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NYS Department of Health

NYS DOH – Meetings, Hearings & Special Events

Committee Meeting of the Public Health and Health Planning Council

On January 25, the Public Health and Health Planning Council ("PHHPC") Committee on Establishment and Project Review ("EPRC") met in New York City. A copy of the agenda can be found here.

The next PHHPC meeting is scheduled for Wednesday, February 8, 2018 in NYC.

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Medicaid Redesign Team

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Governor Affirms Continued Medicaid Coverage for DACA Recipients

Governor Cuomo recently announced that recipients of the Deferred Action for Childhood Arrivals ("DACA") policy will remain eligible for state-funded Medicaid, regardless of any federal changes to or termination of the program. Under New York law, DACA recipients are considered "Permanently Residing Under Color of Law" ("PRUCOL") and eligible for state-funded Medicaid or CHIP. The state funds all of the costs associated with this coverage.

DACA allows for undocumented immigrants who entered the country as minors to be eligible for work permits and receive renewable periods of deferred action from deportation. There are approximately 42,000 DACA recipients in New York.

The New York State of Health ("NYSOH") has released a FAQ document for information on Medicaid-eligible DACA Recipients. The FAQ may be accessed here.

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New York, Minnesota File Suit Against Feds Over Essential Plan Funding

New York Attorney General Schneiderman and Governor Cuomo announced the filing of a lawsuit challenging the Trump administration's cutoff of funding for state operated Basic Health Programs ("BHPs"), known in New York as the Essential Plan ("EP"). The suit stems from the October 2017 cut of the cost-sharing reduction ("CSR") component of the BHP payments to States. Specifically, the complaint alleges that, in changing the BHP payment methodology, the U.S. Department of Health and Human Services ("HHS") not only violated requirements set forth in the Affordable Care Act, but it also violated rulemaking process requirements under the federal Administrative Procedure Act ("APA").

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DSRIP Updates

PPS Quarterly Reports and Achievement Value (AV) Scorecards

The DSRIP Year 3 Quarter 2 Reports and Achievement Value (AV) scorecards for each PPS have been posted to the DSRIP website, here. The scorecards cover PPS activity from July 1, 2017 to September 30, 2017.

PPSs earned $469 Million (91%) of available funds for this payment period (DSRIP year 3 quarters 1 and 2). Total overall PPS earnings overall through the second quarter of DSRIP Year 3 alone reached $3.01 Billion (95%) of all available funds**.** PPSs earned 81% of all *performance-based* funds through the second quarter of DSRIP Year 3.

This close the second quarter of DSRIP Year 3 (DY3) marks the completion of the halfway mark for DSRIP. PPS have also successfully met all state and/or PPS implementation requirements for 13 projects in DY3, Q2, bringing the total number of complete projects to 44.

The next PPS payments will be determined following the completion of DY3, Q4 on March 31, 2018.

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VBP Updates

MLTC VBP Guidance

The Department of Health has provided VBP contracting guidance for MLTC fully capitated plans, which include PACE, FIDA, and MAP.

In the guidance, DOH confirms that the same VBP Roadmap provisions that apply to mainstream managed care plans will apply to these products because they are fully capitated. Accordingly, PACE, FIDA, and MAP plans will need to have 10% VBP Level 1 contracts in place by March 31, 2018 to avoid Roadmap penalties. The VBP percentage for Level 1 increases to 50% Level 1 by March 31, 2019 and 80% by March 31, 2020. Beginning March 31, 2019, Level 2 requirements kick-in, requiring fully capitated plans to achieve 15% Level 2 by March 31, 2019, and 35% by March 31, 2020. Level 2 and higher contracts also require subcontracting with at least one "Tier 1" community based organization (CBO) in order to implement a social determinant of health (SDH) intervention.

Notably, the Department is automatically treating PACE programs as "Level 3" arrangements if they include at least one subcontract with a Tier 1 CBO and implement a SDH. However, to the extent a PACE relies on providers not employed by the PACE, these individual contracts would assessed individually to determine what VBP level it satisfies (these subcontracts will be evaluated for VBP level independent of the PACE) and the PACE satisfies the requirement to contract with a Tier 1 CBO to implement a Social Determinant of Health intervention.

More information on VBP in MLTC is available here.

VBP Workgroup Meeting

Last Wednesday, the VBP Workgroup met via webinar to review Level 1 partial cap MLTC VBP requirements, MLTC product lines, measure categories, new recommended VBP quality measures for fully capitated MLTC product lines, and a proposed VBP Roadmap Update regarding the Program of all-inclusive care for the elderly (PACE). The PowerPoint from the webinar is available here.

Recap of VBP Level 1 in MLTC

According to DOH staff, 76% of all MLTC contracts that were required to be converted to VBP Level 1 by January 1, 2018 have been converted. VBP Level 1 will remain a pay-for-performance program based on the potentially avoidable hospitalization (PAH) quality measure. The State is working to define what a VBP Level 2 arrangement will mean for partial cap MLTC plans, and anticipates distributing guidance to MLTCs between March and April.

MAP, FIDA, and PACE VBP

MAP, FIDA, and PACE VBP arrangements will consist of total cost of care MLTC subpopulation arrangements for members of those respective plans. Because these plans are fully capitated, they will follow the VBP Roadmap requirements applicable to mainstream managed care plans, including penalties for failing to reach Level 2 and higher VBP arrangements consistent with mainstream MCOs.

The State is asking for comments on the MLTC arrangements and PACE Roadmap language by February 9. The next VBP Workgroup meeting is being targeted for the end of February.

More information on VBP in MLTC is available here.

VBP Frequently Asked Questions for PACE, FIDA, and MAP

Last week the Department of Health posted an FAQ document to address questions related to the implementation of VBP within MAP, FIDA, and PACE. FAQs include contracting guidance, an example of how penalties will be calculated (the same used in the VBP Roadmap), and several finance related questions.

Notably, MAP, PACE, and FIDA will have $1 million in VBP stimulus funds available to them. The $1 million in stimulus will be distributed based on the number of attributed members with the potential to be recouped by DOH, similar to how the Department administered stimulus funds for partial cap MLTC. It will be up to the plans to determine how and whether to pass on stimulus funds to their providers. The FAQs also clarify that the $50 million in VBP performance funds is only for partially capitated MLTC plans for the payment of performance bonuses to providers. MAP, FIDA, and PACE VBP performance adjustments are still to be determined.

PPS 2018 Tier One CBO Surveys

Last week, the Department of Health posted 2018 Tier 1 CBO Survey responses from the State's 25Performing Provider Systems (PPS). The purpose of the survey is to identify all Tier 1 CBOs participating in a PPS's network. The survey identifies Tier 1 CBOs and includes information regarding total payment amounts made by the PPS to the CBO, the start and end date of any CBO-PPS contractual relationship (if applicable), how compensation for the CBO was determined, and two-three sentences describing the activities of the CBO on behalf of the PPS.

While the survey is only intended to capture information for "Tier 1 CBOs", it is not clear to what extent individual PPSs or the State have vetted the list to ensure that only Tier 1 CBOs are identified in the survey. According to DOH guidance documents issued this September, a Tier 1 CBO means a non-profit, non-Medicaid billing, community based social and human service organizations (e.g. housing, social services, religious organizations, food banks). A CBO will not meet the definition of non-Medicaid billing and will not be considered a Tier 1 organization, if any component of a CBO entity bills Medicaid. For example, if a CBO is structured so that one business unit is Medicaid billing and another business unit is non-Medicaid billing (and both components of the CBO are part of the same overarching organization and tax code) then the CBO would not meet the non-Medicaid billing definition. By extension, the CBO would therefore not meet the Tier 1 definition.

MLTC VBP Quality Measure Data Reporting Timeline

The Department of Health has announced the release of the MLTC VBP Quality Measure Data Reporting Timeline, a supplement to the 2018 VBP Reporting Requirements Technical Specifications Manual. The purpose of this document is to provide Partially Capitated MLTC Plans with a visual tool that outlines the timing of the data elements and information flow for VBP quality measurement.

VBP QIP Monthly Update

DOH staff recently provided their monthly update on VBP QIP.

As part of the update it was announced that due to provider concerns about attaining 80% VBP Level 1 contracting with MCOs by April 1, 2018, the VBP QIP program will introduce a service exclusion waiver that if approved, would allow a facility to calculate their VBP percentage based on the percentage of inpatient and emergency department MCO dollars captured in the VBP arrangement as a percentage of the total inpatient and emergency department MCO dollars. In other words, providers granted the service exclusion waiver could focus solely on attaining the VBP requirements only for acute care hospital services. While the waiver will be program-wide, DOH said it will not be granted to every facility and the Department will evaluate the facility's specific circumstances in order to determine whether the waiver is warranted, including a detailed account of the providers they attempted to partner with, and an up-to-date look at their current MCO reimbursement, as well as more periodic updates and reporting if the waiver is granted.

The new service exclusion waiver is available here. Applications will be accepted through June 27, 2018. DOH has committed to reviewing waiver applications within 72 hours. The contract submission deadline to avoid penalties is June 29, 2018.

More information on the VBP QIP program is available here.

Contract Guidelines: VBP Off-Menu Checklist

The VBP Off-Menu Checklist has been posted here.

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Governor, DOH Take Steps to Address Flu Epidemic

Executive Order

Governor Cuomo has issued an executive order ("EO") allowing pharmacists to administer flu vaccines to children ages 2 to 18. The EO aims to increase access to flu vaccination as the number of confirmed New York cases now exceeds 25,000. As of January 20th, 7,101 people have been hospitalized with influenza and there has been one pediatric flu-related death in NYS this season.

The EO, which is effective as of January 25, suspends the section of state education law that limits the authority of pharmacists to administer immunizing agents to anyone under age 18 to allow vaccines to be administered to anyone age 2 and up.

Medicaid Managed Care ("MMC") Plan Guidance on EO

As a result of the Executive Order, and severe influenza season, the DOH Division of Health Plan Contracting and Oversight issued guidance to all MMC Plans encouraging Plans to take steps to ensure patient accesses to flu vaccination, especially when presenting at a pharmacy. This guidance is effective immediately for as long as the Executive Order remains in place.

Additionally, the Department of Health has issued Medicaid fee-for-service pharmacy billing guidance for flu vaccine administration for children between the ages of 2 years and 18 per Executive Order. A number of resources related to the statewide non-patient specific standing

order for NYS pharmacists have been posted at the top of the "Pharmacists as Immunizers" web page.

Medicaid Managed Care ("MMC") and Commercial Plan Guidance on Antiviral Medication Prescriptions

In addition to the above vaccination guidance, the Department of Health issued antiviral medication prescription guidelines to MMC Plans and commercial health plans to help reduce the clinical and public health burden of influenza this season. The guidance, which can be viewed here, addresses the use of neuraminidase inhibitor ("NAI") antiviral medications prescribed for the treatment of influenza. Specifically, the guidance advises on actions Plans should take to loosen prior authorization protocols and point of sale restrictions that may lead to improper denials. It also reminds Plans to abide by CDC guidance on antiviral treatment, antiviral drug supply, and outbreaks in LTC facilities.

MMC CMOs should have reported their Plan's response to the Guidelines, to the Medicaid Managed Care Medical Director, Khalil Alshaer, MD, MPH, **by Wednesday, January 31, 2018**.

Commercial insurers should have reported their response to the Guidelines, to Mary Anne Dutcher at Mary Anne Dutcher **by Wednesday, January 31, 2018**.

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Governor Announces Efforts to Combat Maternal Depression and Prevent Maternal Mortality

Governor Cuomo recently announced that he has directed the Department of Financial Services ("DFS") to require that all health insurance policies issued in the State include coverage for maternal depression screening by both adult and pediatric primary care providers, as well as speedy referrals to treatment specialists. The guidance reflects current state law and DFS policy, but extends this policy to "child only" health plans.

The Governor also will direct the Department of Health ("DOH") and the Office of Mental Health ("OMH") to launch a strategic awareness campaign to provide information about symptoms and treatment options, and to more broadly remove the stigma associated with maternal depression. OMH will also be directed to advance specialty programs to treat maternal depression, including a mother-baby inpatient unit and outpatient programs that focus on maternal depression.

Finally, the Department of Health will establish a Maternal Mortality Review ("MMR") Board that will implement a multidisciplinary analysis of every maternal death in the state and to develop actionable recommendations to improve maternal outcomes and clinical care. The MMR Board will also be tasked with developing recommendations to the Commissioner of Health on strategies to address Severe Maternal Morbidity and racial disparities. It noteworthy that the Governor intends to include enabling legislation for the MMR as part of the "Women's Agenda" in his executive budget proposal.

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Medicaid Community First Choice Option (CFCO) Services

Last week, the Department of Health issued notification to Medicaid plans of modification to the plan benefit package to include Community First Choice Option ("CFCO") State Plan Services.

The modification applies to Medicaid Managed Long Term Care ("MLTC") Partial Capitation, Medicaid Managed Care ("MMC"), Medicaid Advantage Plus ("MAP"), and Program of All Inclusive Care for the Elderly ("PACE") plans (individual notices provided in above hyperlinks).

Effective April 1, 2018, Plans will be responsible for identifying enrollees eligible for CFCO service and reporting this information to the State's enrollment broker to facilitate identification on the individual's enrollment file, in accordance with Department guidance. For a list of Benefit Package services available to CFCO enrollees and a list of CFCO enrollee eligibility criteria, click the above hyperlinks.

Plans will be responsible for providing and coordinating CFCO services according to the phase-in dates indicated in the notices, and will be required to enhance networks and update policies, procedures and plan benefit materials accordingly.

Prior to April 1, 2018, reviews to assure plan readiness will be conducted by the Department. The Department has indicated that further details on implementation of the CFCO services into the manage care are forthcoming.

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September 2017 Medicaid Global Cap Report

The September 2017 Global Cap Report was recently posted on the on the Medicaid Redesign Team (MRT) website. The 2018 state budget extended the Global Spending Cap through March 2019. Pursuant to legislation, the Global Spending Cap has increased from $18.6 billion in FY 2018 to $19.5 billion (including the Essential Program) in FY 2018, an increase of 5.2 percent.

Total State Medicaid expenditures under the Medical Global Spending Cap for FY 2018 through September resulted in total expenditures of $10.702 billion, which was $35 million *above* the $10.667 billion target.

Medicaid spending in major Managed Care categories was $101 million *over* projections. Mainstream Medicaid Managed Care was $28 million *over* projections through September. Long Term Managed Care spending was $73 million *over* projections. Medicaid spending in major fee-for-service categories was $45 million (1.0%) *over* projections.

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Special Needs Assisted Living Residence ("SNALR") Waiver Form

The DOH Division of Adult Care Facility and Assisted Living Surveillance recently issued a Dear Administrator Letter (DAL 18-02: Special Needs Assisted Living Residence Waiver Form DOH-5257) to inform adult care facilities of a new waiver request form, specifically designed for ALRs that are seeking additional certification as a Special Needs Assisted Living Residence ("SNALR"). The waiver request form was developed to streamline the waiver request and approval processes and eliminate the need for an applicant to submit individual waiver request forms for each regulation with SNALR applications.

The new waiver form is available here. The ACF Waiver Request/Equivalency Notification Form (DOH-5257) must be filled out in its entirety, and submitted to the Regional Office for processing.

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2018 Minimum Wage Rate Adjustment for Nursing Homes, ALPs, CHHAs, & Hospices

The Department of Health has issued two Dear Administrator Letters ("DALs") on the 2018 minimum wage rate adjustment for Nursing Homes, Assisted Living Programs ("ALPs"), Certified Home Health Agencies ("CHHAs") and hospice providers.

The DALs provide information regarding a rate change due to the State minimum wage increases that began January 1, 2018. As a result of the increases, DOH has revised the Medicaid rates for these providers effective January 1, 2018 for the minimum wage increases. The rates were adjusted based on providers' attested survey data submitted for the period of April 1, 2017 through June 30, 2017 and annualized.

The DALs remind providers that these additional funds may only be used to fulfill appropriate statutory wage obligations directly associated with the minimum wage increase, and that unspent funds shall be returned to the state through a rate adjustment or some other mechanism to be determined by the Department. The Department intends to issue a minimum wage supplemental cost report in the first quarter of each calendar year to ensure dollars were used appropriately. Cost reports will be due back to the Department in April.

The DALs also note that the Office of Medicaid Inspector General ("OMIG") will conduct audits of all providers to ensure that payments were made in accordance with statutory requirements and that providers should maintain all records and reports required to verify that appropriate salary increases were directly associated with the minimum wage increase.

The minimum wage rate adjustment packages are awaiting Division of Budget ("DOB") approval. Once approved by DOB, the increased rates will be loaded to the eMedNY payment system in the next available Medicaid payment cycle.

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Deadline Extended for LTC WIO & Plan Agreement and VBP Addendum Submission

The deadline for Long Term Care Workforce Investment Organization ("LTC WIO") & Plan Agreement(s) and VBP addendum(s) submission has been extended to close of business **Friday, February 2, 2018**.

Questions may be directed to MLTCWorkforce@health.ny.gov.

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Health Home Update

Guidance for Improving Access to Adult BH HCBS for HARP and HARP-Eligible HIV Special Needs Plan Members Not Enrolled in Health Homes

The Department of Health recently issued new guidance to Health and Recovery Plans ("HARPs") and HIV Special Needs Plans ("HIV SNPs") to ensure HARP members and HARP-Eligible HIV SNP members who are not currently enrolled in a Health Home are given the opportunity to access Adult BH HCBS. The guidance outlines processes and protocols for HARPs and HIV SNPs contracting with Designated Entities.

Importantly, **effective April 1, 2018**, in accordance with Model Contract, HARPs and HIV SNPs will contract directly with State Designated Entities ("SDEs") for the purposes of performing Adult BH HCBS assessment, referral, and HCBS Plan of Care development for HARP members that are not currently enrolled in a Health Home.

A webinar will be held in the near future to provide further information.

CANS-NY Training & Technical Assistance Institute

The Department of Health has launched a "CANS-NY Training & Technical Assistance Institute". The Institute will provide training, coaching, and technical assistance in effective use of the Child Adolescent Needs and Strengths–NY (CANS–NY) as a collaborative assessment and treatment planning / monitoring tool for Health Home Serving Children. In addition, the Institute will use data analytics to guide and support the use of the CANS-NY in Health Home care management.

The Institute has also developed an Impact Board, consisting of state agency partners along with other key stakeholders to support relationship building aspects of the collaborative experience and to provide opportunities for other stakeholders and system partners to interact with members of the Institute collaborative leadership.

The Institute will be conducting a Learning Needs Survey which will be distributed to agencies across NYS who are using the CANS-NY tool. This survey is designed to identify current and needed supports and competencies related to using the CANS-NY.

To find out more about the "CANS-NY Training & Technical Assistance Institute", email the Institute Director, Dr. Suzanne Button, or its Project Manager, Angela Pollard, call the Institute at 833-802-2267.

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Regulatory Update

Department of Labor

Home Care Aide Hours Worked

The Department of Labor ("DOL") recently issued a notice of continued emergency rulemaking that aligns NYS regulatory requirements with DOL's interpretation and enforcement of New York's wage law as applicable to 24-hour "live in" home care attendants. The continued emergency regulation clarifies that the DOL residential exception, which provides that residential employees need only be paid for 13 hours of every 24–hour shift ("13 hour rule"), applies to non-residential home care aides who maintain their own residence and therefore might not actually "live in" the home of his or her employer.

The continued emergency rule is scheduled to expire on **April 4, 2018**.

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Legislative Spotlight

The Legislature will be in session on Monday, February 5th through Tuesday, February 6th. The Senate Health Committee will be meeting on Tuesday, February 6th. The Assembly Health Committee will also be meeting on Tuesday, February 6th.

Bills of potential interest include:

- S.6940/A.8781 (Hannon/Rosenthal)**:** This bill would establish certain restrictions on pharmacy benefit manager ("PBM") contracts with pharmacies. The bill would prohibit PBMs from penalizing pharmacies from disclosing to the patient 1) the cost of a prescription medication, 2) the availability of any alterative medications, or 3) alternative methods of purchasing a medication. It would also prohibit PBMs from charging a copayment in excess of the amount paid to the pharmacy. This bill is on the Senate Health Committee agenda.
- S.4496/A.5061 (Carlucci/Zebrowski)**:** This bill would prohibit smoking in adult care facilities. It would also remove an existing provision allowing residents of adult care facilities and nursing homes to smoke in a designated smoking room. This bill is on the Senate Health Committee agenda.
- S.5643/A.7505 (Klein/Benedetto)**:** This bill would direct the Department of Health to establish rules and regulations for ambulance operation. Rules and regulations would include minimum age of ambulance drivers, allowable number of consecutive work, and driver training. This bill is on the Senate Health Committee agenda.
- S.6054-A/S.8916-A (Hannon/Abinanti)**:** This bill would allow a Medicaid recipient approved for in-home private duty nursing to apply to the Department of Health to allow a relative, other than a spouse, who is a registered nurse, to provide such care and receive the private duty nursing rate of pay. This bill is on the Senate and Assembly Health Committee agendas.
- S.6867/A.8656 (Hannon/Gottfried)**:** This bill would require that a majority of the appointed voting membership constitute a quorum for the early intervention coordinating council. This bill is on the Senate Health Committee agenda.
- S.7164/A.7377 (Ritchie/Jenne)**:** This bill would establish a pilot program in St. Lawrence County that would allow certified nursing aides ("CNAs") to be certified as medication aides and administer medications in nursing homes under the supervision of a registered nurse, and upon completion of a training program approved by the Department of Health. This bill is on the Senate Health Committee agenda.
- A.5514-A/S.1165-A (Galef/Carlucci)**:** This bill would deem it medically necessary, and thereby requiring health insurance coverage, for a patient requiring central venous line ("CVL") after discharge from a hospital to have an appropriate medical professional provide the care for the administration of the CVL. This bill is on the Assembly Health Committee agenda.
- A.8988/S.7329 (Jones/Hannon)**:** This bill would amend the appointments of the Rural Health Council within the Department of Health that advises the Commissioner of Health on all aspects of rural health care. This bill is a chapter amendment to the 2017 bill that established the Rural Health Council. This bill is on the Assembly Health Committee agenda.
- A.9521/ (Gottfried)**:** This bill would ensure that Medicaid cannot exclude from coverage a service that is otherwise covered under Medicaid because the service is delivered via telehealth. This bill is on the Assembly Health Committee agenda.
- A.9562 (Lupardo)**:** This Bill creates a certificate of need ("CON") process for assisted living program ("ALP") beds based on demonstrated community need. . This bill is on the Assembly Health Committee agenda.

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Upcoming Calendar

Monday, February 5, 2018	Spinal Cord Injury Research Board 12:00 p.m. to 4:00 p.m. NYS DOH Metropolitan Area Regional Office, 90 Church Street, Conference Room 4B, New York, NY
Thursday, February 8, 2018	Public Health and Health Planning Council 9:30 a.m. 90 Church Street, 4th Floor, Conference Rooms 4A and 4B, New York, NY
Monday, February 12, 2018	Joint Legislative Budget Hearing on Health/Medicaid 10:00 a.m. Legislative Office Building, Hearing Room B, Albany, NY
Tuesday, February 13, 2018	Joint Legislative Budget Hearing on Mental Hygiene 10:00 a.m. Legislative Office Building, Hearing Room B, Albany, NY
Thursday, February 15, 2018	Drug Utilization Review Board (DURB) 9:00 a.m. to 4:00 p.m. Empire State Plaza, Concourse Level, Meeting Room 6, Albany, NY
Thursday, February 15, 2018	Bureau of Tobacco Control and The New York State Tobacco Use Prevention and Control Advisory Board 10:30 a.m. to 3:00 p.m. Empire State Plaza, Corning Tower Building, 2876A Conference Room, Albany, NY
Wednesday, April 18, 2018	NYS Board of Examiners of Nursing Home Administrators 10:30 a.m. Department of Health, Main Conference Room, 875 Central Avenue, Albany, NY

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