DEVORAH ADLER
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Files:

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Diabetes
Disability
Disability
EPSDT
EPSDT
Elec. Med Rec
NEDSS
Fraud
FAA/HIV
Fam Care
Dietary Supp
Dean Ornish
Dean Ornish
CRNA
CHIP Crowd Out
CHIP Outreach
CHIP Outreach

DRAFT

FACT SHEET 7/27
July 1999

NEW YORK'S MANAGED CARE MEDICAID PLAN

Overview: ***On July XX, 1999, the Health Care Financing Administration(HCFA) sent a letter informing the State of New York that it could begin enrolling Medicaid beneficiaries in mandatory managed care in Staten Island, lower Manhattan and parts of Brooklyn. This approval is part of a New York State Medicaid Section 1115 waiver that was first approved in July 1997 and has been implemented in various upstate counties since then. HCFA's recent letter to New York confirms that the State has met the conditions of approval required prior to enrolling Medicaid beneficiaries in managed care. HCFA will permit the phase-in to expand to the other areas only after the State has demonstrated that all the terms and conditions have been fulfilled for those additional areas.***

The Social Security Act permits the Secretary of Health and Human Services discretion in waiving certain aspects of the Act in order to conduct experimental demonstration projects. These demonstrations are frequently aimed at redesigning a State's health system to better serve greater numbers of Medicaid beneficiaries while reducing costs through the use of various mechanisms, such as managed care. The Partnership Plan is one such demonstrations. The State has effectively dealt with many difficult issues in implementing the Partnership Plan in twelve upstate counties and in preparing to implement Phase 1 in New York City.

The Partnership Plan. On March 20, 1995, New York State submitted a section 1115 waiver application that would permit Federal financial participation in a demonstration called the Partnership Plan. The State proposed to move over two million currently eligible individuals and approximately 370,000 "Safety Net" (Home Relief) recipients into a managed care environment. When the Partnership Plan is completely implemented, about 85 percent of New York State's Medicaid eligible population will be in managed care.

Today's action will allow the State to begin enrolling Medicaid beneficiaries into managed care in Staten Island, lower Manhattan, and parts of Brooklyn. The State is required to submit ongoing monitoring and oversight items to HCFA within ninety days of commencement of mandatory enrollment.

Roll-out Plan for New York 1115 Wavier

Necessary Paper

Letter to State
Qs and As
Talk Points

Day of Roll-out

- Schedule Richardson/Whalen conference call

At Scheduled Time:

- Sally Richardson calls:
  Dennis Whalen, Executive Deputy Commissioner (518) 473-0458,

Upon Completion of Richardson/Whalen phone call:

- In coordination with OS/IGA, HCFA/IGA will fax letter and Qs and As to NYS Regional Office/RA and RD

- David Cade calls:
  Ellen Anderson (Director) or Phyllis Silver (Deputy Director),
  Office of Managed Care, NYS Department of Health
  (518) 474-5737

- L. Bishop calls:
  Donna Farlow, Medicaid Deputy Director
  (518) 474-3018, NYS Department of Health

- Mail and Fax Letter to Whalen and Farlow (HCFA/IGA)
  (518) 473-7071

- In coordination with OS/IGA, HCFA/IGA will call and fax letter to:
  Governor Pataki's Washington Office

- OL will call and fax letter to:
  Senate Finance Minority Staff (Moynihan),
  House Ways and Means Minority Staff (Rangel), and
  the Entire NYS delegation

- Allision Green will communicate with appropriate state legislative contacts and Judy Berek will contact advocate groups. These calls will be the same as for the conditional approval announcment.

- HCFA Press to Brief Ray Hernandez (NYT Reporter)

- With Qs and As: HCFA Press Office will field calls from press

The New York State Proposal. The New York State Partnership Plan proposal incorporates four broad initiatives:
(1). The transition of the State's acute care program from fee-for-service to managed care.
(2). Converting approximately 370,000 residents covered by the State's "Safety Net" program to Medicaid beneficiaries covered by a Federal entitlement program.
(3). The development of Special Needs Plans (SNPs) to serve: people who are HIV-positive or who have AIDS; adults who are seriously and persistently mentally ill; and children with serious emotional disturbances.
(4) The creation of a $1.2 billion fund to assist hospitals in moving to managed care. These funds help cover both retraining staff and establishing or expanding neighborhood-based clinics and health centers. This transition initiative will be funded by redirecting a portion of the State's Medicaid allotment for hospitals that treat a significant percentage of indigent or uninsured patients.

Delivery system. Counties in New York State will obtain contracts with managed care organizations. In order for a county to be permitted to implement the Partnership Plan, it must offer its Medicaid population a choice of at least two managed care organizations. Partially capitated plans will be utilized to ensure access to care in areas of the State that do not have sufficient managed care capacity. Managed care organizations will be encouraged to establish network arrangements with traditional providers, such as Federally Qualified Health Centers, school-based health centers, and Ryan White CARE Act providers.

Conditions. Before enrollment began in Phase 1 of New York City, the State fulfilled the conditions of approval. The following three principal conditions identified in HCFA's May 26, 1999 letter to the State have been met:

- The New York State Department of Health provided a detailed interim quality monitoring plan for early evaluation of the quality of care provided to Medicaid beneficiaries.
- The New York State Department of Health provided a detailed Statewide Quality Assurance Monitoring Plan, which included a subset specifically for New York City. [Both monitoring plans pay particular attention to vulnerable, at-risk populations such as people with diabetes, AIDS, asthma or hemophilia.]
- New York State submitted the final Partnership Plan Operational Protocol --the rules that govern the functions of the waiver. This protocol included the State's fair hearing policy for people who believe that they have not received the care or service that they needed.

Phase-In Process. Due to the complexity of the project, the State suggested that there be five separate phase-in areas of the waiver in New York City. The first two implementation phases are: Phase 1-- Staten Island, lower Manhattan, parts of Brooklyn; and Phase 2 -- Northeast Queens and the North Bronx. HCFA has today only approved implementation of Phase 1, although Phase 2 could be ready for approval as early as November. There are currently no specific time frames beyond Phase 2.

Benefits. Medicaid managed care enrollees will be entitled to the same benefits that are available under Medicaid fee-for-service. Medicaid beneficiaries will receive a comprehensive benefits package through their managed care organization but certain services (e.g., long-term care services and prescription medicines) will continue to be provided on a fee-for-service basis.

Eligibility and enrollment. Most Medicaid-eligible New York residents eventually will be required to enroll in managed care. Enrollment will be phased in county by county or, in the case of New York City, zip code by zip code.

Exempted and excluded populations. Some Medicaid beneficiaries are exempted or excluded from the Partnership Plan. Exempted populations will have the option to enroll in managed care organizations but will not be required to enroll. Those exempted include: people with HIV/AIDS, people who are seriously and persistently mentally ill, people for whom a managed care provider is not geographically accessible, pregnant women already receiving prenatal care from a non-participating primary care provider, and Native Americans. Some of these populations (such as those living with HIV/AIDS or suffering from mental illness) could, within the next several years, be required to participate in manage care through Special Needs Plans. This could only occur after a series of milestones designed to protect these beneficiaries are fulfilled.

Because some patients need specialized care and/or live in institutions, they will be excluded from the option to enroll in managed care organizations. Some examples of excluded populations are: people who are dually eligible for Medicaid and Medicare, residents of nursing facilities, residents of State-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers. Medicaid beneficiaries in these excluded groups represent approximately 15 percent of the State's Medicaid eligibles.

Community input. Since signing the Partnership Plan waiver in July of 1997, HCFA and New York State have been conducting many efforts to ensure a smooth transition to Medicaid managed care in New York State. Quarterly public meetings are conducted at which community groups and the general public can provide comments about managed care to HCFA, New York State and City officials.

Meetings are also held with health advocacy workgroups every 4-6 weeks to discuss access and quality of care issues. We have elicited advocates' opinions and concerns on the waiver and have received significant support and information through these activities. We will continue to solicit community advice about all aspects of the waiver. These forums have provided HCFA, New York State, and New York City staff with an opportunity to dialogue with the community about their concerns and suggestions. This partnership with the advocates has helped -- and will continue to help -- shape the policies and procedures of the Partnership Plan.

Current status. On July 15, 1997, HCFA approved the State's 1115 waiver application and issued Special Terms and Conditions for program implementation. The first five New York counties "went live" with Medicaid managed care on October 6, 1997. As of April 1999, twelve counties have begun to implement the waiver. These counties are: Albany, Broome, Columbia, Erie, Greene, Monroe, Niagara, Onondaga, Ontario, Rensselaer, Saratoga and Oswego. Schnectady County is scheduled to implement September 1, 1999.

On May 26, 1999, HCFA granted conditional approval to implement the Partnership Plan in Phase 1 of New York City. All required documentation was submitted by the State and approved by HCFA. The State will now begin notifying Medicaid beneficiaries to enroll in managed care plans.

DRAFT 7/27

GENERAL QUESTIONS

Q. HCFA sent New York State a letter on May 26, 1999 granting conditional approval to implement its Medicaid managed care waiver in New York City. What were the conditions of approval and have they been met?

A. Based on documentation received from the State, the conditions have been met. As a result, HCFA announced today that the State could move forward with mandatory enrollment of Medicaid beneficiaries into managed care within Phase 1 of New York City. Phase I includes lower Manhattan, parts of Brooklyn, and Staten Island.

The three principal conditions of approval listed below:

- The New York State Department of Health provided a detailed interim quality monitoring plan for early evaluation of the quality of care provided to Medicaid beneficiaries.
- The New York State Department of Health provided a detailed Statewide Quality Assurance Monitoring Plan, which included a subset plan for New York City. [Both monitoring plans pay particular attention to vulnerable, at-risk populations such as people with diabetes, AIDS, asthma or hemophilia.]
- New York State submitted the final Partnership Plan Operational Protocol --the rules that govern the functions of the waiver. This protocol included the State's fair hearing policy for people who believe that they have not received the care or service that they needed.

As I said, based on the State's documentation and their acceptance of the waiver Terms and Conditions, HCFA will allow the State to begin notifying Medicaid beneficiaries of the managed care plans available to them.

Q. Why is HCFA's recent letter putting so much emphasis on these conditions?

A. HCFA's first responsibility is to assure that high quality standards for health care are maintained in Medicaid and that the rights of Medicaid beneficiaries are protected. This letter is the latest step in a careful process developed by HCFA to achieve those goals. That process has established procedures to protect the needs and rights of New Yorkers enrolling in Medicaid managed care, as were agreed to under the waiver. HCFA expects New York State to implement these conditions and assure quality health care and full protection of the rights of Medicaid beneficiaries.

To that end, HCFA and the State agreed in the terms and conditions when the waiver was approved in 1997 that the specified conditions would be met.

Q. What exactly is the Partnership Plan?

A. The Partnership Plan is New York State's Medicaid Section 1115 waiver for a statewide health reform demonstration that was approved by HCFA on July 15, 1997. The waiver grants authority for the State to serve Medicaid beneficiaries through managed care plans. These demonstrations are frequently intended to restructure a State's health system and reduce costs through the use of various mechanisms, such as managed care, while providing high quality care to greater numbers of Medicaid beneficiaries.

Q. How many people will the Partnership Plan cover?

Once fully implemented statewide, the Partnership Plan will enroll approximately 2.1 million people, or about 85% of the New Yorkers who are currently eligible for Medicaid. The plan will also extend Medicaid eligibility to approximately 370,000 safety net beneficiaries. Additionally, the Partnership Plan waiver requires the State to provide three types of enhanced managed care organizations, known as Special Needs Plans, to serve individuals with HIV/AIDS, adults with serious mental illness, and children with serious emotional disturbances.

The Partnership Plan is being implemented statewide in a series of phases, with the last phase scheduled for implementation in August 2000. Implementation began on October 6, 1997, with five upstate counties: Albany, Rensselaer, Columbia, Greene, and Saratoga. To date seven additional upstate counties have been approved for implementation: Ontario (January 1, 1998), Monroe (March 1, 1998), Erie and Broome (May 4, 1998), Niagara (September 4, 1998), Onondaga (October 16, 1998), and Oswego (April 1, 1999). Schnectady is scheduled to begin September 1, 1999.

Phase 1 of New York City's implementation of the Partnership Plan will include Staten Island, lower Manhattan, and parts of Brooklyn. This will be followed by the phase-in of additional areas of the City as appropriate.

Q. What successes have been seen in the current counties that have implemented the Partnership Plan to date?

A. There are several indicators demonstrating that Medicaid beneficiaries have greater access to high quality care under the Partnership Plan.

- Access -- The access of Medicaid managed care enrollees to their primary care physicians and to specialists has significantly improved when compared to the previous fee for service system. Another indicator of success is that the number of Medicaid complaints per thousand enrollees decreased from 1.5 in the last quarter to 1.1 this quarter.
- Quality -- In several of the upstate counties, a number of plans are performing significantly

better than the statewide Medicaid average in the following areas: childhood immunizations; well child visits in the first 15 months of life; well child visits in the third, fourth, fifth and sixth year of life; and cervical cancer screenings. Another area showing early promise is improved management of asthma.

Close to 28,000 Medicaid beneficiaries enrolled in managed care between October and December of 1998, bringing total enrollment in the counties participating in the Partnership Plan to over 150,000 beneficiaries. This is nearly 60% of the Medicaid eligible population in the first eleven counties to implement the Partnership Plan.

Q. How many people does HCFA expect to be enrolled in Medicaid managed care in Phase 1 in New York City? How many when the City is completely enrolled?

Approximately 260,000 to 300,000 Medicaid beneficiaries will be enrolled in Phase 1. When the Partnership Plan is implemented throughout New York City, approximately one million City residents will be enrolled in Medicaid managed care.

Q. Why does HCFA believe that the waiver will be good for beneficiaries in New York City?

A. The Partnership Plan is bringing new doctors into the Medicaid health care delivery system. For example, in Phase 1 in lower Manhattan, there are 100 obstetricians/gynecologists participating in fee-for-service (traditional Medicaid) compared to 170 in managed care. The number of pediatricians participating in fee-for-service is 75, compared to 125 in managed care. The State reported 3,159 specialists in the Medicaid managed care networks as compared with 1,859 specialists in fee-for-service Medicaid. This represents a 70% increase in the number of specialists available to Medicaid recipients in Manhattan.

Moreover, the New York State Department of Health has reported that in Phase 1 in lower Manhattan, there are high ratios of providers:

- 62,000 Medicaid eligibles
- 447 primary care providers in the managed care networks (not including obstetricians and gynecologists)
- 139 Medicaid eligibles per primary care provider

- 29,000 Medicaid children under the age of 20
- 125 pediatricians (without taking into consideration family practice providers)
- 232 Medicaid children per provider

Q. Will Medicaid beneficiaries have a choice of health care plans in the City?

A. The Partnership Plan must guarantee choice of Medicaid managed care plans under the waiver. Although there have been some high profile health plan withdrawals recently (e.g., Oxford, Empire Blue Cross/Blue Shield), Medicaid beneficiaries will enjoy a wide choice of Medicaid managed care plans. The HCFA Regional Office has worked extensively to ensure access to providers and choice of Medicaid managed care plans. There will be a total of 14 plans participating in New York City, four of which are City-wide. Here are the number of plans participating, by borough:

- Manhattan 6
- Brooklyn 9
- Staten Island 9
- Queens 6
- Bronx 9

Any Medicaid beneficiary can select any plan in their borough, and see any provider in the network regardless of location.

Q. What does approval mean for New York City hospitals preparing for this transition to managed care?

A. Under the terms and conditions, as soon as New York City implements the 1115 waiver, hospitals will be able to draw more funds from the Community Health Care Conversion Demonstration Project Fund. This program provides special help for safety net hospitals that have traditionally cared for Medicaid beneficiaries, supports work force restructuring and other changes necessary for a smooth transition to managed care. Hospitals have already received 15 percent of the funds to begin the transition. They were eligible to receive another 15 percent upon Federal and State agreement of a start date. They will receive the remainder as Medicaid beneficiaries enroll into managed care. These funds will help secure a future in the managed care world for the safety net providers who have the most experience caring for Medicaid beneficiaries.

Q. How do health care advocates, community groups and the general public feel about the waiver?

A. Since signing the Partnership Plan waiver in July of 1997, HCFA and New York State have been conducting many efforts to ensure a smooth transition to Medicaid managed care in New York State. Quarterly public meetings are conducted at which community groups and the general public can provide comments about managed care to HCFA, New York State and City officials. Meetings are also held with health advocacy workgroups every 4-6 weeks to discuss access and quality of care issues. We have elicited advocates' opinions and concerns on the

waiver and have received significant support and information through these activities. We will continue to solicit community advice about all aspects of the waiver. These forums have provided HCFA, New York State, and New York City staff with an opportunity to dialogue with the community about their concerns and suggestions. This partnership with the advocates has helped -- and will continue to help -- shape the policies and procedures of the Partnership Plan.

Q. Under the waiver, the State was supposed to implement managed care in New York City by early to mid-1998. It is now a year later. Why the delay?

A. Implementing the Partnership Plan in the upstate counties took longer than New York State and HCFA anticipated. In addition, the State and the City were not prepared for HCFA to conduct onsite readiness reviews until October of 1998. Since the Partnership Plan was approved, HCFA has provided technical assistance to the State. In fact, a year ago HCFA offered to meet with the State to conduct the readiness review. That review generated the conditions identified in HCFA's recent conditional approval letter to New York State.

Q. New York City hasn't done a very good job of helping people get Medicaid. Isn't this just another way for the City to save money at the expense of a vulnerable group of people?

A. HCFA and the US Department of Agriculture have been working with New York City and State officials to ensure that eligible people are enrolled in the Medicaid and food stamp programs. Based on our ongoing work with the State, HCFA believes that the City and State are now moving in the right direction. However, there is more work to be done and we will continue to work with appropriate officials in New York on this issue to ensure that the law is followed.

But this is a different issue. By moving people into managed care, the Partnership Plan will enable more Medicaid beneficiaries to access quality health care services. In fact, the waiver is expected to enroll nearly 400,000 individuals who were previously covered by a State-only program. HCFA's recent agreement with New York on fair hearings ensures that Medicaid managed care enrollees have access to every possible method for maintaining access to treatment and monitoring quality of health care.

Q. What protections will there be in the Partnership Plan for people with AIDS and other special needs?

A. Protecting the needs of special populations has been a special focus of HCFA's negotiation of the fair hearings process with New York. The Partnership Plan waiver requires the State to provide three types of enhanced managed care organizations, known as Special Needs Plans (SNPs), for individuals who are HIV positive or who have AIDS, adults with serious mental illness, and children with serious emotional problems. These populations can enroll in Special

Needs Plans on a voluntary basis until at least April 2001, at the earliest. The State is prohibited from requiring people with special needs to enroll into the SNPs needs plans until the plans have been operating on a voluntary basis for at least one year and HCFA has certified that the SNPs have fulfilled all the requirements under the Partnership Plan Terms and Conditions.

In addition to the exemption policy, there are requirements for monitoring the quality of care delivered to special populations. For example, the State is required to submit a plan detailing how it will collect quality of care data for people with special needs who enroll in Medicaid managed care organizations. The State is further required to ensure that the External Quality Review Organization, which will annually monitor quality in managed care organizations, specifically monitor activities for people with special needs.

Q. Are there any other groups exempted or excluded from participating in Medicaid managed care?

A. Yes. Other groups considered to be exempted are:

- persons for whom a participating managed care organization is not geographically accessible,
- pregnant women already receiving prenatal care from a primary care provider not participating in a Medicaid managed care network,
- Native Americans.

They will have the option of enrolling in managed care organizations, but will not be required to join.

In addition, certain Medicaid populations are excluded because they require specialized care and/or live in institutions. People in these groups will not be given the option to enroll in Medicaid managed care. Some examples of excluded populations are persons who are dually eligible for Medicaid and Medicare, residents of nursing facilities, residents of state-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers.

Q. How can HCFA ensure that the terms and conditions of the waiver will be enforced?

A. HCFA's Regional Office in New York City as well as the Central Office in Baltimore will closely monitor the demonstration to assure that the State adheres to all of the requirements of the waiver and that patient's rights are safeguarded.

If New York State were to be found out of compliance with any aspect of the section 1115 waiver, the Secretary of Health and Human Services has the discretion to require that the State implement a corrective action plan. As part of this process, the Secretary could stop the enrollment of Medicaid beneficiaries into managed care. The Federal government could penalize

the State by withholding funds until the Partnership Plan is brought in line with requirements of the waiver. We do not anticipate problems with New York's waiver.

Q. Isn't managed care inherently bad for people with expensive or long-term illnesses? What is HCFA going to do to make sure people with serious problems get the care they need?

A. In fact, managed care can provide preventive services and a coordinated system of care that many people may never have enjoyed before. And, in addition to the oversight and enforcement that will be done by New York State, HCFA will carefully monitor the progress of this large and complex demonstration project. Before going forward, HCFA will review the managed care organizations that will participate, assure that proper marketing materials and enrollment procedures are in place, and make sure that the special health care needs of individuals can be met.

If HCFA believed that New York State or the City were not ready to manage this transition, we would not allow it to go forward. HCFA received an unprecedented number of inquiries and regular input from advocacy organizations and other interested parties during the discussions about the Partnership Plan. These groups are continuing their involvement. Between HCFA, New York State, and New York City staff, many people will be monitoring the progress of this waiver. We will immediately respond to any concern.

PATIENT RIGHTS AND FAIR HEARING QUESTIONS

Q. Why should vulnerable Medicaid beneficiaries be stuck in a system that denies care and makes them go through an appeals process?

A. HCFA has worked hard with New York State to protect beneficiaries' access and quality of care. For example, as Phase 1 is implemented, Medicaid beneficiaries will have access to a greater number of providers than they did under fee for service. In the event that a beneficiary does not receive the care that they feel they deserve, the waiver has protections regarding notice and appeal rights. These protections are an important part of the President's Patient Bill of Rights. Disclosure of information, choice of providers, access to emergency care, the right to a second opinion on treatment decisions, and the right to a complaints and appeals process are all components of that Bill of Rights. The Administration is committed to ensuring those rights for Medicaid beneficiaries.

Q. What are the requirements of the fair hearing process?

A. The fair hearings process guarantees Medicaid beneficiaries the right to be heard when they believe they have been denied access to proper medical care, or when they believe their benefits have been improperly reduced. Medicaid beneficiaries must be given written notice explaining the reason for any decision to deny, reduce, suspend or terminate services. The right to a hearing also applies when beneficiaries' claims for Medicaid benefits are not acted on promptly. Beneficiaries also retain the right to review evidence and the right to a fair hearing before an impartial decision maker. These rights are crucial for all health care consumers and the Federal government could not allow the Partnership Plan to go forward until the fair hearings policy with New York was firmly established.

Q. Are fair hearing requirements the same in every 1115 waiver demonstration project?

A. No. HCFA works with every State receiving a Medicaid waiver to develop fair hearing requirements based on the State's unique situation and the nature of their demonstration program. In New York, the fair hearing requirements were finalized after many discussions with New York State and City officials and after seeking input from concerned patient advocacy groups, health care providers, consumers, and the general public.

Q. What does this requirement mean for Medicaid beneficiaries enrolled in the Partnership Plan?

A. Medicaid beneficiaries will have the right to request a State fair hearing for denials of service. The State may require that they first exhaust the internal managed care plan grievance process. In addition, beneficiaries may also choose to use the following safeguards prior to requesting an external fair hearing:

- Beneficiaries may complain to the New York State Department of Health at any time.
- Beneficiaries may change primary care physicians without cause twice a year.
- Beneficiaries may receive a second opinion from another physician for the diagnosis of a condition, treatment or proposed surgical procedure.

Q. Will this policy have a significant impact on New York's fair hearing process?

A. We expect that New York will have a strong fair hearing process. New York State has demonstrated that it provided various safeguards in an attempt to resolve issues prior to reaching a fair hearing. Therefore, we believe that New York State will not encounter a significant increase in the number of fair hearings. In the special terms and condition of the waiver the State agreed to implement the fair hearings process and we expect them to follow through on that commitment.

Q. What are the Special Term and Conditions governing fair hearings in New York?

A. The Special Terms and Conditions of the Partnership Plan outline the complaint and appeal procedures for the Partnership Program. This section states, "All beneficiaries must be informed of their right to file complaints, [whether oral or written], appeals, and their right to fair hearings. The State must assure that all managed care plans have approved internal complaint and appeal procedures in place." New York State agreed to these terms and conditions on July 15, 1997.

Q. Why is establishing the fair hearing appeals process so difficult, and how long has HCFA been negotiating this with New York?

A. The Partnership Plan waiver was agreed to by New York State on July 15, 1997. That waiver, as negotiated between HCFA and New York, contained a section establishing the fair hearing rights of Medicaid beneficiaries enrolled in managed care. At the time the waiver was signed, there was clear agreement about the requirement for a fair hearing process. It is true that New York State raised the fair hearing process as an issue earlier this summer. However, they withdrew their objections and are now complying with HCFA's requirements.

HCFA believes the fair hearing policy is essential to ensure beneficiary rights and to provide a course of action when beneficiaries believe that their benefits have been erroneously reduced or denied. In addition, the Partnership Plan requires that New York State hold training sessions for health care providers, managed care plans and administrative law judges to ensure that they are clear about Medicaid beneficiaries' rights to promptly appeal decisions that reduce or deny medical care.

Q. Exactly what patient rights are being mandated by HCFA in New York?

A. HCFA is merely requiring New York to follow the agreement reached with the approval of the Partnership Plan in July of 1997. Under that agreement, New York State agreed to allow beneficiaries fair hearings when a Medicaid managed care enrollee's services are denied, terminated, or reduced. Prior to requesting a fair hearing, the State may first require a beneficiary to exhaust the managed care plan's internal grievance and appeal processes.

New York State agreed that individuals are further protected by other rights, including the right to complain to the New York State Department of Health at any time, to change primary care doctors twice a year for any reason, and to seek a second opinion of their doctor's diagnosis or recommendation for surgery.

Q. What will happen if the State doesn't comply with the terms of the fair hearings set out in HCFA's recent letter?

A. In the event New York was unable to comply with the fair hearing conditions set forth in our letter, HCFA would not have permitted the New York City Partnership Plan to begin enrollment in New York City. If the State was found to be out of compliance with this or any other component of the Section 1115 waiver while the Partnership Plan is in operation, the Secretary of Health and Human Services has the discretion to require that New York State implement a corrective action plan. As part of this process, the Secretary could stop enrollment into Medicaid managed care plans. In addition, the Federal government could penalize the State by withholding funds until the demonstration was brought in line with requirements of the waiver.

New York has a long history of being able to work with HCFA and resolve complicated issues. We are certain that this issue will be worked out as well. HCFA does not anticipate problems with New York's complying with the Partnership Plan waiver agreement as signed in July of 1997.

Q. Did HCFA just make up this fair hearing requirement, as alleged by New York State?

A. No. This requirement has been known for a significant period of time. At the time the waiver was signed in July of 1997, there was clear agreement about the requirement for a fair hearing process.

Q. Can beneficiaries complain to the New York State Department of Health?

A. Beneficiaries can complain to the New York State (NYS) Department of Health at any time. They do not have to wait for the completion of the Medicaid managed care internal grievance and appeal process to file a complaint with the New York State Department of Health. The complaint can be heard by both the managed care plan and the NYS Department of Health on parallel tracks. A decision on the part of either the plan or the NYS Department of Health to deny the service will trigger notification of an adverse action. The managed care plan or State must at this point notify the beneficiary of their right to apply for a Fair Hearing. Information outlining this process will be part of the Member Handbook provided to all Medicaid beneficiaries participating in the Partnership Plan.

Q. What are the implications of New York's Fair Hearings policy on the Department's position on Grijalva?

A. In 1997, New York State and HCFA agreed on a set of Terms and Conditions for approval of the 1115 waiver. These Terms and Conditions include a Fair Hearings policy that New York is required to follow, and we have ensured that New York will abide by those requirements. The policy is based on what was agreed to with New York, and the policy is relevant only to that State. Moreover, when HCFA's final regulation on Medicaid managed care is published, New York will be required to follow the Fair Hearings policy established in that rule.

CDF

Legal Aid

NY Lawyers for the public Interest

FQHC Ass

Jim Tallon; United Hosp

Health Crisis Center

Human Srcs Society

Housing Works

Judy Wexler; Comm for Pub Hosp. minors complaints

Allison Green (RD)

Dennis

Legislators → Giuliani

Antonia Novello

July 1999

Health Insurance Coverage in New York

A BRIEFING PAPER

Prepared by Greater New York Hospital Association

For more information, please contact
Rima Cohen, Vice President for Insurance Options Development, GNYHA

Overview

In spite of a booming economy, the number of uninsured New Yorkers continues to grow at a rapid pace. Over 3 million individuals in the State—19% of the nonelderly population—are currently uninsured, and a staggering 28% of New York City's nonelderly residents have no coverage. While the proportion of uninsured was well below the national average less than a decade ago, New York is now worse off than the nation as a whole by nearly any measure of health coverage. Absent significant policy changes, these trends are expected to continue unabated into the new millennium.

Growth has been particularly sharp in the number of uninsured who earn too much to qualify for Medicaid but too little to afford private coverage. New York began to tackle this problem last year when it expanded the popular Child Health Plus (CHP) program, which subsidizes coverage for uninsured children in low-income, working families. Unfortunately, there is no comparable program for working adults, leaving this group with few options if they cannot afford to purchase insurance on their own. Medicaid is the only statewide, subsidized insurance program for nonelderly adults, but generally only the very poorest qualify for the program. It is therefore not surprising that 75% of the uninsured in New York are between the ages of 18 and 65.

To address this problem, GNYHA and the 1199 National Health and Human Service Employees Union, SEIU developed the Family Health Plus (FHP) proposal. Building on the successful CHP foundation, FHP would use proceeds from New York State's share of tobacco settlement funds to extend subsidized coverage beyond children to uninsured families and single working adults. A broad coalition of organizations has formed to support the proposal, and in June 1999 the New York Assembly overwhelmingly passed FHP legislation. While neither the Senate Majority Leader nor the Governor has spelled out a specific strategy for expanding insurance, they both favor devoting a portion of tobacco settlement funds to health coverage.

For the first time in many years, a consensus appears to be forming around the need to expand affordable health coverage to working families, and supporters of FHP will continue to build on this momentum until this goal is attained.

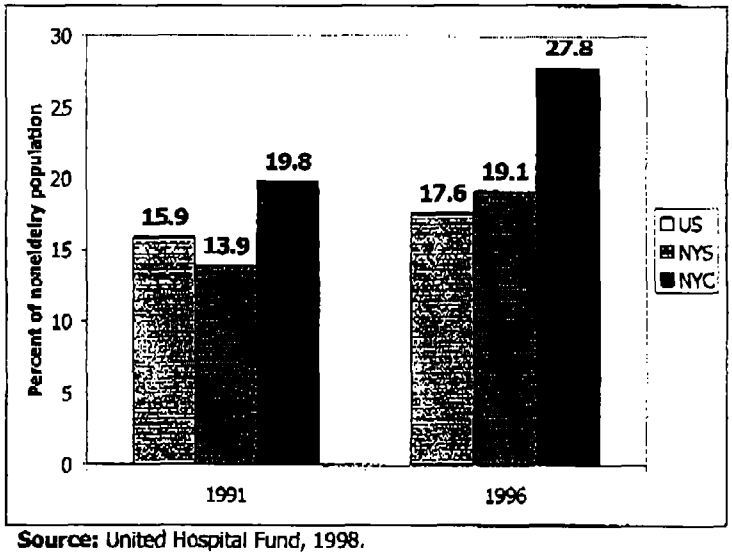
Background on the uninsured in New York

Over the past decade, New York's uninsured rate has grown rapidly. Currently, over 3.1 million New Yorkers—nearly one in five nonelderly residents—are uninsured, and 180,000 more individuals are added to the ranks of the uninsured each year. Absent significant policy changes, this trend is expected to continue into the new millennium.

While the proportion of uninsured has grown across the country, New York's uninsured rate has increased over three times faster than the national average over the past decade. New York entered the 1990s with an uninsured rate lower than the national average, but the proportion of uninsured is now higher and growing faster than in the rest of the nation.

The problem is particularly severe in New York City, where 28% of the nonelderly population is uninsured. As a result, the percentage of uninsured in New York is 50% higher than the national average.

Figure 1
Percent of nonelderly population without health insurance



Source: United Hospital Fund, 1998.

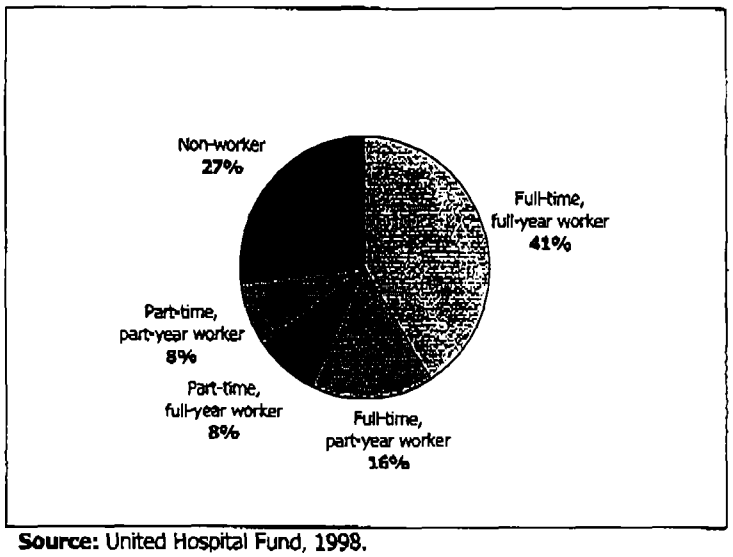
Characteristics of the uninsured

Contrary to common perceptions, the vast majority of the uninsured live in working families; nearly three-fourths of uninsured adults are employed at some point during the year and 40% work full-time, full-year. However, the uninsured also tend to be low-income, with two-thirds living in families that have incomes below 200% of the Federal poverty level (roughly $33,000 per year for a family of four).

Though much attention has been focused lately on uninsured children, 75% of the uninsured in New York are adults, and single childless adults are the group most likely to lack coverage. This situation reflects the long-standing direction of state and Federal policies, which call for much more generous coverage of children through public programs.

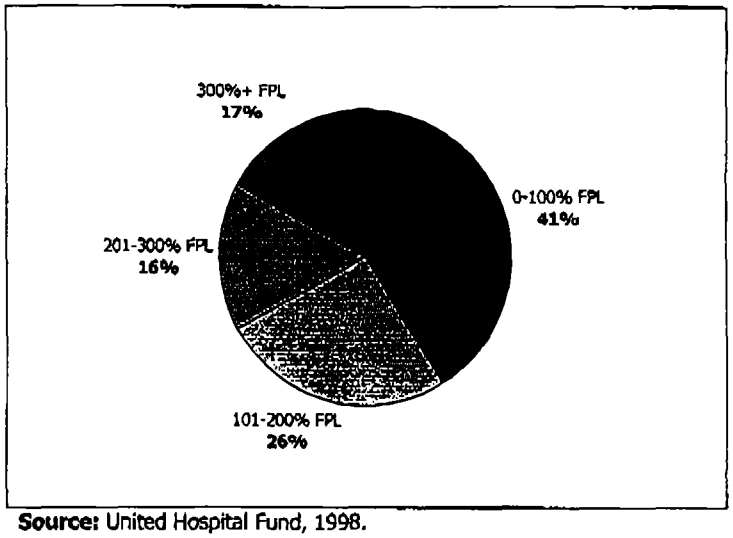
Citizenship status is another predictor of health insurance status. Among non-US citizens, 46% were uninsured in 1996 compared with only 15% of US citizens. Roughly one-third of New York's 3.1 million uninsured are immigrants.

Figure 2
Uninsured persons by employment status



Source: United Hospital Fund, 1998.

Figure 3
Poverty status of nonelderly uninsured



Source: United Hospital Fund, 1998.

Factors contributing to New York's uninsured problem:

Drop in private coverage

Key to the rapid growth in New York's uninsured population is the steady decline over the past decade in private health insurance coverage, both employer-sponsored and individually purchased insurance. From 1991 to 1996, the percentage of nonelderly New Yorkers with private insurance dropped eight percentage points—from 71% to 63%—compared to the national average, which dropped only three percentage points—from 72% to 69%—over the same period.

Research suggests two primary reasons for the decline in employer-sponsored insurance. First, firms that do offer health benefits have been steadily increasing employees' share of premium contributions, making coverage unaffordable for many workers. Second, employment growth in New York has been concentrated in smaller firms that are less likely to offer coverage to their employees. Indeed, workers in the smallest firms (under 25 employees) experienced the sharpest declines in coverage.

Low-income workers without employer-based insurance have few options for obtaining coverage. Medicaid is the only statewide public insurance program for nonelderly adults, but it is available only to the very poorest individuals. To qualify for the program, a parent with two children must earn less than $7,900 per year, and childless adults less than $4,300 per year. New York's private individual market, among the most expensive in the country, is equally inaccessible, with premiums averaging $3,400 per year for individuals and $10,000 for families.

Low participation in existing programs

Another factor contributing to the State's high uninsured rate is the low participation of eligible people in existing public insurance programs. Over 800,000 individuals—one-fourth of the uninsured population—are eligible for Medicaid or Child Health Plus but have not signed up for these programs. Often, these individuals fail to enroll because they are not aware they are eligible or they find the application process confusing and difficult.

Another likely cause of this low participation is the 1996 welfare reform law, which delinked Medicaid from cash assistance. Historically, welfare has been the main avenue to Medicaid eligibility; anyone eligible for welfare automatically received Medicaid. As a result of welfare reform, however, many former welfare recipients mistakenly think they are no longer eligible for medical assistance or simply fail to apply for health benefits in the first place. In only three years, from 1995 to 1998, Medicaid enrollment dropped by 300,000 people, a trend that is likely due in large part to the implementation of welfare reform.

New York's subsidized health insurance programs

New York State has a long-standing tradition of support for the health care of vulnerable populations. The State's two largest public health insurance programs for nonelderly residents—Medicaid and Child Health Plus (CHP)—provide comprehensive benefits, and recent eligibility expansions in these programs ensure relatively generous coverage for children. However, there has still been a net increase in New York's uninsured because these programs have failed to keep pace with both the decline in private coverage in the State and the recent increase in the number of eligible individuals losing Medicaid coverage. Following is a brief description of the major programs providing subsidized health coverage in New York.

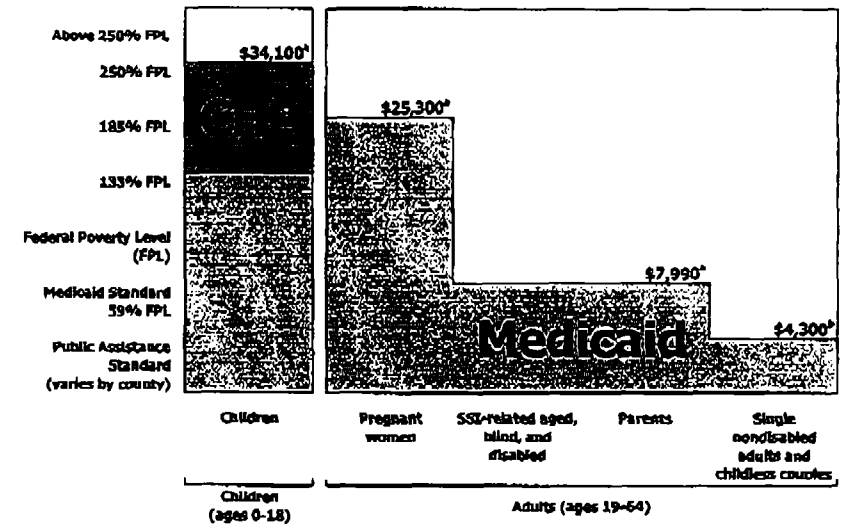
Medicaid

With over 2.5 million enrollees, New York's Medicaid program is one of the largest in the country. The program offers comprehensive health benefits at no cost to individuals, with eligibility capped at roughly 54% of the poverty level for adults without dependent children, 87% for parents with dependent children, 185% for pregnant women, and 133% for children. While the benefits are generous, the low eligibility threshold for most adults makes the program accessible only to the poorest of the poor. In addition, a complex and confusing application process serves to deter enrollment of those who are eligible for the program. The delinking of Medicaid and cash assistance, as described earlier, has exacerbated this problem.

Child Health Plus

Child Health Plus is the largest non-Medicaid, publicly funded children's health insurance program in the country. CHP offers comprehensive, subsidized, private coverage to uninsured children in families earning less than 250% of the poverty level, with premium contributions determined on a sliding scale basis. Over 300,000 children are currently enrolled in the program and thousands more are signing up for CHP each month. The Federal Title XXI program finances 65% of CHP's budget and the State pays the remaining 35% share.

Figure 4
Eligibility levels for New York's public insurance programs



Notes: Income levels shown above are gross income for CHP and net income for Medicaid.
* Based on 1998 Health and Human Service poverty guidelines for three-person families.
* Based on 1998 Health and Human Service poverty guidelines for single adults.

Health insurance demonstration programs:

New York State also operates a number of small-scale health insurance subsidy programs for businesses and individuals. Overall, these initiatives have had only a minimal effect on the number of uninsured. However, the lessons learned from these programs can be useful in shaping future proposals to expand coverage.

New York State Partnership Program

The New York State Health Insurance Partnership Program (NYSHIPP) offers subsidies to small employers to cover 45% of a group health plan. The program is funded at $6 million per year and has enrolled just over 1,000 businesses (as of August 1998), with an average of two to three employees per firm. While NYSHIPP has a waiting list of firms interested in participating, this may be a function of the very limited available funds. The program has not been thoroughly evaluated, but similar programs in other states suggest that even generous subsidies fail to induce large numbers of businesses to offer coverage.

Regional Pilot Project

Through the $6 million Regional Pilot Project (RPP), the State subsidizes individuals and families for the purchase of private coverage from a limited selection of managed care plans. The program is similar to Child Health Plus, where families contribute to the cost of their coverage on a sliding scale, but unlike CHP, entire families and childless adults can participate. The program appears to be relatively successful at enrolling uninsured families, though it has not yet been thoroughly evaluated.

New York City demonstration programs

Over the past year, the New York City government has implemented two demonstration programs designed to expand or improve the quality of employer-provided health insurance: the New York Health Purchasing Alliance (NYHPA) and the Small Business Health Insurance Demonstration (SBHI).

NYHPA was started with a $1 million grant from the City that provided seed money to establish a small business health insurance purchasing alliance for the more than 200,000 small businesses across the City. The Alliance contracts with a variety of commercial managed care plans to provide employees of participating firms with a choice of plans that offer the same standard set of benefits. Employees benefit from a broad selection of insurers, while employers enjoy reduced administrative costs. Enrollment in NYHPA is expected to begin this year.

Also targeted at small employers is SBHI, a collaborative effort of the New York City Health and Hospitals Corporation (HHC) and the Group Health Incorporated (GHI) insurance company. Under the program, GHI provides very low-cost, comprehensive health insurance coverage to uninsured businesses. GHI reduces its costs by restricting patients to only HHC providers and by negotiating deep discounts with these facilities. The program has recently started enrolling businesses and currently covers 250 individuals.

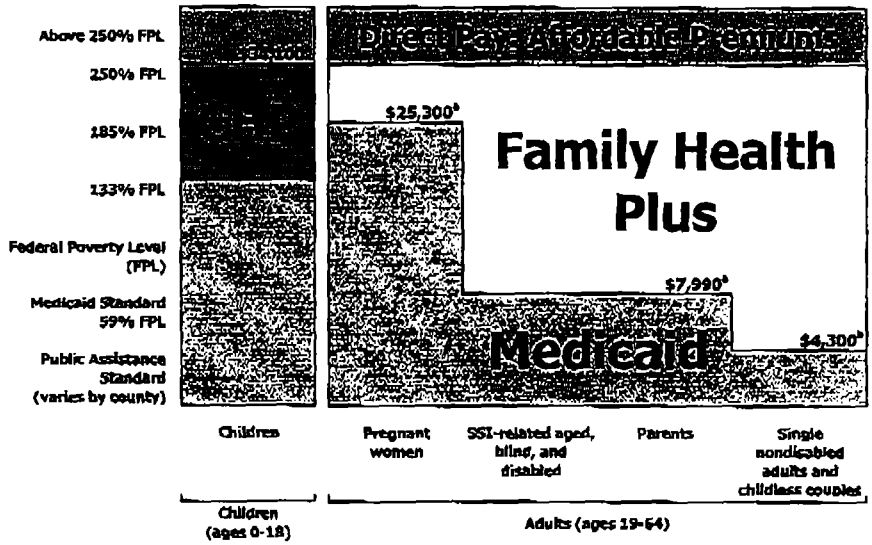
Family Health Plus

CHP for adults

To address the dearth of insurance options for working families without access to affordable employer-based coverage, GNYHA and 1199/SEIU jointly developed Family Health Plus (FHP), a proposal to make affordable health insurance available to New York's working families and individuals.

FHP builds on the successful foundation that Child Health Plus (CHP) now provides to children, extending subsidized, private insurance to the uninsured parents of CHP children and other working adults who do not qualify for Medicaid or Medicare. A separate provision of the proposal, targeted to those who can afford to purchase reasonably priced coverage, establishes a pool to lower premiums in the individual insurance market.

Figure 5
FHP proposal



Note: Income levels shown above are gross income for CHP and net income for Medicaid.
[a] Based on 1998 Health and Human Service poverty guidelines for three-person families.
[b] Based on 1998 Health and Human Service poverty guidelines for single adults.

Many aspects of FHP mirror the CHP program. For example, eligibility for FHP, like CHP, would be set at 250% of the poverty level; FHP's benefits and premium subsidies are based on CHP's benefit package and premium schedule; and, to the extent possible, health plans participating in FHP would also offer CHP and Medicaid coverage.

Simplification of New York's insurance programs

FHP would be coordinated with CHP and Medicaid to keep families in the same health plans and ensure seamless transitions between the programs. To advance this goal and to eliminate the barriers to enrollment in existing public programs, the FHP proposal calls for a simplified, uniform application process for all of New York's health insurance programs, and vigorous outreach and other measures to maximize family enrollment in the programs for which they are eligible.

Together, these proposals would reduce the administrative complexity of enrolling in public programs and guarantee access to affordable health coverage for all working New Yorkers with an income under 250% of the poverty level, regardless of age or family status.

FHP funding

Funding for FHP would include a portion of the proceeds from New York's $1 billion share of the national tobacco settlement and Federal funds available through a provision of the Federal welfare reform law allowing states to expand health coverage to working families.

Outlook for FHP passage

FHP got a boost earlier this year when GNYHA and 1199/SEIU joined with the New York State Health Care Campaign, a coalition of 75 health care and consumer groups, to push for passage of the bill. With the encouragement of this broad-based coalition, the Assembly included a version of the GNYHA/1199 FHP proposal in its "HCRA 2000" bill reauthorizing New York's expiring Health Care Reform Act. The Assembly's version of FHP is very similar to the GNYHA proposal, though its eligibility is more limited (200% of the poverty level for parents and 120% of poverty for childless adults). This FHP plan passed the Assembly with overwhelming support in June 1999.

Neither Senate Majority Leader Joseph Bruno nor Governor George Pataki has released a proposal to expand health insurance coverage in New York. However, both have stated their support for using some portion of tobacco proceeds for health care, and Senator Bruno is currently developing his own health coverage expansion bill that will be funded by tobacco settlement proceeds.

While obstacles to final enactment of a family health insurance program remain, the outlook for a coverage expansion is more positive than it has been in decades, and GNYHA/1199 will be mounting a vigorous campaign in the coming months in support of FHP. Passage of this proposal would once again make New York a model for the rest of the nation when it comes to serving the health care needs of vulnerable populations.

Facts about the uninsured in New York, 1996	
	▫ **19.1% of New York State's nonelderly population is uninsured, compared with 17.6% for the rest of the country.**
New York City	▫ Nearly 28% of New York City residents are uninsured compared with 13% of other New York State residents.
	▫ New York City has 41% of the State's population and 60% of the uninsured.
Poverty	▫ More than two-thirds of the nonelderly uninsured live in families with incomes below 200% of the poverty level.
Age	▫ Nearly one-third of nonelderly single adults are uninsured.
	▫ Despite expansions in insurance programs for children, 15% of all children are uninsured.
Employment	▫ Full-time, full-year workers account for nearly 40% of the uninsured.
	▫ Nearly three-fourths of the uninsured were employed during the year.
Private coverage	▫ Private coverage among workers declined by 6.3 percentage points between 1990 and 1996.
Citizenship	▫ Nearly one-third of the uninsured are not US citizens.

Source: United Hospital Fund, 1998.

Statistics on the uninsured in New York, 1996

Uninsured by percentage (nonelderly)

United States	17.6%
New York State	19.1%
New York City	27.8%

Uninsured by number (nonelderly)

United States	41.3 million
New York State	3.1 million
New York City	1.8 million

Uninsured by employment status

Worked at some point during year	73%
Unemployed	27%
Worked full-time, full-year	41%

Percent distribution of the uninsured in various groups:

Uninsured by poverty status (by % FPL)

0-100	41%
101-200	26%
201-300	16%
301+	17%
Total	**100%**

Uninsured by age group

0-18	25%
19-64	75%
Total	**100%**

Uninsured by citizenship status

US citizen	68%
Non-US citizen	32%
Total	**100%**

Source: United Hospital Fund, 1998.

The Administrator
Washington, D.C. 20201

MAY 5 1999

TO: The Deputy Secretary
Through: COS _____
ES _____

FROM: Administrator
Health Care Financing Administration

SUBJECT: Roll-Out of Managed Care Enrollment in New York City under the Section 1115 Waiver -- INFORMATION

As you know, the Health Care Financing Administration (HCFA) has been working with the Department for the past several months to develop a letter to the State of New York regarding a requirement under the waiver that Medicaid beneficaries must be able to participate in an external fair hearings process. Per your conversation with Mike Hash yesterday, I have attached for your review what we believe is the final draft of this letter -- known as the Whalen letter. All Department comments that have been provided to HCFA have been incorporated into the attached draft. Compliance with the requirements outlined in the Whalen letter is the final, major step needed prior to New York exercising its waiver authority and initiating mandatory managed care enrollment for Medicaid beneficiaries in New York City. As you know, the State has already begun to phase-in mandatory managed care enrollment in several counties in up-state New York.

It is HCFA's intention to mail simultaneously the State the Whalen letter and a second letter known as the "green light" letter. This second letter will inform the State that it may begin the process of mandatory managed care enrollment in New York City following our acknowledgment that the State has agreed to all the conditions listed in the "green light" letter. The "green light" letter will contain approximately 20 conditions in all; with the exception of the fair hearings requierment, we believe that these other requierments are not controversial and are technical in nature. HCFA will recommend that there should be a low key roll-out of both the Whalen letter and the "green-light" letter. However, we are also considering the possibility that the letter acknowledging the State's acceptance of the conditions listed in the "green light" letter warrant a larger roll-out.

99-0328

We intend to be prepared to roll-out these letters early next week. Prior to the roll-out, we will provide you complete package of the roll-out materials. This will include five documents:

1) Roll-Out Plan with Press Strategy,
2) Question and Answers (new and improved from the earlier draft),
3) Fact Sheet,
4) The final draft of the Whalen letter, and
5) The "Green Light" Letter with Plain English Cover Note.

It is our hope to be able to provide the above documents by COB Thursday --COB Friday at the latest. We will not roll this policy out until receiving clear guidance from your office that we may proceed. HCFA is eager to roll-out these letters due to the fact that the State wants to begin managed care enrollment in New York City in June.

If you have any questions or would like discuss our approach, please feel free to contact me or Mike Hash at your convenience.

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Dennis P. Whalen
Executive Deputy Commissioner
State of New York Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Mr. Whalen:

I am responding to your letter to Nancy-Ann Min DeParle regarding implementation of the terms and conditions of New York's section 1115 waiver, the Partnership Plan. Specifically, you are concerned about our position that enrollees in Medicaid managed care plans have the right to a fair hearing when requested services are denied.

First, we would like to recognize the State for the Partnership Plan. The State has effectively dealt with many difficult issues in implementing the Partnership Plan in the 12 upstate counties and preparing to implement Phase I of New York City. We want to do everything possible to continue the momentum toward full implementation.

We recognize the unique and complicated circumstances involving the implementation of Phase I in New York City. We are concerned, however, with protecting Medicaid beneficiaries' rights to the State fair hearings process, particularly in light of the structural complexity of the program and the large number of beneficiaries to be served. To that end, as a condition of the State's section 1115 demonstration, the State and HCFA agreed that New York must allow a service denial to be eventually subject to the State fair hearing process. In relevant part, Section III.E.3.a.* of the Special Terms and Conditions (STCs) states that *"All beneficiaries must be informed of their right to file complaints, whether oral or written, appeals, and State Fair Hearings. The State must assure that all MCOs have approved internal complaint and appeal procedures in place and that these, along with LDSS-and State-level complaint and appeal processes, are in accordance with Federal regulations on grievance procedures at 42 CFR 434.32 and with Federal Regulations on Fair Hearings at 42 CFR 431, Subpart E."*

[redacted]

This requirement of the terms and conditions was first discussed with the State in April 1996. In fact, a workgroup consisting of Federal and State officials from HCFA's Central Office, New York Regional Office and the New York State Department of Health (DOH) was formed to discuss fair hearings policy. As a result, the term and condition that allows service denials to be subject to the State fair hearing process was adopted by the State and ultimately included in the final set of terms and conditions dated July 15, 1997. State officials confirmed this understanding during the initial 1115 readiness review on September 16, 1997. HCFA clarified the policy again in a conference call on November 25, 1998. As you know, the Partnership Plan was approved for implementation on October 1, 1997 based, in part, on the fact that enrollees in Medicaid managed care plans have such a right to a fair hearing.

As we have discussed with you, New York may require the beneficiary to exhaust the internal MCO grievance and appeal process prior to requesting an external State fair hearing. We note that, during our site visit for the "1115 New York City Readiness Review" conducted with officials from both New York City and the State, the MCOs' understanding of State policy was that beneficiaries could use the internal MCO grievance process to appeal a denial of service and then proceed to a State fair hearing based on the outcome of the MCO's decision.

Based on your most recent letter, we are concerned that the State would now like to implement a policy that differs from our previous agreement. We do not agree that any change is warranted. Applying the fair hearing policy to the Partnership Plan will not place an undue burden on the State fair hearing process. Currently, New York resolves managed care-related fair hearings in a timely manner, and there are mechanisms in place to resolve issues prior to reaching the fair hearing stage. Beneficiaries may be required to use the internal MCO grievance process prior to using the State fair hearing process. In addition, beneficiaries may complain to the New York State Department of Health at any time, change primary care physicians without cause twice a year, and receive a second opinion from another physician for the diagnosis of a condition, treatment or surgical procedure.

We believe this policy is an efficient use of administrative resources and preserves the rights of Medicaid beneficiaries to proceed to a State fair hearing. As you know, we are in the process of issuing additional instruction on the application of the fair hearing process in managed care. When HCFA issues formal instruction on Medicaid fair hearing rights, all States will need to comply with that instruction and New York will have to amend The Partnership Plan policies to conform with the most recent HCFA policy on fair hearings. I look forward to working with you on this critical project. If

you have any additional concerns on this issue, please contact Mike Fiore of my staff on (410) 786-0623.

Sincerely,

Sally K. Richardson
Director

cc: Ellen Anderson

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE: Devocah **PHONE:** _____	**FROM:** Peter **OFFICE OF THE ADMINISTRATOR** **200 INDEPENDENCE AVE., S.W.** **ROOM 314G** **WASHINGTON, DC 20201** **PHONE: 202-690-6726** **FAX : 202-690-6262**

TOTAL PAGES:	**ADDRESSEE'S FAX MACHINE NUMBER:**	**DATE:**

REMARKS:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration
Washington D.C. 20201 – 0001

HCFA FACT SHEET

FOR IMMEDIATE RELEASE
July 30, 1999

Contact: HCFA Press Office
(202) 690-6145

Managed Care and Medicaid
New York State's Partnership Plan

Overview: On July 30, 1999, the Health Care Financing Administration (HCFA) sent a letter informing the state of New York that it could begin enrolling Medicaid beneficiaries in mandatory managed care in Staten Island, lower Manhattan and parts of Brooklyn. This approval is part of a New York State Medicaid Section 1115 waiver, called the Partnership Plan, that was first approved in July 1997 and has been implemented in various upstate counties since then. HCFA's recent letter to New York confirms that the state has met the conditions of approval required prior to enrolling Medicaid beneficiaries in managed care.

Due to the complexity of the project, the state suggested that there be five separate phase-in areas of the waiver in New York City. The area selected for Phase 1 is Staten Island, lower Manhattan, and parts of Brooklyn. Further expansion of the waiver is contingent on the successful implementation of Phase 1 and on the state's compliance with all terms and conditions in carrying out Phase 1 and in preparing for Phase 2. The area proposed for Phase 2 is Northeast Queens and the North Bronx. However, HCFA has only approved implementation of Phase 1, and there are currently no specific time frames for expanding the waiver beyond this initial area of New York City.

The Social Security Act permits the Secretary of Health and Human Services discretion in waiving certain aspects of the Act in order to conduct research and demonstration projects. These demonstrations are frequently aimed at redesigning a state's health system to better serve greater numbers of Medicaid beneficiaries while reducing costs through the use of various mechanisms, such as managed care. The Partnership Plan is one such demonstration. The state has effectively dealt with many difficult issues both in implementing the Partnership Plan in twelve upstate counties and in preparing to implement Phase 1 in the selected area of the city.

The Partnership Plan. On March 20, 1995, New York State submitted a section 1115 waiver application that would permit Federal financial participation in a demonstration called the Partnership Plan. The state proposed to move over two million currently eligible individuals and approximately 370,000 "safety net" (Home Relief) recipients into managed care. When the Partnership Plan is completely implemented, about 85 percent of New York State's Medicaid enrollees will be in managed care.

- more -

Today's action will allow the state to begin enrolling Medicaid beneficiaries into managed care in Staten Island, lower Manhattan, and parts of Brooklyn. The state is required to submit ongoing monitoring and oversight items to HCFA within ninety days of commencement of mandatory enrollment.

The New York State Proposal. The New York State Partnership Plan proposal incorporates four broad initiatives:

(1) The transition of the state's acute care program from fee-for-service to managed care;
(2) The conversion of approximately 370,000 residents covered by the state's "safety net" program to Medicaid beneficiaries covered by a federal entitlement program;
(3) The development of Special Needs Plans (SNPs) to serve: people who are HIV-positive or who have AIDS; adults who are seriously and persistently mentally ill; and children with serious emotional disturbances; and
(4) The creation of a $1.2 billion fund to assist hospitals in moving to managed care. These funds help cover both retraining staff and establishing or expanding neighborhood-based clinics and health centers. This transition initiative will be funded by redirecting a portion of the state's Medicaid allotment for hospitals that treat a significant percentage of indigent or uninsured patients.

Delivery system. Counties in New York State will obtain contracts with managed care organizations. In order for a county to be permitted to implement the Partnership Plan, it must offer its Medicaid population a choice of at least two managed care organizations. Partially capitated plans will be utilized to ensure access to care in areas of the state that do not have sufficient managed care capacity. Managed care organizations will be encouraged to establish network arrangements with traditional providers, such as Federally Qualified Health Centers, school-based health centers, and Ryan White CARE Act providers.

Conditions. Before Phase 1 enrollment began in New York City, the state fulfilled the conditions of approval. The following three principal conditions identified in HCFA's May 26, 1999 letter to the state have been met:

- The New York State Department of Health provided a detailed interim quality monitoring plan for early evaluation of the quality of care provided to Medicaid beneficiaries
- The New York State Department of Health provided a detailed Statewide Quality Assurance Monitoring Plan, which included a subset specifically for New York City. [Both monitoring plans pay particular attention to vulnerable, at-risk populations such as people with diabetes, AIDS, asthma or hemophilia.]
- New York State submitted the final Partnership Plan Operational Protocol -- the rules that govern the functions of the waiver. This protocol included the state's fair hearing policy for people who believe that they have not received the care or service that they needed.

Phase-In Process. Due to the complexity of the project, the state suggested that there be five separate phase-in areas of the waiver in New York City. The area selected for Phase 1 is Staten Island, lower Manhattan, and parts of Brooklyn. Further expansion of the waiver is contingent on the successful implementation of Phase 1 and on the state's compliance with all terms and conditions in carrying out Phase 1 and in preparing for Phase 2. The area proposed for Phase 2 is Northeast Queens and the North Bronx. However, HCFA has only approved implementation of Phase 1, and there are currently no specific time frames for expanding the waiver beyond this initial area of New York City.

Benefits. Medicaid managed care enrollees will be entitled to the same benefits that are available under Medicaid fee-for-service. Medicaid beneficiaries will receive a comprehensive benefits package through their managed care organization but certain services (e.g., long-term care services and prescription medicines) will continue to be provided on a fee-for-service basis.

Eligibility and enrollment. Most Medicaid-eligible New York residents eventually will be required to enroll in managed care. Enrollment will be phased in county by county or, in the case of New York City, zip code by zip code.

Exempted and excluded populations. Some Medicaid beneficiaries are exempted or excluded from the Partnership Plan. Exempted populations will have the option to enroll in managed care organizations but will not be required to enroll. Those exempted include: people with HIV/AIDS, people who are seriously and persistently mentally ill, people for whom a managed care provider is not geographically accessible, pregnant women already receiving prenatal care from a non-participating primary care provider, and Native Americans. Some of these populations (such as those living with HIV/AIDS or suffering from mental illness) could, within the next several years, be required to participate in managed care through Special Needs Plans. This could only occur after a series of milestones designed to protect these beneficiaries are fulfilled.

Because some patients need specialized care and/or live in institutions, they will be excluded from the option to enroll in managed care organizations. Some examples of excluded populations are: people who are dually eligible for Medicaid and Medicare, residents of nursing facilities, residents of state-operated psychiatric facilities, and Medicaid-eligible infants living with incarcerated mothers. Medicaid beneficiaries in these excluded groups represent approximately 15 percent of the state's Medicaid eligibles.

Community input and listening to providers. Since signing the Partnership Plan waiver in July of 1997, HCFA and New York State have been conducting many efforts to ensure a smooth transition to Medicaid managed care in New York State.

Quarterly public meetings are conducted at which community groups, healthcare providers, and the general public can provide comments about managed care to HCFA, New York State and City officials. Meetings are also held with health advocacy workgroups every 4-6 weeks to discuss access and quality of care issues. HCFA has elicited opinions and concerns regarding the waiver from the community, the providers, and the advocates, gaining significant input and information through these activities. This partnership with these groups has helped -- and will continue to help -- shape the policies and procedures of the Partnership Plan.

HCFA will continue to solicit advice and input from the community, the providers, and the advocacy groups about all aspects of the waiver. When specific and documented concerns are raised, HCFA will respond to those concerns and work toward their resolution.

Current status. On July 15, 1997, HCFA approved the state's 1115 waiver application and issued Special Terms and Conditions for program implementation. The first five New York counties began implementation of Medicaid managed care on October 6, 1997. As of April 1999, twelve counties have begun to implement the waiver. These counties are: Albany, Broome, Columbia, Erie, Greene, Monroe, Niagara, Onondaga, Ontario, Rensselaer, Saratoga and Oswego. Schnectady County is scheduled to implement the plan on September 1, 1999.

On May 26, 1999, HCFA granted conditional approval to implement the Partnership Plan in Phase 1 of New York City. On June 11, 1999, the state indicated acceptance of our conditional approval. Subsequently, all required documentation was submitted by the state and approved by HCFA. Upon receipt of the letter of approval HCFA is sending today, the state will initiate the process of getting notice to Phase 1 Medicaid beneficiaries about the transition to Medicaid managed care.

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Health Care Financin Administration

Center for Medicaid and State Operations
Family and Children's Health Programs Group
7500 Security Boulevard
Baltimore, MD 21244-1850

JUL 30 1999

Ms. Ellen Anderson
Director, Office of Managed Care
New York State Department of Health
Empire State Plaza
Corning Tower, Room 2001
Albany, NY 12237

Dear Ms. Anderson:

On behalf of the Health Care Financing Administration (HCFA), I am pleased to notify you that the State of New York has met the conditions of approval in our correspondence of May 26, 1999. Therefore, New York City may begin the process of enrolling Medicaid beneficiaries in mandatory managed care plans under your Section 1115 waiver, the Partnership Plan, in Phase I of New York City (Staten Island, lower Manhattan, parts of Brooklyn) on August 1, 1999.

Our goal is to increase access, quality, and coordination of care for the Medicaid beneficiaries in New York. As you know, the Social Security Act (the Act) permits the Secretary of Health and Human Services discretion in waiving certain aspects of the Act in order to conduct experimental demonstration projects. These demonstrations are frequently intended to restructure a State's health system and reduce costs through the use of various mechanisms, such as managed care, while providing high quality care to greater numbers of Medicaid beneficiaries. The Partnership Plan is one of these demonstrations. This approval is part of the waiver that was first approved in July 1997 and has been implemented in various upstate counties over the past two years.

HCFA's approval to implement mandatory Medicaid managed care in New York City is only for the area designated as Phase I (Staten Island, lower Manhattan, and parts of Brooklyn). HCFA has not provided conditional or final approval to move forward with implementation of the waiver in any areas of New York City beyond those designated in Phase I for the City. This implementation approval for parts of New York City is based on State and City submission of required materials, and subsequent approval of the conditions set forth in the May 26, 1999, attachment Sections I A&B. It is also based on the State's agreement to fulfill the requirements regarding fair hearings as specified in our letter dated May 21, 1999.

Under the conditions of the State's waiver, the New York State Department of Health (SDOH) is the principal administrator of the Partnership Plan. If the State chooses, it may delegate the administration and monitoring of aspects of this demonstration to the New York City Department of Health (CDOH). However, the State will still be held ultimately accountable for the administration and monitoring of all aspects of the Partnership Plan. In addition, the State remains obligated to comply with Section II of the Attachment of the May 26, 1999 letter.

Upon receipt and acceptance of this letter by the SDOH, in accordance with the section 1115 waiver terms and conditions, Attachment J, item 6, eligible hospitals will receive an additional 15 percent of the Community Health Care Conversion Demonstration Project (CHCCDP) funds. The remaining 70 percent of the CHCCDP funds become available to hospitals when the State sends notices of mandatory enrollment to eligible Medicaid beneficiaries in New York City. It is our understanding that the State intends to send notices to Medicaid beneficiaries on August 9, 1999, provided that everything is in order with the contractor.

Additionally, the State agrees to send notices of the Medicaid supplemental payment rate calculation to Federally Qualified Health Centers (FQHC) upon receipt of this letter as per the methodology outlined in our June 4, 1999, correspondence.

We appreciate the State's assistance in providing information throughout this process. We believe that the State and City Departments of Health have sufficiently documented adequate managed care capacity in the Phase I areas of New York City and have an adequate staffing plan to implement managed care on a mandatory basis. HCFA staff remain committed to working with you to implement the Partnership Plan. All correspondence should be directed to:

Lori P. Maatta
Health Care Financing Administration
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

and

Michael J. Melendez
Health Care Financing Administration
Division of Medicaid and State Operations
26 Federal Plaza, Room 3800
New York, NY 10278

Following final approval of each phase of the waiver's implementation in New York City, HCFA will continue to monitor SDOH and CDOH progress toward compliance on an ongoing basis with the required conditions.

I wish you continued success on this project and look forward to working with you as it progresses. In the event that you have any questions regarding the above conditions, please call Lori Maatta at (410) 786-7711 or Michael Melendez, HCFA NY Regional Office, at (212) 264-9121.

Sincerely,

Richard Fenton

for David S. Cade
Director

TOTAL P.04

TOTAL P.08