NEW YORK STATE | Department of Health | Medicaid Redesign Team

2017-18 Budget Agreement Overview

April 2017

Managed Care Initiatives

- Require Medicare Coverage for Medicaid Eligibility ($51M Gross 17/18; $204M Gross 18/19)
  - ✓ Medicaid enrollees would be instructed to apply for Medicare or prove they are ineligible for Medicare or after a grace period they would lose Medicaid coverage
  - ✓ OSC Audit Finding
- Reduction in Managed Care Quality Bonuses ($70M Gross)
  - ✓ Mainstream Managed Care ($40M Gross)
  - ✓ Managed Long Term Care ($30M Gross)
  - ✓ Exploring operationalizing this reduction thru an adjustment to the quality award for lower performing quality tiers
- Decrease Payments for Facilitated Enrollment ($20M Gross)
  - ✓ Reflects the decline in the uninsured rate
  - ✓ Targeted to Plans with active facilitated enrollers

Managed Care Initiatives Continued

- Reduce Funding for VBP Pilots ($10M Gross)
  - ✓ Reduces annual funding from $25M Gross to $15M Gross
  - ✓ Funding will now be $40M Gross for two years
- Eliminate MLTC Partial Cap Marketing ($6M Gross 17/18; $24M Gross 18/19)
  - ✓ Attempts to stabilize the sharp growth of MLTC enrollees
  - ✓ Ceases marketing and advertising activities for the MLTC Partial Capitated product. The goal is to stabilize the sharp growth of MLTC enrollees through the cutting of marketing by the plans
- Implementation of MLTC Fining Mechanism ($4M Gross 17/18; $5M Gross 18/19)
  - ✓ Address issues that arise out of surveillance, UAS errors and infractions, contract violations and other identified areas of concern
  - ✓ Fines will be assessed against the Plans themselves, rather than taken from capitation rates

Managed Care Initiatives Continued

- Apply Wage Parity to CDPAP
  - ✓ Extends Wage Parity to CDPAP direct care workers for the NYC and LI regions
  - ✓ Separate statute creates an authorization process for CDPAP(S) Fiscal Intermediaries (FI)
- Realignment of End-of-Life Services ($9M Gross)
  - ✓ The Department intends to provide clarity and guidance on the best practices for billing of hospice services to providers and plans
- Reduction for DSRIP Avoidable Hospital Admission ($50M Gross)
  - ✓ Savings achieved through PPA/LANE Adjustment
- Additional funding for VBP Implementation and Targeted Provider Rate Increases ($75M Gross 18/19)
  - ✓ Incentivize MCOs and providers to accelerate their movement to VBP

Pharmacy Initiatives

- Establish Rebates for High Cost Drugs ($110M Gross 17/18; $170M Gross 18/19))
  - ✓ Limits drug spending in 17/18 to the 10-year rolling average of the medical component of the Consumer Price Index plus five percent, less the State share rebate target of $55M;
  - ✓ Provides the authority to negotiate enhanced rebates with drug manufacturers in the event the cap is exceeded;
  - ✓ Allows Commissioner to refer certain drugs to the Drug Utilization Review Board (DURB) if negotiations with the drug manufacturers are unsuccessful;
  - ✓ Provides DURB with the authority to request drug development, cost/pricing and other data to determine appropriate target rebate amount; and
  - ✓ Permits the Commissioner to utilize “super powers” such as the ability to remove drugs from the preferred drug list, waive prescriber prevails provisions and accelerate rebates.

Other Initiatives

- Enhanced Safety Net Hospital ($20M Gross) and Critical Access Hospital Investments ($20M Gross)
  - ✓ Legislative proposals to provide enhanced funding to providers meeting certain criteria
  - ✓ May be paid through managed care
- Reduce Hospital Quality Pool ($30M Gross)
  - ✓ Reduces annual funding from $88M Gross to $58M Gross
- Donor Breast Milk
  - ✓ Includes donor breast milk as a Medicaid covered service as medically indicated for inpatient use only

Side Letter Agreement

- Explore Separate Rate Cells with CMS
  - ✓ Re-engage CMS regarding the nursing home, high cost / high need and HARP population rate cells
- Improve Transparency with Legislature
  - ✓ Present overview and updates on recent managed care rate packages/adjustments on a quarterly basis
  - ✓ Transmit actuarial memorandum
  - ✓ Provide Monthly Plan Meeting materials
- Universal Assessment Tool
  - ✓ Establish a workgroup with DOH, Legislature and health care stakeholders to analyze and formulate recommendations

Side Letter Agreement Continued

- NHTD/TBI Waiver Transition
  - ✓ Delay the NHTD/TBI Waivers transition into managed care to January 1, 2019
- School Based Health Centers
  - ✓ Continues the SBHC Medicaid Managed Care carve-out until July 1, 2018
- Essential Plan Cost Sharing
  - ✓ Maintains the current level of cost sharing requirements from enrollees for SFY 2017-18

Questions