

PUBLIC NOTICE

The Department of Health is proposing to modify its two 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, as part of a major redesign of New York State's Medicaid program. Changes affecting the State's waiver programs are intended to streamline and maximize enrollment in managed care programs, simplify the program, improve quality of care and reduce costs.

Changes are effective on or after April 1, 2011, as indicated.

A. Expand Medicaid Managed Care Enrollment of Non-duals

The State is proposing to amend its federal Social Security Act Section 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, to expand enrollment in Medicaid managed care programs by requiring some of the populations previously exempt or excluded to enroll in a managed care organization (MCO). Enrollment of the new populations will be phased in over three years beginning July 2011.

Beginning 7/1/11, the following individuals will be required to enroll in a managed care plan:

- Individuals in the Recipient Restriction Program

Beginning 10/1/11, the following individuals will be required to enroll in a managed care plan:

- Individuals who have a relationship with a primary care provider not participating in any MCOs
- Individuals living with HIV (outside of New York City)
- Individuals without a choice of primary care provider within 30 miles or 30 minutes
- Non-SSI adults diagnosed as seriously and persistently mentally ill and non-SSI children diagnosed as severely emotionally disturbed
- Individuals temporarily living outside of their home district
- Pregnant women whose prenatal provider does not participate in any MCOs
- Persons receiving Mental Health Family Care
- Individuals who cannot be served by a managed care provider due to a language barrier.

Beginning 10/1/11, the following exemption from enrollment will be limited to 6 months or the completion of a course of treatment, whichever occurs first:

- Individuals with chronic medical issues under the care of a specialist provider not participating in any MCOs

Beginning 4/1/12, the following individuals will be required to enroll in a managed care plan:

- Individuals enrolled in the Long Term Home Health Care Program (LTHHCP) where capacity exists will have the option to opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program
- Individuals with characteristics and needs similar to those in the LTHHCP
- Individuals with end stage renal disease
- Individuals receiving services through the Chronic Illness Demonstration Program
- Homeless persons
- Infants under 6 months of age who were born weighing under 1200 grams or are disabled
- Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY) programs

Beginning 10/1/12

- Residents of residential health care facilities (nursing homes)

Beginning 4/1/13, the following individuals will be required to enroll in a managed care plan providing program features are in place:

- Residents of an intermediate care facility for the mentally retarded or developmentally disabled (ICF/MR or ICF/DD)
- Individuals with characteristics and needs similar to residents of an ICF/MR
- Individuals receiving services through the Nursing Home Diversion and Transition waiver
- Residents of Long Term Chemical Dependence programs
- Children enrolled in the Bridges to Health (B2H) foster care waiver program
- Non-institutionalized foster care children living in the community
- Individuals receiving services through a Medicaid Home and Community-based Services Waiver (these individuals may enroll while remaining in the waiver program)
- Individuals with characteristics and needs similar to those receiving services through a Medicaid Home and Community-based Services waiver
- Individuals receiving services through a Medicaid Model Waiver waiver (Care at Home) Program (these individuals may enroll while remaining in the waiver program)
- Individuals with characteristics and needs similar to those receiving services through a Medicaid Model Waiver (Care at Home) Program
- Individuals eligible through the Medicaid Buy-In for the Working Disabled (those who pay a premium and those who pay no premium)
- Residents of State-operated psychiatric centers
- Blind or disabled children living separate and apart from their parents for 30 days or more
- Institutional foster care children

B. Streamline the Enrollment Process

Effective on or after 10/1/2011, the State proposes to streamline the enrollment process by standardizing the period during which all beneficiaries may select a plan. New applicants will be required to indicate their choice of plan at the time of application for Medical Assistance (MA), and if they do not choose a plan, they will be auto-assigned to a plan using the existing process. Persons already in receipt of MA will have 30 days from the day the local district or State indicates to choose a plan. If they do not choose a plan within that 30 day window, they will be auto-assigned to a plan. Pregnant women will be required to choose a plan when they apply for presumptive eligibility and will be auto-assigned after 30 days if they fail to do so.

C. Pharmacy “Carve-in” and Other Benefit Changes

Effective on or after 10/1/2011, pharmacy services will be included in the Medicaid managed care and FHPlus benefit packages. For Medicaid managed care only, personal care agency services will become the responsibility of Medicaid managed care plans effective 7/1/2011, and effective 10/1/2012, nursing facility care will be included in the benefit package.

D. Mandatory Enrollment of Medicaid Eligibles in Managed Long Term Care

Effective April 1, 2012 the State will require the transition and enrollment of people who meet the following criteria into Managed Long Term Care (MLTC) plans or other care coordination models approved by the Commissioner of Health: age 21 and older; eligible for Medicare and Medicaid; and, in need of community-based long term care services for more than 120 days. Non-dually eligible disabled adults who meet these criteria will have the option of joining a MLTCP in lieu of an MMC plan. Three MLTC models now operate in New York – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. Partially capitated plans are expected to be the primary type of plan these individuals will enroll in because there is no requirement for concurrent Medicare enrollment. However, where available and when additional plan-specific enrollment criteria are met, people will have an option to select PACE or MAP as well.

Mandatory enrollment will begin in New York City and be phased-in throughout the rest of the State as plan capacity is developed. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office People with Developmental Disabilities would be exempted from mandatory enrollment in a MLTC program until the State develops appropriate program features for these populations.

Additional information concerning the Partnership Plan and the proposal can be obtained by writing to:

New York State Department of Health
Division of Managed Care
Bureau of Program Planning and Implementation

Empire State Plaza
Corning Tower, Rm. 1927
Albany, New York 12237

1115 waiver information is also available to the public on-line at www.nyhealth.gov
Written comments concerning extension of the program will be accepted at the above
address for a period of thirty (30) days from the date of this notice.