

1. ORGANIZATION AND ADMINISTRATION

This chapter describes the organizational structure for the oversight, administration, and coordination among the various agencies involved in implementation of The Partnership Plan. The chapter begins with a brief overview of the State's approach to implementing managed care followed by a more complete discussion of the responsibilities of the agencies involved.

Background

Under the Statewide Managed Care Act of 1991 (amended in 1996), local Departments of Social Services (LDSSs) were directed to develop Medicaid managed care programs that would result in the enrollment of 50% of their population over a five-year period. In response to the 1991 legislation, 43 of the state's 58 local districts developed voluntary managed care programs. At the time The Partnership Plan was implemented, two mandatory Medicaid managed care programs had been successfully implemented, one in a ten-zip-code region of Brooklyn, and the other in Westchester County. Through these efforts, over 650,000 Medicaid recipients were enrolled in managed care.

The 1996 legislation amending the Act required all counties to participate in a statewide voluntary managed care program and authorized a statewide mandatory program pursuant to federal approval. Counties with insufficient managed care capacity may apply for exemption from participation.

Overview of the Program

The Partnership Plan built on these efforts and expanded managed care into all areas of the State where sufficient managed care capacity exists. The program was implemented in five phases, with enrollment in each of the phases initially limited to TANF (formerly AFDC), Safety Net [formerly Home Relief (HR)], and related eligibility categories. The State anticipates that enrollment of SSI and SSI-related categories will follow the same locality by locality phase-in schedule after TANF/SN-related enrollment has been implemented. Two models of health care delivery systems were developed under The Partnership Plan: a mainstream system that serves a large majority of the eligible population through Managed Care Organizations (MCOs) which are HMOs, IDSs¹ or PHSPs; and Special Needs Plans designed to meet the unique needs of the HIV+ populations and serve as an alternative to the mainstream options for these recipients.

Mandatory enrollment was implemented in five phases. Phase I started October 1, 1997; Phase II began in early 2001; Phase III was implemented in late 2001; Phase IV and Phase V began in 2002. CMS approval must be obtained prior to enrollment in any county. Appendix 1 – 1 contains a list of counties and the date mandatory enrollment was implemented.

¹ As of April 1, 2002, IDSs are no longer authorized by State law.

Mainstream Managed Care Organizations (MCOs)

In November 1995, the State issued a Request for Proposals (RFP) for MCOs seeking qualification to participate in The Partnership Plan. The RFP covered 31 counties and the five boroughs of New York City; a similar qualification process took place prior to expansion of The Partnership Plan to counties not included in the 1996 plan qualification process.

The RFP established the MCO participation standards for The Partnership Plan with particular emphasis on factors such as quality of care, demonstrated capacity to serve Medicaid clients (including sufficient numbers of health care providers distributed in a geographically appropriate manner), and the ability to serve individuals with special health care needs, including persons with developmental disabilities and chronically ill children. MCOs were also required to demonstrate that their contracted provider networks include sufficient primary care capacity to serve the projected enrollment. Special consideration was given to MCOs with networks that include linkages to community providers who have traditionally served as a safety net for the poor and uninsured, including public health clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Title X and Presumptive Eligibility providers, and school-based health centers/clinics.

As a result of the RFP process, contracts reflecting these requirements were put into place. The contracts allowed MCOs to operate in the voluntary program, with provisions for amendments to implement the mandatory program upon the approval of the waiver and certification of the local district by the State and HCFA (now CMS).

Special Needs Plans

Special Needs Plans (SNPs) were developed for individuals with HIV/AIDS. Individuals with HIV/AIDS may choose to enroll in a SNP, voluntarily enroll in MCOs, or remain in the fee-for-service program.

The HIV/AIDS Special Needs Plans integrate Medicaid recipients with HIV infection or disease into The Partnership Plan by building on the existing HIV continuum of care in New York State.

The HIV continuum of care is a coordinated system of medical and support services subject to clinical and program standards developed by the State over the past twenty years and supported through multiple funding sources, including Medicaid, State and/or Federal grants and private insurance. This coordinated system of care includes Designated AIDS Centers (DACs) which are Centers of Excellence for provision of specialized inpatient and outpatient care, HIV Primary Care Providers providing services in non-DAC-outpatient departments (OPDs), community health centers, diagnostic treatment centers, substance abuse treatment programs, county Health Departments, and chronic care providers including AIDS home care, AIDS adult day health care, and AIDS nursing facility care. A high standard of quality is maintained through program certification and review and through an extensive quality improvement program implemented by the AIDS Institute within the State Department of Health.

As a first step in the development of HIV/AIDS SNPs, the Department awarded \$2 million in planning grants to 18 organizations interested in developing HIV managed care models. The planning grants were intended to assist these organizations in preliminary feasibility studies and development activities. The DOH also convened an HIV SNP Workgroup to assist in developing standards related to the HIV SNP milestones.

As SNPs become available, managed care eligible Medicaid recipients with HIV and their related children up to the age of 19 in those areas are afforded an opportunity to choose between joining a SNP, a mainstream MCO, or receiving services through fee-for-service Medicaid. Under the terms of The Partnership Plan the State may, with CMS approval, remove the Managed Care enrollment exemption for persons with HIV, and require such persons to enroll in either a mainstream managed care plan or a SNP.

Following a competitive procurement process (RFA released in 1999), in April 2000 New York State selected eight HIV SNP applicants to move forward toward SNP Certification. Two applicants subsequently withdrew from the process, and in 2003 five of the six remaining SNPs received their Certificates of Authority and began voluntary enrollment in the five boroughs of New York City. Two of the five certified plans withdrew from the program in 2005.

Organizational Structure for Single State Agency Responsibilities

Prior to the development of The Partnership Plan, the State Department of Social Services had primary responsibility for overseeing and administering Medicaid managed care efforts, with significant input from the State Department of Health and the local districts. The following is a brief synopsis of the historical roles of each of the agencies:

State Department of Social Services (SDSS)

SDSS had overall responsibility for overseeing the implementation of local districts' Medicaid managed care plans, as well as for general Medicaid policy and oversight. This included the establishment of policy and operations for all ambulatory, acute care, transportation services, utilization thresholds and review programs, as well as pharmacy, long-term care, and home care services. SDSS also oversaw Medicaid eligibility, MMIS and fiscal agent operations, and provider enrollment and communications.

State Department of Health

The Department of Health was primarily responsible for quality assurance activities, including establishing standards for providers; certifying managed care organizations, including network adequacy; conducting quality care surveillance activities, both directly and through the State's external quality review organization; and the overall measurement and evaluation of quality of care. The Department was also responsible for developing systems of health care reimbursement, including capitation rates for MCOs. Through its AIDS Institute, the Department also coordinated the State's response to the HIV/AIDS epidemic.

Local Social Services Districts/New York City Department of Health and Mental Hygiene (NYCDOHMH), Health Care Access and Improvement Division (HCAID), and Human Resources Administration (HRA)

The local districts were responsible for the general administration of public assistance and care, including determination of eligibility. For Medicaid managed care initiatives, the local districts were also responsible for developing a local managed care plan, contracting with State-qualified HMOs, PHSPs or partial capitation plans, and conducting education and enrollment activities.

Revised Organization

In 1995, the State underwent a major reorganization to provide better and more coordinated support for The Partnership Plan. The Department of Health assumed responsibility for Medicaid as the new Single State Agency, as well as for commercial managed care development within the State. All of the Department's responsibilities and functions central to the managed care initiative were centralized in the Office of Managed Care (now called the Division of Managed Care and Program Evaluation). The Department continues to work closely with other State agencies, including the State Department of Insurance, the Offices of Mental Health, Alcoholism and Substance Abuse Services, and Mental Retardation and Developmental Disabilities, as well as the local districts.

Generally, the Division of Managed Care and Program Evaluation is responsible for the overall design, implementation, and oversight of The Partnership Plan. Fair hearing policy, eligibility standards and policy, and claims processing are the responsibility of the Division of Coverage and Enrollment and the Division of Program Operations and Systems within the Office of Health Insurance Programs in the Department of Health. The local districts are responsible for actual eligibility determinations (made in accordance with State standards and policy), education and enrollment functions, some MCO monitoring activities, and in NYC contracting with qualified MCOs.

In some areas of the State the education and enrollment functions are carried out by the State's contracted enrollment broker, currently Maximus, Inc. Maximus provides educational materials and counseling to Partnership Plan enrollees as well as pre-printed enrollment forms, an explanation of rights and responsibilities under managed care, as well as choices of plans and primary care providers.

The State Offices of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and Office of Alcoholism and Substance Abuse Services (OASAS) also contribute to establishing criteria and standards for mainstream MCOs.

Waiver Development and Implementation

The final design of The Partnership Plan was developed through exhaustive consultation with, and input from, a wide range of community, provider, and consumer advocacy organizations, as well as the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS). As the Plan was implemented, SDOH continued to receive

feedback and input from these parties. To that end, State DOH established the following subcommittees of the Managed Care Advisory Committee:

- ADA Advisory Workgroup (NYC)

Members of the Workgroup included representatives from: NYC CDOHMH-HCAID, SDOH OMC, MCOs, advocacy groups, and the NYC Mayor's Office for People with Disabilities. The workgroup was convened for the purpose of drafting ADA compliance guidelines to assist MCOs in assessing their ability to meet their responsibilities under Title II of the ADA.

- Court Ordered Services Workgroup

A court has the right to order a number of services, some of which may be medical services included in the Medicaid benefit package. With MCOs responsible for these services, the Court Ordered Services Workgroup focused on helping county services workers and court officials understand how managed care services can be promptly and appropriately accessed when they are ordered by the court. A video teleconference was held in May of 1997 to share with every county the good practices already developed by some counties and to encourage county court officials, services workers, and MCOs to develop appropriate procedures to ensure provision of court ordered services.

- Dental Issues Workgroup

Members of the Workgroup included representatives from: SDOH OMC, SDOH Office of Public Health, MCOs, practicing dentists from the community, and representatives from dental schools. The workgroup was convened for the purpose of developing network standards and quality monitoring criteria.

- Foster Care Workgroup

NYSDOH convened a Workgroup consisting of representatives from County Departments of Social Services, managed care organizations, foster care administrators/clinicians, OMH and advocates. The groups provided recommendations concerning the enrollment of foster care children in managed care.

- HIV Special Needs Plan Workgroup

The Workgroup was comprised of representatives from State staff, the AIDS advisory groups, community-based organizations, substance abuse providers, primary care providers, and SNP planning grantees. The purpose of the Workgroup, expanded from the earlier HIV Subcommittee, was to assist the State in defining and refining issues identified through the SNP planning grants process and to raise any additional areas which needed to be addressed.

The process was time-limited (over several months) and resulted in the issuance by the State of an RFA for a SNP voluntary program in the spring of 1999.

- Mental Health Subcommittee

The Mental Health Subcommittee consisted of providers, advocates, family members, MCOs, and State staff. It met monthly to discuss design and implementation issues related to Mental Health Special Needs Plans. Four subcommittees of this Workgroup (systems design, clinical linkages, quality assurance/member relations, and admissions/discharge) met to discuss particular aspects of the SNP program, culminating in recommendations to the Subcommittee, which produced its final report in July 1996. The Subcommittee re-convened on an as-needed basis to continue to provide advice and support to DOH/OMH as it refined its SNP approach. With the expiration of legislative authority to implement MH SNPs, this Subcommittee was eliminated.

- OMRDD Subcommittee

Members of the Workgroup include representatives from SDOH OMC, disability related advocacy groups (Association for Retarded Citizens Epilepsy Foundation, United Cerebral Palsy), Developmental Disabilities Planning Council, and OMRDD. The OMRDD Subcommittee provides OMRDD with comments and recommendations about managed care for persons with developmental disabilities. In addition, the Developmental Disabilities Planning Council (DDPC) funds and oversees the Managed Care Information Project. Activities include arranging seminars for consumers, families and advocates on managed care issues; the development of a managed care information kit for consumers, families, case managers; and the development of training curriculum for case managers who will use information kits with consumers and families. The first subcommittee meeting was held on May 16, 1995.

- Phase I County Workgroup

Members of the Workgroup included representatives from SDOH OMC, Phase I local districts, and MCOs. The Workgroup was convened to serve as a forum for the discussion and clarification of issues related to Medicaid managed care in Phase I counties (e.g., client notices, contract amendments, county readiness, and systems changes). The first Phase I County Workgroup meeting was held on February 27, 1997.

- Medical Directors Workgroup

The Workgroup is comprised of Medical Directors from all MCOs. The Workgroup was convened to serve as an open forum for the discussion and clarification of a variety of issues related to Medicaid managed care (e.g. QARR, Encounter Data, PCAP, and clinical studies), and as such, continues to meet.

- Medicaid Managed Care Advisory Committee

The Medicaid Managed Care Advisory Committee was established during New York's voluntary Medicaid managed care program. This Committee provided a forum for interested parties to raise issues and concerns, discuss solutions and make recommendations on the

development of The Partnership Plan. This Committee was superseded by the Medicaid Managed Care Advisory Review Panel, which was established by Chapter 649 of the Laws of 1996, as described below.

Twelve subcommittees of the Medicaid Managed Care Advisory Committee were convened to allow stakeholder input into program development and into development of the Health Plan Request for Proposals. These subcommittees were co-chaired by a NYS DOH representative and a stakeholder representative and are listed below:

Alcohol and Substance Abuse
Bad Debt and Charity Care/Capital
Capacity Building
Consumer Education
Enrollment/Payment Process
Family Health
Graduate Medical Education
HIV Managed Care
Local Government Issues
Mental Health Special Needs Plans
People with Developmental Disabilities
Quality/Information

The subcommittees concluded their work and no longer meet.

- Special Advisory Review Panel on Medicaid Managed Care

The Medicaid Managed Care Advisory Review Panel (MMCARP) consists of nine members, including three members appointed by the Governor, three members appointed by the NYS Senate, and three members appointed by the NYS Assembly. The Panel was established by Chapter 649 of the Laws of 1996 to assess and evaluate multiple facets of the Medicaid Managed Care Program, including provider participation and capacity; enrollment targets; phase-in of mandatory enrollment; the impact of marketing, enrollment and education strategies; and the cost implications of exclusions and exemptions.

- Systems Issues Subcommittee/Workgroup

Members of the Workgroup included staff from SDOH OMC, SDOH Office of Medicaid Management, and SDSS. The Workgroup was convened to identify and implement all the systems changes required to support mandatory managed care. Key tasks included developing the enrollment system; developing the auto assignment process; assuring that exempt or excluded populations are not mandatorily enrolled; and overseeing the establishment of all payment edits to providers, which was superseded by the Operational Issues Workgroup, as described below.

- Medicaid Managed Care Operational Issues Workgroup

Members of the Workgroup include representatives from SDOH DMCPE, NYC DOHMH-HCAID, local districts, MCOs and their associations. The Workgroup was convened to serve as an open forum for the discussion and clarification of operational issues related to Medicaid managed care.

Functional Responsibilities

Although SDOH has primary responsibility for The Partnership Plan, some functions continue to be provided by other agencies. This section describes the key functions of the agencies involved in The Partnership Plan in each key area.

Plan Qualification

To participate in The Partnership Plan, MCOs must be certified and must participate in the State's MCO procurement process. The SDOH DMCPE has primary responsibility for both of these functions.

- Certification - The Bureau of Certification and Surveillance provides for the certification and licensure of MCOs participating in the Medicaid program. The OMC and the AIDS Institute jointly developed licensing and certification requirements for the SNPs.
- Contract Qualification - The Bureau of Certification and Surveillance in DMCPE coordinates the MCO qualification process. Standards and criteria defined in the qualification process were developed in consultation with OMH, OASAS, and OMRDD, as well as the local districts. SDOH makes the final determination of qualification. Since the advent of the new October 2005 combined Medicaid managed care/Family Health Plus model contract, the New York State Department of Health contracts directly with managed care organizations (MCOs) under the model contract for provision of Medicaid managed care and Family Health Plus covered services for eligible persons in all districts except New York City. In New York City, the New York City Department of Health and Mental Hygiene continues to contract with participating MCOs for Medicaid managed care, and the State Department of Health contracts with participating MCOs for Family Health Plus. The Model Contract is available at http://www.nyhealth.gov/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf.
- Contracting – The Bureau of Intergovernmental Affairs is responsible for developing and executing the Medicaid Managed Care MC/FHPlus contract. Initially the contract was between the Local Districts and the MCOs. However, since October 1, 2005, the contract is between the State and the MCO, except for New York City.

Plan Oversight

Primary responsibility for MCO oversight resides with the Bureau of Certification and Surveillance in DMCPE. Several additional units within the DMCPE, as well as DMCPE regional staff and the local district's staff participate in the oversight process.

- Operational Reviews - The Bureau of Certification and Surveillance oversees teams of personnel to:
 - conduct pre-operational MCO readiness reviews;
 - conduct on-site operational compliance and performance reviews;
 - review reports from MCOs;
 - conduct focused reviews;
 - review management reports and analyses;
 - evaluate MCO health provider networks;
 - review member services and provider participation;
 - review and/or conduct targeted appointment availability studies;
 - monitor complaints; and
 - conduct follow-up activities.

Staff from other agencies and/or local district staff may be included on the pre-operational, operational, and/or targeted site visit reviews. On-site readiness reviews and pre-contract operational reviews are conducted as part of the MCO qualification process, and the results from these visits are shared with CMS.

- Data Validation - The Bureau of Program Quality, Information & Evaluation in DMCPE pulls samples from encounter and other MCO reports and validates the data on-site using medical records and other sources of information to measure the quality, completeness, and accuracy of the data. Additionally, the Department has contracted with the National Committee for Quality Assurance and the Island Peer Review Organization (IPRO) to conduct validation of data submitted in compliance with the Quality Assurance Reporting Requirements (QARR), and to provide other technical assistance to the State and MCOs.
- Quality Assurance/Utilization Review - The Bureau of Certification and Surveillance and the Bureau of Program Quality, Information and Evaluation in DMCPE are responsible for assuring the quality, necessity, and appropriateness of care provided by MCOs. The AIDS Institute's Office of the Medical Director and Division of HIV Health Care are responsible

for Quality Assurance/Quality Improvement in HIV SNPs. Specifically, these responsibilities are:

- Review MCOs' internal quality assurance programs
 - Monitor MCOs' provision of health care services
 - Develop performance standards and measures and practice guidelines
 - Develop, collect, and evaluate QARR data submitted by MCOs
 - Develop satisfaction surveys and evaluate survey results
 - Review utilization data
 - Work with EQRO to perform focused clinical studies.
- MCO Reporting - The Bureau of Program Quality, Information and Evaluation in DMCPE is also responsible for collecting, analyzing, and monitoring MCO encounter data. The Bureau works with all contracted MCOs to ensure timely and accurate submission of encounter data. The Bureau has developed a system of corrective action for non-compliant MCOs, including County-imposed sanctions, as a means to ensure full compliance.
 - Marketing and Enrollment Oversight of MCOs – Oversight of marketing activities is shared between the DMCPE's Bureau of Intergovernmental Affairs and the local districts, as outlined on the chart on pages 1-18 and 1-19. Oversight of the individual districts' enrollment programs is performed by the Bureau of Intergovernmental Affairs. Implementation of systems to support the enrollment function is jointly accomplished with the DOH staff charged with the operation of management information systems (see Systems section beginning on page 1-13).

LDSS Oversight and Technical Assistance

The Division of Managed Care and Program Evaluation has assumed responsibility for oversight and technical assistance to local districts in all areas related to the Medicaid managed care program.

- Readiness Reviews - The Bureau of Intergovernmental Affairs in DMCPE, through its County Relations staff, provides training for local district staff and conducts readiness reviews prior to implementation of The Partnership Plan in each county (the CMS County readiness review guide is included in Appendix 28.1). CMS may also conduct a separate review of each local district going mandatory. The review ensures that each local district has developed a detailed enrollment plan, produced appropriate education and enrollment materials, devoted adequate staff resources to the program, and has systems in place to manage and coordinate enrollment.

- Ongoing monitoring: The County Relations staff monitor enrollment and disenrollment levels, auto-assignment rates, rates of transfers, complaints and grievances, and enrollee satisfaction survey results pertaining to the education and enrollment functions. The staff is also responsible for conducting periodic audits of MCO marketing materials, which have been approved to assure compliance with State standards.
- Technical assistance: The County Relations staff assist local districts in the design of their individual enrollment programs and the development of education and enrollment materials. The staff assist the LDSS in monitoring the marketing activities of MCOs by serving as a source of information across counties and alerting staff of infractions by MCOs in other areas of the State.

Service Coordination: Special Populations

The State special population agencies, including the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Retardation and Developmental Disabilities (OMRDD), and the AIDS Institute (AI) will continue their historical roles of establishing policy, providing services, and/or coordinating services for their populations. These agencies also will assist in conducting special outreach and education efforts targeted to their respective populations.

- OMH- OMH's primary mission is to develop and support a coordinated, comprehensive, and community-based public mental health system. New York's public mental health system includes State-operated, certified, and funded programs as well as locally funded and operated programs. This Office advises the Department on participation standards for managed care organizations and provides consultation to DOH in monitoring the provision of capitated mental health services by MCOs.
- OASAS - OASAS is responsible for planning, funding, licensing, and monitoring a system of over 1,000 alcohol and substance abuse providers located in hospitals, health clinics, mental health programs, and free-standing community settings. DOH, in consultation with OASAS, will monitor access to and quality of alcoholism and substance abuse services through MCOs under the basic benefit.
OMRDD- OMRDD is the State agency charged under the State's mental hygiene law to oversee, plan, and provide services and supports to persons of all ages with mental retardation or other developmental disabilities and to their families.
- AI- The AIDS Institute is the New York State government entity responsible for directing and coordinating New York State's response to the HIV/AIDS epidemic. Created as a Center within the State Department of Health in 1983 by legislative mandate, the AIDS Institute formulates HIV/AIDS policy; initiates, develops and monitors HIV prevention, health care and supportive service programs; guides regional and statewide HIV/AIDS planning; and educates health care providers and the public. The AIDS Institute works in cooperation with the Division of Managed Care and Program Evaluation to monitor services to persons with HIV/AIDS enrolled in Special Needs Plans and MCOs.

Program Evaluation and Improvement

The Bureau of Program Quality, Information, and Evaluation within the DMCPE has primary responsibility for ongoing program evaluation and improvement efforts. Their responsibilities include the following:

- **CMS Documentation** - The Bureau is responsible for preparing and providing documentation and information to CMS, as requested, in support of The Partnership Plan, as well as preparing any future amendments. During the implementation period the Bureau worked closely with the *CMS Documents Workgroup* (described later in this chapter) and the Bureau of Intergovernmental Affairs to respond to CMS documentation requirements, including development of quarterly and annual progress reports.
- **Research & Evaluation Activities** - The Bureau has lead responsibility for collaborating with CMS in the research component of the program. The Bureau also collaborates with the Bureau of Certification and Surveillance to collect and analyze data from managed care organizations, providers, and consumers to monitor program performance against established objectives.

Systems

There are three mainframe information systems, which are linked to provide the comprehensive data necessary for eligibility, claims processing, and provider notification:

- *Welfare Management System (WMS)* - This system is the statewide file for client eligibility and demographic data. The New York State Office of Temporary and Disability Assistance in the Department of Family Assistance is responsible for maintaining and upgrading the WMS, at the direction of the Department of Health.
- *Electronic Medicaid Eligibility Verification System (EMEVS-now MEVS)*- This system is operated under contract and is supervised by the Division of Program Operations & Systems within the Office of Health Insurance Programs in the Department of Health. This system allows providers to verify eligibility.
- *eMedNY (Electronic Medicaid New York), formerly the Medicaid Management Information System (MMIS)*, is the name of the new electronic Medicaid system of New York State. This system allows New York State providers to receive payments for Medicaid-covered services provided to qualifying clients, and offers several features to make this process easier and more convenient. The eMedNY contract is operated by Computer Sciences Corporation (CSC), New York State Medicaid's fiscal agent, and involves a complete replacement of the system formerly in place. The new system was implemented in two phases: Phase I, which includes eligibility verification and NCPDP (National Council for Prescription Drug Programs, Inc.) pharmacy claim submission capabilities; and Phase II, which adds billing functionality for all other claim types and features new, enhanced submission methods.

- *Medicaid Management Information System (MMIS)*— The State’s fiscal agent (Computer Sciences Corporation) is under contract and is supervised by the Division of Program Operations & Systems within the Department of Health. The fiscal agent modified the MMIS to comply with the processing necessary for managed care. These changes include a re-structuring of the rate file to accommodate capitation rate cells; development of a special rate code to pay the inpatient costs of newborns; enhancements to encounter data processing capacity; modification of the Prepaid Capitation Plan sub-system; and modification of the benefits file to manage capitated and wrap-around benefits under the waiver.

LDSS Activities

The local districts work in tandem with the Department of Health in the administration of The Partnership Plan. The level and scope of responsibility assumed by each local district vary depending on the size of the program in the local district and the availability of resources. However, the State retains responsibility for setting policy related to The Partnership Plan, establishing guidelines and standards for the local districts to follow in carrying out their responsibilities, and overseeing local district activities.

The specific policies and procedures of each district are described in their county specific policy and procedures plans, which are reviewed and approved by the Department between 60 and 90 days prior to commencement of enrollment. The chart at the end of this chapter depicts the division of responsibility between the State and the local districts, as related to marketing, education, and enrollment activities.

To carry out implementation of The Partnership Plan, each local district is required to have at least one full time staff assigned to the managed care program or to comply with a staffing ratio of at least one managed care program FTE for every 10,000 managed care enrollees, whichever is greater. Managed care staff may be employed or contracted. This ratio will apply throughout program implementation, but may be revised when a district has completed the first year phase-in of enrollment and is transitioning to “maintenance” status in the program.

Eligibility Determinations

With the oversight and supervision of the State Department of Health, local districts conduct eligibility determination activities in accordance with State policy and standards.

Education/Outreach

Local districts have the option of conducting client education and outreach activities with their own staff, or through the State-contracted enrollment broker, Maximus. This includes development of a consumer helpline to answer questions and provide assistance to enrollees during normal business hours.

The AIDS Institute undertook an extensive outreach and education effort to the HIV/AIDS population. Similarly, OMRDD and OASAS participated in the development and implementation of outreach programs for the populations that each agency serves. The State agencies coordinate with the local districts in carrying out these activities.

Enrollment

Local districts are also responsible for enrollment activities, including assisting in the identification of individuals excluded/exempted from the program.

Districts establish the sites at which MCO representatives may be permitted to market and assist with enrollment forms.

MCO Monitoring

The degree to which local districts participate in MCO monitoring varies significantly. For some of the smaller districts the State provides all MCO monitoring activities, while larger districts, in particular New York City, Buffalo, Rochester, and Westchester, assume a more active role. In general, local districts are responsible for the following:

- Routine on-site monitoring of the MCO marketing and enrollment assistance activities
- Monitoring MCO enrollments against projections to ensure MCOs do not exceed capacity
- Investigating/resolving enrollment and marketing-related complaints and grievances, and referring all other complaints to the State

New York City Activities

Given that approximately 60% of the State's Medicaid population resides in the five boroughs of New York City, New York City Department of Health and Mental Hygiene(CDOHMH), Division of Health Care Access and Improvement, and the New York City Human Resources Administration (HRA) have historically assumed a significant degree of responsibility for the Medicaid managed care program.

Implementation Activities

The Division of Managed Care and Program Evaluation had lead responsibility for the implementation of The Partnership Plan. Under the leadership of the Deputy Director, five Workgroups assumed responsibility for the operational tasks, as follows:

MCO Relations and Site Visit Teams

This Workgroup was responsible for conducting and following up on the county readiness review process. The State conducts a readiness review of each LDSS prior to commencement of enrollment within the county. Following the State's review, local districts are also reviewed by CMS. CMS is responsible for giving final approval for a district to begin mandatory enrollment under The Partnership Plan.

CMS Documents Clearinghouse

This Workgroup was responsible for monitoring MCO contracts to assure all contracts were reviewed and approved by HCFA (now CMS); preparing and submitting quarterly progress reports; and complying with any other CMS reporting requirements.

Enrollment, Marketing, and Member Materials

This Workgroup reviewed and approved all member materials developed by MCOs and the local districts for use in The Partnership Plan. Standardized review tools were used to ensure consistent and comprehensive reviews.

Systems

This Workgroup was responsible for monitoring the ongoing systems modifications and improvements. The Workgroup coordinated its activities with the local districts and with managed care plans.

Operational Protocol

This Workgroup monitored implementation activities for conformity with the operational protocol, and periodically reviewed and updated the protocol as necessary (with CMS's approval) as the program developed.

Contracted Services

Fiscal Agent

The State contracts with Computer Sciences Corporation (CSC) to serve as its Fiscal Agent. CSC's responsibilities and system enhancement activities were described earlier in this Chapter.

Actuarial Consultant

The State contracts with William M. Mercer to provide actuarial consulting services, including capitation rate development.

Benefits Counseling Contractor (Enrollment Broker)

Local districts are responsible for conducting most education and enrollment activities. The local districts may elect to conduct these activities with their own staff, or they may use the State-contracted benefits counseling contractor – Maximus. New York City and other counties use Maximus to conduct the enrollment, outreach, and educational activities listed below:

- Educate potential enrollees, and other interested parties regarding the State's managed care program;

- Educate potential enrollees regarding managed care concepts;
- Educate potential enrollees with respect to their enrollment options and provide assistance with their MCO selection;
- Assist enrollees with PCP selection if enrollee is prepared to make a selection;
- Provide an efficient and cost-effective enrollment process; and
- Provide an effective data reporting system regarding enrollment, transfers and outreach.

Accordingly the benefits counseling contractor will be responsible for the following activities:

- Enrollment functions, including the processing of exemption requests;
- Data exchange/reporting capabilities;
- Outreach/Education Activities;
- Distribute, receive, and process requests for exclusions, exemptions and, except in Suffolk County, where disenrollments are processed by LDSS staff, disenrollments from mandatory enrollment in managed care; and
- Ongoing education/maintenance of helpline.

A more complete description of the scope of work is provided in the Benefits Counseling RFP, appended to the protocol as **Appendix 1.2**.

External Quality Review Organization (EQRO)

The State Department of Health has contracted with the Island Peer Review Organization (IPRO) to serve as its independent external review agent. IPRO conducts an annual independent review of medical care provided to Medicaid recipients enrolled in managed care.

1. ORGANIZATION AND ADMINISTRATION—FHP

Background

The New York Health Care Reform Act of 2000 (HCRA) amended Article 5 of the Social Services Law by adding a new Title 11-D establishing the Family Health Plus (FHPlus) Program. FHPlus is an expansion of Medicaid coverage aimed at lower income adults without health insurance, who have income or resources which currently disqualify them for Medicaid. It was estimated that 600,000 uninsured adults would be eligible for coverage under FHPlus once fully implemented. The phase-in of qualifying income levels is:

- Parent(s) living with a child (or children) under the age of 21, with a gross family income up to and including 133% of the FPL will qualify; this increased to 150% of the FPL as of October 1, 2002.
- Individuals without dependent children in their households with gross family incomes up to and including 100% of the FPL.

To assure access to the new program, the legislation authorized the expansion of facilitated enrollment activities used for children in Medicaid and Child Health Plus (CHPlus).

The FHPlus program offers a comprehensive prepaid benefit package through managed care organizations on a statewide basis. In counties where there is no managed care participation, the State Department of Health (SDOH) contracts with an indemnity insurer to provide the FHPlus benefit package.

In June 2000, New York submitted a request to amend its Section 1115 Demonstration Project, The Partnership Plan, to expand Medicaid eligibility for certain groups and to waive certain statutory and regulatory requirements necessary to implement FHPlus as defined in State legislation. In May 2001, federal approval of the amendment was received.

Mainstream Managed Care Organizations

Participation Process for FHPlus

In February 2001, the SDOH issued a Recruitment Notice to MCOs participating in the Medicaid and Child Health Plus (CHPlus) Programs, as specified in the authorizing legislation.

MCO selection was a two-phase process. Phase one consisted of a program proposal submitted by applicants in response to the Notice. Applicants were subject to review and approval based on network adequacy and current performance. During Phase Two, SDOH requested the submission of a business proposal by applicants. MCOs were required to demonstrate their financial capacity to provide FHPlus coverage, and to develop rate proposals.

Part B of the Recruitment Notice offered MCOs who currently provide facilitated enrollment services under the CHPlus program the opportunity to expand their services to adult applicants for Medicaid and FHPlus. The scope of services includes assisting applicants with completing the application; explaining and assisting in obtaining necessary documentation; explaining managed care; assisting with MCO selection; submitting completed applications to LDSS or MCOs (CHPlus B only) for eligibility determinations; following-up on applications and reporting on application outcomes.

In April 2001, the SDOH released a procurement to solicit participation of community based lead agencies to provide facilitated enrollment services for adult applicants for Medicaid and FHPlus.

Organizational Structure for Single State Agency Responsibilities

The administrative structure for FHPlus involved a short-term approach during the initial implementation phase, followed by a permanent matrix organizational structure utilizing the existing areas of Medicaid and CHPlus management. A leadership team, consisting of the Medicaid Director, the Director of the Division of Managed Care and Program Evaluation and the Director of the Division of Planning, Policy and Research Development (DPPRD) provide ongoing policy guidance, reporting to the Commissioner of Health.

Waiver Development and Implementation

FHPlus Committees

In addition to the meetings and conferences held during the waiver design period (submitted as Figure 7 in the FHPlus Waiver Request), the SDOH established workgroups intended to provide full representation of all critical stakeholders throughout the design and planning stages. Membership consisted of representatives from managed care organizations, consumer advocacy groups, local departments of social services, facilitated enrollment agencies and SDOH staff from those key areas responsible for current Medicaid and CHPlus operations.

- Plan Relations Workgroup – convened to discuss service delivery issues for the new program.
- Facilitated Enrollment Workgroup – distinguished information needed to conduct the face-to-face interview in accordance with Medicaid requirements, policies and procedures; identified training material and other tools needed to assist with the expansion of community based application and enrollment assistance to adults.
- Eligibility Workgroup – identified ways to simplify Medicaid and FHPlus applications while meeting all legal requirements; identified potential coverage gaps as individuals transition between public programs.
- Application Design Workgroup – developed a simplified screening tool and joint health care coverage application.

SDOH Workgroups convened on a regular basis to discuss issues related to design, implementation and integration, and to provide ongoing support for the new program.

- Key Issues Meetings –the leadership from Office of Health Insurance Programs (OHIP), DPPRD, FHPlus, and Division of Legal Affairs met to discuss key issues and provide guidance on the administration of FHPlus.
- Systems Workgroup – SDOH staff discussed the modification of eligibility, enrollment, claims processing, client notices and reporting systems for FHPlus.
- LDSS Operations Workgroup – staff from key areas in SDOH and contract training staff met to design forms, tools, training materials and curriculum for local social services district offices and facilitated enrollment agencies. They also drafted directives to assist in the implementation and integration of FHPlus into existing eligibility and managed care operations at state and local levels.
- The Medicaid Managed Care Operational Issues Workgroup includes FHPlus issues in its open forum discussions.

Local District Role in FHPlus

Local district offices maintain the administrative responsibilities they currently perform for The Partnership Plan. Clarification of these responsibilities is provided through statewide training, administrative directives and memoranda, and through ongoing technical support provided by OHIP.

The role of the LDSS is augmented by the use of Facilitated Enrollment - an expanded system of community-based enrollment assistance that enables applicants to apply for health insurance at locations other than the LDSS offices. The LDSS coordinates the application process with the approved organizations in their communities through the use of jointly developed protocols. The SDOH is responsible for monitoring the Facilitated Enrollment process.

Implementation Activities

To assure that FHPlus does not become another separate, complex program, the SDOH has worked to integrate its operations, enrollment, service delivery system and administration with the state's Medicaid, Medicaid managed care and CHPlus programs.

Contracted Services for FHPlus

In addition to the existing contracted services under the Partnership Plan, the SDOH contracts for the following for FHPlus:

Enrollment Broker

Given the voluntary nature of FHPlus enrollment, the role of the Enrollment Broker is more limited than for The Partnership Plan. Their responsibilities are limited to a subset of their current activities for those counties that opt to utilize the Enrollment Broker. They handle

enrollments and MCO transfers, and can receive complaints from FHPlus enrollees as they do from Medicaid managed care enrollees.

Facilitated Enrollment

The SDOH issued a single source procurement to expand the functions of the existing CHPlus agencies that provide facilitated enrollment services to adult Medicaid (MA) and FHPlus populations. The scope of activities includes assisting applicants with completing the application and renewal forms; explaining and assisting in obtaining necessary documentation; explaining managed care; assisting with MCO selection; submitting completed applications to LDSS or MCOs (CHPlus B only) for eligibility determinations; following-up on applications and reporting on application outcomes.

Family Planning Services

The SDOH amended contracts with the designated third party insurers who provide family planning services to enrollees in FHPlus MCOs whose health plan benefit package excludes such services.