNERSHIP
SECTION 1115 DEMONSTRATION FACT SHEET**

October 1, 2006

Name of Section 1115 Demonstration:	Federal-State Health Reform Partnership (F-SHRP)
Waiver Number:	11-W-00234/2
Date Proposal Submitted:	April 27, 2005
Date 1115(a) Demonstration Approved:	September 29, 2006
Date 1115(a) Demonstration Effective:	October 1, 2006
Date 1115(a) Demonstration Expires:	September 30, 2011

SUMMARY

New York will undertake significant reforms to promote the efficient operation of the State's health care system by:

- a) reducing excess capacity in its acute care hospital industry;
- b) shifting emphasis in long-term health care services from an institutional to a community-based setting consistent with the President's New Freedom Initiative by reducing nursing home excess capacity and worker retraining;
- c) investing in health information technology initiatives, including e-prescribing, electronic medical records and regional health information organizations; and
- d) reorienting New York's health care system away from inpatient facilities to outpatient and primary-care focused delivery systems, including pay-for-performance initiatives.

Under F-SHRP, the Federal government will provide funding up to \$1.5 billion (up to \$300 million per year) to the State for specific designated expenditures. The Federal funds "free up" State funds for New York to invest in the reforms outlined above. However, Federal funds are conditioned upon the following:

- The State must meet a series of established performance milestones set forth in the demonstration terms and conditions; and
- The demonstration must generate Federal savings sufficient to offset the Federal investment.

STRUCTURE OF DEMONSTRATION

Designated State Health Programs

The Federal government will provide Federal financial participation (FFP) for designated State health programs (DSHP). These are State-funded health care programs, which serve low-income and uninsured New Yorkers, not otherwise eligible for Federal matching funds. These programs must be funded completely with State dollars at current levels without in-

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kind contributions or maintenance-of-effort requirements for other Federal programs.

Funding of Reforms

After incurring DSHP expenditures, the State may draw down FFP only as it is ready to expend State funds on the health reform initiatives. In essence, Federal funds replace some of the State funding for the DSHP, thereby “freeing up” State funds for New York’s health reform initiatives outlined above. Federal funds are limited to \$300 million annually, and may not be rolled over into subsequent years. However, the State has two years after each demonstration year to claim Federal funds and pay for investment expenditures incurred during the demonstration year, which is consistent with Medicaid requirements.

Performance Milestones

The State must meet all milestones throughout the demonstration period. Failure to meet any milestone (except the fraud and abuse recoveries milestone) will result in cessation of FFP for DSHP. Failure to meet the fraud and abuse recoveries milestone will require New York to pay the Federal government the difference between the demonstration year goal and actual recoveries, up to a limit of \$500 million over the five-year demonstration period. Additionally, if New York ends any of the initiatives implemented as part of this agreement prior to the end of the five-year demonstration, the Federal government will immediately cease providing FFP for DSHP. These milestones include:

- Increasing fraud and abuse recoveries to 1.5 percent of the State’s FFY 2005 total Medicaid expenditures by the end of the demonstration;
- Implementation of a preferred drug program for the entire New York Medicaid program;
- Implementation of an employer-sponsored insurance program;
- Implementation of one new Medicaid reform initiative (exclusive of the items above); and
- Implementation of a single point-of-entry system for long-term care service assessment.

Savings

The reform initiatives to right-size and restructure the State’s health care delivery system and to expand use of health information technology are expected to generate significant savings to both the State and Federal government. However, these reforms will be implemented over a number of years and although some of the savings are expected to accrue in the next 5 years, much of the savings will be long term.

The State is required to generate \$3 billion in gross Medicaid savings (\$1.5 billion Federal) over the 5-year demonstration period. Should the State not achieve these savings by the end

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of the demonstration, it will be required to refund to the Federal government the difference between the Federal investment in the F-SHRP reforms and the Federal savings generated.

In order to generate sufficient Federal Medicaid savings to offset its investment, CMS will count savings in two areas – savings generated due to decreased hospital utilization resulting from eliminating excess acute care capacity and savings generated through Medicaid managed care expansions. The managed care expansions include the current implementation of mandatory SSI enrollment and expansion of mandatory Medicaid enrollment in additional counties. Counting these managed care savings for F-SHRP required moving these populations from the State’s existing section 1115 demonstration, Partnership Plan, to the new F-SHRP demonstration.

ELIGIBILITY, ENROLLMENT AND BENEFITS

Effective October 1, 2006, the authority to require disabled adults and children, as well as the elderly, to enroll in the Medicaid managed care program has been transferred from this demonstration to the Federal-State Health Reform Partnership (F-SHRP) Demonstration (11-W-00234/2). This includes individuals dually eligible for Medicare and Medicaid who are included in the F-SHRP demonstration but may enroll on a voluntary basis.

Additionally, under this demonstration, all beneficiaries in 14 counties will now be required to enroll in a managed care organization. These counties include:

Allegany	Cortland	Dutchess	Fulton	Montgomery
Putnam	Orange	Otsego	Schenectady	Seneca
Sullivan	Ulster	Washington	Yates	

The State directly contracts with commercial MCOs and State-certified Prepaid Health Services Plans (PHSPs) for the Partnership Plan. Capitated Special Needs Plans (SNPs) have been developed to serve individuals with HIV/AIDS who require intensive case-managed care regimens, and their families. All beneficiaries in the demonstration must use providers within their managed care plan.

Managed care beneficiaries in the Partnership Plan receive the same comprehensive benefits package available under the fee-for-service program. Certain services, such as long-term care services, continue to be provided on a fee-for-service basis. Other services, such as transportation and dental care, may be provided on a fee-for-service basis or as part of the capitated managed care service package at county discretion. Family planning services can be obtained from any provider offering such services to Medicaid beneficiaries.

The State also offers certain services on a fee-for-service wraparound basis to individuals who exceed a basic benefit threshold within their managed care plans. For example, individuals who

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exhaust their basic benefits as defined in the capitation rates are able to receive mental health inpatient and outpatient services, and medically necessary chemical dependency treatment services on a fee-for-service basis. (See the fact sheet for the Partnership Plan for additional details).

EVALUATION

F-SHRP is a five-year demonstration that will end on September 30, 2011. Over the five-year term, the State will be required to report quarterly and annually to CMS on the progress of the demonstration. Reporting will include a number of quantifiable metrics to assist CMS in evaluating the effectiveness of the State's reforms including grant activity, data on hospital and nursing home utilization and debt, progress on implementation of the recommendations of the Governor's Commission on Health Care Facilities in the 21st Century, and managed care enrollment information. In addition to these reporting requirements, a formal evaluation of the demonstration is required, with a report due to CMS when the demonstration expires.

STATE FUNDING SOURCE

The demonstration is funded with Title XIX funds.

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