

New York Health Act FAQ

Federal Waivers

Q: In order to efficiently integrate federal funds into the new system, the New York Health program will seek waivers from the federal government to enable bulk transfer of funds based on global, prospective budgeting. What options are available should such waivers not be forthcoming?

A: Over half the funds for providing and administering health care services in New York comes from federal and federal-state public programs. These include Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and Affordable Care Act (ACA) refundable tax credits.

The New York Health Act (NY Health) explicitly provides that the Commissioner of Health will seek federal waivers needed to smoothly and efficiently integrate these funds into the NY Health trust fund (See the bill Introduction and Section 5109).

Medicaid and CHIP waivers

States manage and partially fund the Medicaid and CHIP programs. Matching funds are provided by the federal government. New York would seek a waiver to allow funds to be received, in bulk, based upon past receipts and estimates of future eligibility numbers and costs, bypassing the need for case-by-case claims processing. This would be similar to a global waiver currently in effect for Rhode Island’s Medicaid program. Rhode Island negotiated a five-year global budget with CMS that caps the federal contribution. The state gains flexibility in how it administers the funds while CMS gains certainty concerning spending. The waiver was recently renewed by the Trump administration. Although New York would not use the Rhode Island managed care methodology, it could apply for a similar waiver.

New York already has a number of approved Medicaid waivers that allow the state to provide services that are not part of original Medicaid including, among others, long-term care services in the home and community and certain behavioral health and addiction services. The services provided by such waivers for special populations would continue under NYHealth.

Medicare waivers

The Medicare program does not have state-based “waivers”, but it does have “demonstration projects”, as defined by the 1967 and 1972 amendments to the Social Security Act, which can potentially serve the same purpose. They are intended to assist Congress and the Department of Health and Human Services (HHS) in designing reforms that would increase the efficiency and cost-effectiveness of the Medicare program, without compromising health quality or access to care. These reforms could include changes in

payment methodology that would allow for seamless articulation of the Medicare program with NY Health.

Maryland was granted such a systemic waiver, establishing uniform pricing, and, more recently, global budgeting, for all hospitals. Maryland is now seeking to extend this Medicare pricing policy to physician reimbursement. The Maryland waiver shows that, provided there is no added cost to the federal government or any reduction in quality or access, significant changes in payment methods can align with the intent of the original Medicare legislation New York could seek a comprehensive, systemic waiver of this sort to streamline claims processing and allow for integration of Medicare payments into the NYHealth system.

ACA Innovation Waivers

ACA Section 1332 waivers will allow refundable tax credits to pass directly into to the New York Health trust fund. In addition, Section 1332 also makes a public option or single-payer program possible through a Coordinated Waiver Process [1332(a)5] wherein “the secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under Title XVII (Medicare), XIX (Medicaid) and XXI (CHIP) of the Social Security Act and any other federal law relating to the provision of health care items or services.” This section permits a state to submit a single application for a waiver “under any or all of such provisions.”

The Innovation Waiver section was added to the ACA through the efforts of Senator Ron Wyden of Oregon, a senior member of the Senate Health Committee. Oregon, at the time was exploring the possibility of developing a state public option or single-payer program. He intended Section 1332 to facilitate such possibilities.

The only statutory requirement for approval of such a waiver is that certain “guardrail” conditions be met. The system should 1- have benefits at least as comprehensive as those mandated by the ACA; 2- not increase the financial burden on enrollees, 3- not increase the number of residents who do not enroll; and 4- not increase costs for the federal government.

NYHealth easily meets these conditions.

NY Health without waivers: Status quo options

The New York Health Act states that, should waivers not be forthcoming, NYHealth would work within the status quo:

The legislature intends that federal waivers and approvals be sought where they will improve the administration of the New York Health program, but the legislature intends that the program be implemented even in the absence of such waivers or approvals...If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or

Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

To facilitate the incorporation of Medicare funds, NYHealth may opt to apply to become or sponsor an HMO that would work like a Medicare Advantage plan. In 1973, Congress codified federal rules for provider collectives that offered services on a capitated basis, and Medicare was authorized to develop demonstration projects that would allow such HMOs to manage services for older adults. This became the basis for the Medicare Part C (Medicare Choice+) legislation in the Balanced Budget Act of 1997 and the Medicare Advantage (MA) legislation in 2003. Although MA organizations are private, usually for-profit, the 1973 law refers to “public or private” HMOs that could be authorized by the federal government to manage programs that serve Medicare and Medicaid enrollees.

Such a public or quasi-public entity could ease the integration of federal funds. The federal government already uses capitated payments for such plans, replacing fee-for-service reimbursements. This would help to smoothly integrate the federal funds. In addition, Section 1109 of the proposed legislation requires that NYHealth applicants also apply for any federal program for which they are eligible so that federal funds become available to the state.

As a fallback option, NYHealth could “wrap around” traditional Medicare. Such a plan would run parallel to Medicare as it currently exists and provide any needed extra payments to providers. While such an approach would limit administrative savings, an efficient electronic claims processing system could minimize the additional administrative effort. There are also provisions under Section 1395kk of the Medicare law that allow the federal government to hire contractors to maintain data and administer benefits under certain conditions. A state or state-related entity could qualify as such a contractor and further unify and simplify the claims administration system.