NEW YORK STATE | Department of Health

Monthly Managed Care Policy & Planning Meeting

2020-21 Enacted Budget Overview

April 17, 2020

Budget Topics Overview

- Medicaid Savings Reductions
- Encounter Data
- Hospital & Nursing Home
- Value Based Payment
- Utilization Review & Credentialing
- Fair Hearing
- Program Integrity
- Care Management
- Pharmacy
- Transportation
- Social Determinants of Health
- Community Health Assessments
- Personal Care
- Consumer Directed Personal Assistance
- Managed Long Term Care Plan Eligibility
- Integrating Care for Dual Eligible Enrollees
- Community First Choice Option
- Licensed Home Care Service Agencies
- HCBS Lookback

Medicaid Savings, Encounter Data & Rate Actions

Continuation of FY 20 Medicaid Savings Reductions

	FY 21	FY 22
Reduce Mainstream Managed Care (MMC) Quality Pool Payments by 50%	($60.00)	($60.00)
MMC Rate Range Reduction	($96.07)	($96.07)
Discontinue Value Based Payment (VBP) Stimulus	($42.50)	($42.50)
Discontinue Delivery System Reform Incentive Program (DSRIP) Equity Pools	($190.00)	($190.00)
Reduce Managed Long Term Care (MLTC) Quality Pool Payments by 25%	($17.25)	($17.25)
MLTC Rate Range Reduction	($20.93)	($20.93)
ATB Rate Reduction (1.0% Annually; Effective 1/1/20)*	($248.00)	($248.00)
Total Savings (State Share)	**($674.75)**	**($674.75)**

*Savings reflects both FFS and MC and exclude an additional ATB rate reduction (0.5% annually Effective 4/1/20).

Encounter Data Accountability

- Implements a withhold on premiums where the State sets aside 2% (MMC) and 1.5% (MLTC) of the monthly capitation payment to MCOs, which the MCOs can earn back if they adhere to proposed encounter data reporting requirements and targets.
- Updates the statutory and contractual penalty language to reflect penalties of 2% (MMC) and 1.5% (MLTC) of annual capitation payments.

Encounter Data Penalty Category	**MMC**	**MLTC**
Untimely	0.33%	0.25%
Incomplete/Inaccurate	1.33%	1.0%
High Rejection Rate	0.33%	0.25%
Total	**2.0%**	**1.5%**

Encounter Data Accountability (continued)

- Effective date April 1, 2020
- The following savings values reflect the net impact of the withhold and penalty provisions:

Savings (State Share)	**FY 21**	**FY 22**
Mainstream Managed Care	($142.50)	($114.50)
Managed Long Term Care	($101.90)	($89.30)
Total	**($244.40)**	**($203.80)**

Hospital Rate Actions

- Applies a 5% reduction to both the budgeted and actual inpatient capital add-ons for rates beginning on and after April 1, 2020.
- Additionally, for inpatient rate add-ons reconciled on and after April 1, 2020, if the difference between the budgeted and actual capital add-ons results in a positive add-on, the positive add-on will be reduced by 10%. Conversely, if the difference results in a negative add-on, the negative add-on will be increased by 10%.
- Discontinues hospital quality and sole community pool payments effective April 1, 2020.

Savings (State Share)	**FY 21**	**FY 22**
Reduce Hospital Capital Rate Add-on (5%)	($17.00)	($17.00)
Reduce Hospital Capital Reconciliation Payment (10%)	($4.00)	($4.00)
Discontinue Hospital Quality and Sole Community Pools	($35.00)	($35.00)
Total	**($56.00)**	**($56.00)**

NH Rate Actions

- Applies a 5% reduction to the nursing home capital rate component.
- Eliminates for-profit nursing home residual equity payments that occur when a facility's useful life has ended, and all equity has been reimbursed through the capital rate. Residual equity payments are calculated at fifty percent of the final year return of equity amount.
- Both actions are effective April 1, 2020.

Savings (State Share)	**FY 21**	**FY 22**
Reduce NH Capital (5%)	($16.00)	($16.00)
Discontinue Return on Equity for For-Profit Nursing Homes	($13.90)	($13.90)
Total	**($29.90)**	**($29.90)**

Questions?

For MMC and HARP: bmcr@health.ny.gov

For MLTC (Partial Cap, MAP and FIDA): mltcrs@health.ny.gov

Utilization Review & Program Integrity

Changes to Public Health Law Articles 44 and 49

- Administrative Denials
- Provisional Credentialing
- COVID-19 Inpatient and ED Services
- Expedited Authorizations for Inpatient Rehabilitation and Skilled Nursing Facilities
- Shorten Appeal Determinations
- Changes to Insurance Prompt Pay Law
- Electronic Noticing

Administrative Denials

PHL 4406-c

- Plans cannot deny payment to general hospitals for medically necessary inpatient, *observation services* and *emergency department* services solely based on non-compliance with certain plan *administrative* requirements.
- Allows general hospital and plan to agree to certain administrative requirements with some limitations.
  - Limitations:
    - If requiring timely notification, must allow reasonable extension for weekends and holidays;

effective 1/01/2021

Administrative Denials (continued)
PHL 4406-c

- Limitations (continued)
  - Reduction in payment for administrative non-compliance cannot exceed 7.5%; and
  - reduction in payment shall not be imposed if the patient's coverage could not be determined by the hospital after reasonable efforts

effective 1/01/2021

Administrative Denials (continued)
PHL 4406-c

- Exceptions:
  - Denials for fraud or intentional misrepresentation of patient diagnosis or services provided or abusive billing;
  - When required by a government program
  - Duplicate claim
  - There is no participating provider agreement between hospital and plan (except for medically necessary inpatient services resulting from emergency admission)

effective 1/01/2021

Administrative Denials (continued)

PHL 4406-c

- Exceptions (continued)
  - During last 12 months, hospital has repeatedly and systemically failed to seek prior authorization where prior authorization was required;
  - A request for preauthorization was denied by the health care plan prior to delivery of the service.

effective 1/01/2021

Provisional Credentialing

PHL 4406-d

- Addition of a **new** paragraph (c) to PHL Article 4406-d, which allows for the **provisional** credentialing of:

  - Newly licensed physicians **or,**
  - Physicians relocating to NYS without previously practicing in NYS **or,**
  - Physicians that change corporate relationship resulting in issuance of a new TIN **and**, previously had a contract with a Health Plan (MCO) immediately prior to the event leading to change in corporate structure.
  - Applicable to credentialing applications received on or after July 1, 2020.

effective 7/01/2020

Provisional Credentialing (continued)

- **Provisional** credentialing applies to physicians only **if the physician becomes employed by:**
  - a general hospital **or,**
  - a Diagnostic and Treatment center pursuant to Article 28 **or,**
  - an Article 16 facility, **or**,
  - an Article 31 facility **or**,
  - an Article 32 facility **and,**
  - the facility has a contract with an MCO, **and,** whose other **employed** physicians are participating providers as in network with the MCO network
- A **provisionally** credentialed physician **cannot** be designated as a PCP until the MCO has fully credentialed the provider.

effective 7/01/2020

COVID-19 Inpatient and ED services

PHL 4902(1)(k); INSL 4902(a)(13)

Utilization Review Program Standards will include:

Establishment of a requirement that emergency department and inpatient hospital services rendered by a general hospital certified pursuant to article twenty-eight of this chapter to an enrollee to treat COVID-19 during a declared state disaster emergency related to COVID-19 shall not be denied on retrospective review on the basis that such services were not medically necessary.

effective 1/01/2021

Expedited Authorizations for Inpatient Rehabilitation and Skilled Nursing Facilities:

PHL 4903(2)(a); INSL 4903(b)(1):

Utilization review agents must make prior authorization determinations for inpatient rehabilitation (in hospital or skilled nursing facility) following an inpatient hospital admission in one business day

effective 1/01/2021

Shorten Appeal Determinations

PHL 4904(3); INSL 4904(c):

- Shortens the timeframe for making internal plan appeal determinations from 60 days to 30 days

- Utilization review agents must comply with prompt pay timeframes if overturning an adverse determination

effective 1/01/2021

Changes to Insurance Prompt Pay Law

Ins Law 3224-a(b);3224-a(i);3224-a(k); 345

- **Product Information and Payment Timeframes**:
  - Requires payors to provide product information when denying or requesting additional information to process claim and
  - After receiving appeal of denied claim or additional information, requires any payment determined due on such claims within 15 days of the determination.
- **Down-coding and Interest:** When payers seek to down-code claims submitted by providers, those down-coding decisions shall be based on national coding guidelines accepted by the Centers for Medicare & Medicaid Services (CMS) and/or the American Medical Association (AMA), and increases the period over which a payer is required to pay interest if claims payment are not timely.

Effective 1/1/21

Changes to Insurance Prompt Pay Law

- **Administrative Simplification Workgroup**: Establishes administrative simplification workgroup led by the Department of Financial Services (DFS) in consultation with the Department of Health (DOH). Workgroup will include hospitals, physicians, payers, and consumers, and will evaluate ways to reduce health care administrative costs and complexities through standardization, simplification, and technology. The workgroup will make recommendations, which may inform the work of Department of DFS, DOH, and the legislature.
- **Health Care Claims Reports**: Adds a new provision of the Insurance Law that would require certain types of health insurers to report to DFS on claims received, claims paid, claims pended, and claims denied, among other information that both payers and providers may be required to report based on accepted recommendations made by an administrative simplification workgroup.

Fair Hearing Process Reform

- Builds on State Fiscal Year 2019-2020 Executive Budget
- Regulatory changes to:
  - reduce administrative lag; limit the number of adjournments; improve scheduling of fair hearings; provide ultimate timeframes for resolution
  - Increase consideration given to clinical determinations/evidence
  - Expand use of telephone hearings to reduce travel costs
  - Align with federal regulation, e.g., exhaust plan appeal process prior to requesting fair hearings
  - Align review with services available in the Benefit Package
- Improve administrative law judge education and training
- DOH to publish managed care plan reported data on member grievances, determinations, appeals, and fair hearings

Electronic Noticing

- MRT II includes establishing procedures for Medicaid managed care plans noticing enrollees of benefit package changes via electronic means
- PHL and INSL statute changes permit electronic noticing to health plan insureds with conditions

effective 10/1/2020

Electronic Noticing

PHL 4408-a(15); INSL 4802(o); PHL 4903(9); 4904(3)(b); INSL 4903(i); 4904(c)(2)

- Health plans/utilization review agents shall have procedures for obtaining an enrollee's, or enrollee's designee's preference for receiving notification, which shall be in accordance with applicable federal law and with guidance developed by the commissioner.
- Written and telephone notification to an enrollee or the enrollee's designee may be provided by electronic means where the enrollee or the enrollee's designee has informed the organization in advance of a preference to received such notifications by electronic means.
- An organization shall permit the enrollee and the enrollee's designee to change the preference at any time.
- PHL 49/INSL 49: To the extent practicable, written and telephone notification to the enrollee's healthcare provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties.
- Health plans/utilization review agents shall retain documentation of preferred methods and present such records to the commissioner upon request.

effective 4/01/2020

Standardized Medicaid Managed Care Prior Authorization Data Set

- Administrative action to reduce the number of unnecessary service request denials and subsequent appeals filed due to Provider submission of inadequate/incomplete data to MCO's for Prior Authorizations.
- Data set will allow MCOs to approve more service requests in the first instance and reduce MCO and provider administrative burden and improve service delivery
- DOH will convene Workgroup of subject matter experts/stakeholders to develop/implement the standard data set, which may include:
    - diagnosis,
    - provider identifiers,
    - procedure codes, and,
    - enrollee clinical information.
- Implementation/completion date: 1/1/2021

Modernize Regulations Relating to Program Integrity

- Implementation Date: 9/2020
- Conforms NYS law to Federal law:
  - Mandatory compliance programs
  - Obligation for returning overpayments
  - Monetary penalties for non-compliance
- Updates existing monetary penalty provisions for specific violations of Medicaid program requirements
- Require aides in home health, personal care and CDPAS to obtain a unique identifier from DOH and include identifier on claims

Modernize Regulations Relating to Program Integrity

- For Medicaid, require MCOs and MLTCs to have fraud and abuse prevention plans, which includes SIUs, if more than 1,000 enrollees and update standards/requirements
- Monetary penalties for plans that submit cost reports containing misstatements of fact
- Update standards for provider financial security
- Update regulations and requirements relating to Medicaid as payer of last resort

Modernize Medicaid Third Party Health Insurance

- Implementation Date: 9/2020
- For Medicaid TPL claims, liable third parties are prohibited from denying claims for lack of prior authorization
- Liable third parties must respond to Medicaid TPL claims within 60 days of receiving the claim

Value Based Payment

Value Based Payment Actions

Advancing and deepening the State's long-standing commitment to Value-Based Payment reimbursement arrangements, the Enacted Budget includes initiatives to:

- Institute a penalty to be applied to MCO premium in cases where MCOs do not meet certain quality measure thresholds. Quality measurement for the purposes of this penalty will utilize the QARR framework.
- Explore opportunities to:
    1. align payments for maternity and newborn services to improve maternity outcomes;
    2. implement more refined behavioral health/substance use disorder VBP arrangements which establish robust integrated care models in variety of settings;
    3. establish data and information sharing standards to support timely, accurate, complete and bi-directional sharing of data and information between MCOs and providers to support VBP arrangements; and,
    4. strengthen approaches to using member incentives through creation of guiding principles and quality outcomes more aligned with the application of member incentives.

Value Based Payment Actions cont.

Design and implement a five-year demonstration program, subject to the approval of the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Financial Services aimed at accelerating:

1. Regional population health improvement initiatives, and
2. Adoption of value-based payment models, in line with the Department's Medicaid Value-Based Payment Roadmap.

Value Based Payment Actions	FY21	FY22
Tiered VBP Quality Penalty(.5% of MC Plans)	$0.0	($3.50)
Advance VBP Models (Maternity; BH/SUD, Data sharing Global Budget, Member Incentives)	$0.0	($5.00)
VBP Global Budgeting Demonstrations	$0.0	($4.80)
Total	$0.0	($13.30)

Care Management

Care Management Actions

- **Comprehensive Prevention and Management of Chronic Disease** Multiple strategies with a focus on diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Efforts include promoting self-care education, optimizing services that are already covered by Medicaid including expanding who can provide services, and focusing on chronic care management. The Department will work with Plans, PCMH practices, and HH programs to maximize the current infrastructure to implement the interventions.

2020-21 State Impact	2021-22 State Impact
($16.8)	($37.1)

Care Management Actions

Promote Evidence Based Preventive Dentistry

- Expand Coverage to include silver diamine fluoride to arrest tooth decay.
  - Silver diamine fluoride is a liquid that when painted on teeth arrests tooth decay, prevents oral complications, and reduces costly restorative procedures.
- Promote existing coverage for fluoride varnish application in the primary care setting including application by registered nurses to increase access to the benefit for children 0-6.
  - Increasing the application of fluoride varnish by primary care providers, including RNs, will decrease early childhood decay and associated restorative costs.

2020-21 State Impact	2021-22 State Impact
($1.6)	($3.6)

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Care Management Actions

Emergency Room Avoidance and Cost Reductions

- Identify Emergency Department (ED) multi-visit patients (MVPs) for targeted interventions and make appointments to Primary Care Physicians (PCP), Federally Qualified Health Centers (FQHCs) and social service providers / Community-based Organizations (CBOs) for appointments upon discharge.
- Create individualized treatment plans, to stabilize those with chronic conditions who frequently attend ED for relief of symptoms and make them available to ED doctors to reduce unnecessary testing, costs and improve patient care.
- Health plans should determine the appropriate care setting and that hospitals should be incentivized to avoid inappropriate use of the ED by enacting lower ED triage fee to be paid for non-emergency visits based upon Anthem Preventable ER diagnosis list implemented in other states.
- Place more urgent care clinics next to or near EDs to provide ready access to less costly alternative and that all Urgent Centers be required to accept Medicaid.
- Promote quality strategies for reducing skilled nursing facilities (SNFs) to hospital admissions similar to the INTERACT (Interventions to Reduce Acute Care Transfers) model that was a project undertaken by some DSRIP PPS.

2020-21 State Impact	2021-22 State Impact
($0.20)	($1.8)

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Care Management Actions

Opportunities to Restructure Health Homes

- Consolidation and Specialization
- Reduce the number of Health Homes based on quality and efficiency factors;
- Promote the option of further developing specialty tracks for care management either at the Health Home or care management agency level;
- Revise the criteria for admission into a Health Home;
- Re-evaluate the benchmarks for stepping patients down to lower levels of care management and/or graduation from a Health Home; and
- Reduce administrative burden on Care Management Agencies (CMAs) through standardizing process thereby allowing them to focus on performance.

Opportunities to Reduce Costs

- Eliminate outreach payments;
- Revise enrollment and step-down criteria; and
- Enforce plan of care requirements.

State Fiscal Year	*2020 – 21*	*2021 – 2022*
HH Restructuring, Eligibility Changes, Step Down Criteria	(11.6)	(15.5)
Elimination of Outreach	(16)	(16)
Plan of Care Enforcement and Penalty	(5.0)	(5.0)
Total State Savings	(32.6)	(36.5)
Gross Savings	(65.2)	(73)

Care Management Actions

Managed Care Process Optimization for Higher Risk Behavioral Health Patients (HARP/BH HCBS)

DOH and OMH are in discussions with CMS to improve utilization of home and community-based services among individuals enrolled in HARPs. Requesting a revision to the HARP 1115 standard terms and conditions to move behavioral health HCBS under Rehabilitation services will eliminate some of the technical barriers to accessing BH HCBS, thereby improving care options available to individuals with serious mental illness

The complexities of the current BH HCBS workflow have resulted in very low uptake in service utilization. Utilization would likely increase but would not exceed the projections used to develop HARP capitation payments.

Savings from this approach will accrue from reduction in administrative costs and reimbursement for the NYS Eligibility Assessment conducted annually. The savings calculated for this proposal assume a 75% decrease in these costs in the first year, followed by a complete elimination in the second year.

State Fiscal Year	*2020 – 21*	*2021 – 2022*
State Savings	(0.4)	(0.5)
Total Savings	(0.8)	(1.1)

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Care Management Actions

- **Children's Behavioral Health Services** The Enacted Budget makes investments in Behavioral Health Services for Children:
  - Rates for Health Homes Serving Children will not be subject to across the board cuts; and
  - Transition rates for Child and Family Treatment and Support Services will remain in place through SFY 20-21.

2020-21 State Impact	2021-22 State Impact
$1.70	$1.70

Care Management Actions

- **Reform Patient Center Medical Homes (PCMH)** The Medicaid PCMH incentive will remain at current levels to support the quality and cost savings benefits of PCMH recognition (average savings is $294 per member per year). Overall State savings in table below are attributable to additional providers becoming PCMH-recognized. The Department will work with Plans on the future incorporation of a tiered quality component into the incentive payment.

2020-21 State Impact	2021-22 State Impact
($6.00)	($18.10)

Care Management Actions

- **Children's Preventive Care and Care Transitions** Initiatives with a focus on:
  - Promoting behavioral health integration in pediatrics with a 2-generational approach to care; and
  - Improving care transitions for children, with a focus on sickle cell disease.

2020-21 State Impact	2021-22 State Impact
($0.10)	($0.20)

Care Management Actions

Promote Maternal Health to Reduce Maternal Mortality Supports a comprehensive effort aimed at reducing maternal mortality, reducing racial disparities in maternal outcomes, and improving health outcomes for mothers and newborns. Initiatives include:

- Optimizing the health of individuals of reproductive age;
- Improving access to prenatal care;
- Ensuring all pregnant people have access to childbirth education classes;
- Supporting participation of birthing hospitals in the Department-led New York State Perinatal Quality Collaborative (NYSPQC); and
- Ensuring all people, who agree, have a home visit after giving birth.

2020-21 State Impact	2021-22 State Impact
$0.50	$(0.70)

Care Management Actions

Medically Fragile Children

- Establishes a Private Duty Nursing (PDN) Provider Directory for fee-for-service providers to promote the delivery and ensure the availability of PDN services.
- PDN providers who enroll and participate in the directory would receive a fee-for-service Medicaid rate increase over three years, effective October 1, 2020.
- The PDN Provider Directory would include <21 years and children transitioning out of such category of care.

2020-21 State Impact	2021-22 State Impact
$12.8	$25.7

Pharmacy Actions

Pharmacy Actions

- Transition the pharmacy benefit to Fee-for-Service (FFS) – Effective 4/1/2021
  - Provides the State with full visibility into prescription drug costs.
  - Centralizes and leverages negotiation power through a single *state drug program.*
  - Provides a single formulary.
  - Establishes a 340B workgroup, charged with providing non-binding recommendations by 10/1/20 for achieving savings on drugs eligible through the 340B program.
- SFY 2020-21: Extensive transition planning will occur, including an implementation and stakeholder engagement process.
  - DOH will work closely with Managed Care Plans and other stakeholders concerning implementation related decisions and activities (i.e. data sharing requirements).

2020-21 State Impact	2021-22 State Impact
$10.9M	($87.2M)

Pharmacy Actions

- Enhance Purchasing Power to Reduce Drug Cap Growth
  - Provides flexibility to negotiate rebates for any drug or drug class and for new drugs.
  - Lays the groundwork for Value Based Payment arrangements with manufacturers.
  - Reduces the allowable growth rate of the Medicaid Drug Cap by 2% in SFY 21; and in SFY 22 aligns the Drug Cap growth rate to that of the Medicaid Global Cap.

2020-21 State Impact	2021-22 State Impact
($45.5M)	($43M)

- Statewide formulary and standardized prior authorization criteria for drugs used to treat Opioid Use Disorder
  - Cost neutral compromise in response to bill S5935-A/A7246-B, which would have eliminated prior authorization for these drugs.
  - Workplan to be developed to identify key deliverables/target dates - to be implemented no later than October 1, 2020.
  - Requires an evaluation of the capitated rate.
  - Will collaborate, and work through details with plan pharmacy directors.

Pharmacy Actions (Not Enacted):

- Expansion of Collaborative Drug Therapy Management (CDTM)
  - Would have allowed the expansion of CDTM to the community setting.
- Pharmacist initiated smoking cessation prescriptions
  - Would have allowed pharmacists to initiate prescriptions for smoking cessation medications.
- Pharmacist administered adult immunizations
  - Would have expanded the immunizations that pharmacists can administer.
- Over-the-Counter (OTC) Products
  - Would have eliminated coverage of certain OTC products and increases the copayments from $0.50 to $1.00, aligning New York more closely with other states.
- Eliminate Prescriber Prevails
  - Would have eliminated the prescriber prevails provision which requires Medicaid to approve prior authorization of a prescription drug regardless of whether clinical criteria is met.

Transportation Actions

Transportation Actions

- **Transition to a Medicaid Transportation Broker**
  - Provides authority to the Commissioner to procure one or more Medicaid transportation management brokers to manage non-emergency medical transportation provided to Medicaid beneficiaries on and after April 1, 2021.
  - The broker(s) would be responsible for, among other duties, verifying Medicaid eligibility, prior approval of transportation services, arranging for a network of transportation providers, and ensuring the high-quality provision of non-emergency medical transportation as a Medicaid covered service through their established network of transportation providers under a risk-based arrangement.
  - Effective 4/1/2021

2020-21 State	2021-22 State
$ --	($35.4)

Transportation Actions

- **Carveout Medicaid Transportation from Managed Long-Term Care**
  - Carve out Medicaid transportation from the Managed Long-Term Care (MLTC) capitated rates to fee-for-service management.
    - Excludes transportation services for enrollees of PACE based on federal requirements and, at the commissioner's discretion, other plans that integrate benefits for dually eligible Medicare and Medicaid beneficiaries.
  - The management of the trips (e.g., scheduling, assignment of the most appropriate mode, prior authorization) will be performed by a professional transportation broker to be procured by the State.
  - Effective 4/1/2021; aligned with the rollout schedule of the broker.

2020-21 State	2021-22 State
$ --	($13.7)

Transportation Actions

- **ER Ambulance Diversion/Emergency Triage, Treat and Transport (ET3) Model**
- Work with approved CMS Emergency Triage, Treat, and Transport (ET3) applicants to implement an ER ambulance diversion pilot program in Medicaid.
- ET3 is a five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs.
- Under the ET3 model, CMS will pay participating ambulance providers to: 1) transport an individual to a hospital emergency department (ED); 2) transport to an alternative destination (such as a primary care doctor's office or an urgent care center); or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connecting using telehealth.
- 25 Approved NYS Applications; CMS delayed implementation until the Fall.

Transportation Actions

Other

- **Reduce Taxi/Livery Rates:** Reduce taxi and livery rates by 7.5% on April 1, 2020 and reduce taxi and livery rates by an additional 7.5% on December 1, 2020 (totaling 15%). The Commissioner may adjust if it determined that there are Medicaid transportation access issues in a region, including rural areas.
- **Maximize Public Transit**: Maximize public transit ridership for Medicaid consumers by increasing its partnership with the MTA and other public transit entities statewide.
- **Establish a Public Emergency Medical Transportation Certified Public Expenditure (CPE) Program**: Allow public entities to obtain a federal match up to their costs for providing services (the difference between the revenue received from the claiming process and the true cost).

2020-21 State Impact	2021-22 State Impact
($0.1)	($0.2)

Social Determinants of Health (SDH)

SDH Actions

- **Medically Tailored Meals Pilot:** Medicaid will pilot up to three projects targeted at individuals diagnosed with cancer, diabetes, heart failure and HIV/AIDs and have 1 or more hospitalization within a year.
- **Medical Respite Pilot:** Medicaid will pilot up to 5 medical respite programs. Medical respite programs provide care to homeless patients who are too sick to be on the streets or in a traditional shelter, but not sick enough to warrant inpatient hospitalization.
- **Street Medicine Pilot:** Medicaid will pilot a Street Medicine program to allow Article 28 Diagnostic & Treatment Centers (D&TCs) to bill offsite in order to serve the chronically street homeless population. Under this proposal, off-site locations would include safe havens, drop-in centers, on the streets, or other transitional housing settings.
- Medicaid will examine the return-on-investment, and if demonstrated, propose to expand additional pilots in more areas of the State.

Questions?

Additional information available at:

https://www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm

Email:

MRTUpdates@health.ny.gov

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Long Term Care

Long Term Care Enacted Budget Initiatives

- The Enacted Budget initiatives for Long Term Care reflect the recommendations of the MRT II, including many proposals that were unanimously supported by the Long Term Care Advisory Group
- The combination of the experience of the MRT II and LTCAG resulted in the enactment of actions that will:
  - Achieve Personal Care and Consumer Directed Personal Assistance Program (CDPAP) Efficiencies
  - Implement CDPAP Administrative Efficiencies and Reforms
  - Provide authorizations to further initiatives to provide integrated care for more than 750,000 dual eligible enrollees

Transfer Responsibility for Conducting Community Health Assessments (CHA) to an Independent Assessor (IA)

- To ensure consistency in how assessments are completed, effective October 1, 2020, responsibility for conducting CHAs will be transferred to an Independent Assessor (IA)
- The IA will conduct CHA assessments and re-assessments now completed by:
  - Managed Long Term Care Plans (Partial, Medicaid Advantage Plus (MAP) and Program of All-Inclusive Care for the Elderly (PACE)) to enroll, assess benefit needs and develop and monitor plans of care
  - Mainstream Managed Care Plans (including HIV SNP and HARP) for members receiving personal care services (PCS) and Consumer Directed Personal Assistance Program (CDPAP)
  - Local Departments of Social Services (LDSS) for members receiving PCS and CDPAP
- Initially, the current Conflict Free Evaluation and Enrollment Center (CFEEC) contract with the State's enrollment broker will be amended to include the responsibilities of the IA. Upon termination of the contract, the IA services will be obtained through a procurement process.

Change Frequency of Required CHA Assessments

- Change frequency of Community Health Assessments (now conducted by the Independent Assessor) from every six months to annually
- The change in the frequency of assessments does not apply to PACE (federal rules require semi-annual) or assessments conducted under Home and Community Based 1915(c) waivers
- Members may be reassessed earlier than the regularly required annual assessment should their status or health condition change (current practice)
- Applicable to assessments required on or after October 1, 2020

Create an Independent Physician Panel for Personal Care Authorizations

- Effective October 1, 2020, the Department will change physician ordering practices by establishing a panel(s) of clinical professionals to provide independent physician's authorizations/orders for personal care services, including those provided through the Consumer Directed Personal Assistance Program (CDPAP)
- The panel will use a clear set of protocols and standards to determine if members seeking to be in CDPAP are capable of self-directing, either independently or with their consumer designated representatives,
- Initially, the current Conflict Free Evaluation and Enrollment Center (CFEEC) contract with the State's enrollment broker will be amended to establish physician panels. Upon termination of the contract, these services will be obtained through a procurement process.

Establish Independent Clinical Reviews of High Hour PCS Authorizations

- Individuals assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) will have the incremental hours above 12 hours reviewed and authorized by the IA independent physician panel, or other clinical professionals with experience applicable to the treatment of the individual
- Review will ensure the individual can remain safely in the home
- Applies to any initial and reassessment of authorizations for PCS or CDPAP services on or after October 1, 2020

Change Criteria for Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP) Services

- In addition to receiving a physician order, to be eligible for personal care/CDPAP services an individual must be assessed (under the Community Health Assessment (CHA)) as:
  - Needing at least limited assistance with more than two Activities of Daily Living (ADLs) (eating, bathing, personal hygiene, dressing, walking, locomotion, toilet use and bed mobility), or
  - For individuals with a Dementia/Alzheimer's diagnosis, needing at least supervision with more than one ADL
- The new criteria only applies to individuals who receive an initial authorization for services made on or after October 1, 2020
- The new criteria is applicable to all managed care members (mainstream and MLTC plans) and fee-for-service members

Implement Evidenced Based Uniform Tasking Tool

- No later than April 1, 2021, the Department (either directly or through a procurement) will implement an evidenced based uniform tasking tool (UTT) to assist all MCOs and LDSS in making determinations for the utilization of home care services, including hours of personal care or CDPAP required each day
- The UTT will also help determine how a member's needs for assistance with activities of daily living (ADLs) assistance can be met by telehealth and other available alternatives, including family and social supports
- The UTT will use data collected from the Community Health Assessment (CHA)
- Information from the UTT will be documented in the plan of care

Implement Consumer Directed Personal Assistance Program (CDPAP) Administrative Reforms

To achieve efficiencies and improve the administration of the CDPAP, regulations or guidance will be implemented to:

- Eliminate the requirement that at assessment and reassessment members receiving personal care services be educated on the availability of CDPAP (members continue to have opportunity to apply for program no less than annually)
- Ban fiscal intermediary marketing and advertising
- Implement conflict of interest rules for fiscal intermediaries, including that an FI cannot be owned or operated by a managed care organization
- Establish consistent standards and roles for CDPAP consumers and designated representatives
- Implement requirement that a consumer may only have one fiscal intermediary
- Permit personal assistants to transport consumers to routine medical visits when safe and appropriate

Modify Managed Long Term Care Plan Eligibility Criteria

Change the eligibility criteria for enrollment in Managed Long Term Care Partial Plans and Medicaid Advantage Plus (MAP) to individuals that require Community Based Long Term Care Services for a continuous period of more than 120 days and demonstrate under the Community Health Assessment (CHA) they:

- Need at least limited assistance with more than two Activities of Daily Living (ADLs) (eating, bathing, personal hygiene, dressing, walking, locomotion, toilet use and bed mobility), or
- For individuals with a Dementia/Alzheimer's diagnosis, need at least supervision with more than one ADL

The new criteria does not apply to a person who has been continuously enrolled in a Partial plan or MAP beginning prior to October 1, 2020

Budget Provisions Support Strategies and Paths for Integrating Care for Dual Eligible Enrollees

- Initiatives for enrolling duals in integrated products will begin with placing a moratorium on new Managed Long Term Care Partial Plans (MLTCPs) and service area expansion over the next two years (April 1, 2020 through March 31, 2022)
- Moratorium does not apply to MLTCP applications submitted prior to January 1, 2020, applications seeking to transfer ownership or control of an existing MLTCP, and/or applications to address a serious issue (e.g., lack of access)
- During the moratorium, the Department will assess the public need for MLTCPs and their ability to provide high quality and cost effective care for their membership. Based on the assessment, the Department will develop a process for conducting an orderly wind-down and elimination of MLTCPs, which may coincide with the expiration of the moratorium on March 31, 2022
- During the moratorium the Commissioner will establish, and enforce by means of a 3% base rate premium withhold, an enrollment cap for each MLTCP

Budget Provisions Support Strategies and Paths for Integrating Care for Dual Eligible Enrollees

- Educate members and enhance marketing materials to emphasize the benefits of integrated plans (i.e., MAP and PACE)
- Modify auto assignment process for duals that need long term services and supports (LTSS) to MAP or PACE. Ensure auto assignment process includes consistency with any prior community-based direct care workers that have recently served the member as well as capacity and geographic access and quality performance criteria
- Use CMS enrollment procedures to provide individuals who are about to become dual and are enrolled in a Mainstream Managed Care Plan the option of enrolling in that same MMCP's aligned Medicaid Advantage Plus (MAP) (for member that need long term services and supports) or Medicaid Advantage (MA) (for "well duals") and preserve continuity of care by keeping other well duals in their Mainstream plan
- Leverage existing alignments by requiring Medicaid fee-for-service members currently enrolled in a plan's Medicare Advantage D-SNP to transfer to that same plan's Medicaid Advantage Product
- Incorporate behavioral health services into integrated duals products

April 1, 2022 Implementation Date for Community First Choice Option (CFCO)

- The implementation date for CFCO Services has been delayed until April 1, 2022
- Services to be implemented on April 1, 2022 include: Assistive Technology (AT), Environmental Modifications (E-Mods), Vehicle Modifications (V-Mods), Home Delivered Meals, Moving Assistance (MA), Community Transition Assistance and Skill Acquisition, Maintenance and/or Enhancement (SAME)

Licensed Home Care Service Agency (LHCSA) Value and Efficiencies

- Currently, there are over 1,400 LHCSAs that are licensed to furnish personal care, nursing, occupational therapy, and/or speech therapy services in New York State.
- To promote quality, value and efficiencies among LCHCSAs, the budget authorizes the Department to issue a request for proposals to create efficiencies to qualify a sufficient number of licensed home care services agencies (LHCSAs) to furnish personal care services in Medicaid fee-for-service or to managed care plans.
- LHCSAs will be evaluated on their adherence to technical requirements, including the ability to perform LHCSA services, past performance history, capacity to serve beneficiaries in the designated services areas, and their administrative costs/efficiencies in delivering LHCSA services.
- Expected contracting date July 1, 2021

HCBS 30-Month Lookback Period

- Applies to community based long term care services – personal care, home care and assisted living (ALP) services received through LDSSs and MLTC plans
- Applies to uncompensated transfers of assets (same as NH) in past 30 months (note: NH lookback is 60 months)
- Needed for implementation
  - 1115 Waiver Amendment
  - State Plan Amendment
- Exceptions:
  - Mainstream Managed Care
  - Care, services or supplies pursuant to a waiver under Subsection (c) or (d) of Section 1915 of the Social Security Act, which are waiver services provided through the Traumatic Brain Injury Program, the Nursing Home Transition and Diversion Waiver Program, the consolidated 1915(c) waiver and the OPWDD Comprehensive Home and Community-Based 1915(c) waiver.

Question & Answers