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Full Meeting of the Public Health and Health Planning Council ("PHHPC")

On April 12, the Public Health and Health Planning Council held a full council meeting in Albany. A copy of the full PHHPC agenda can be found here.

During the special meeting of the Committee on Establishment and Project Review ("EPRC"), the Department of Health made a motion to defer a number of applications for the establishment of new Licensed Home Care Services Agencies ("LHCSAs"). Dan Sheppard explained that the deferral was justified in light of the 2018 budget provision establishing 2-year moratorium on new LHCSA licensures. While the moratorium includes a number of exemptions, including one for LHCSAs associated with Assisted Living Programs ("ALPs"), Sheppard indicated that the Department needed more time to evaluate the implications of the new law.

Also of note, the EPRC committee declined to recommend approval for a pair of related applications for the transfer of ownership of dialysis centers. The applicants, Davita Inc. and Northwell Health, and Quinum One, LLC, proposed to jointly purchase the centers from Knickerbocker Dialysis, Inc. The applications, which were deferred during last month's EPRC meeting, were met with opposition from Atlantic Dialysis Management Services. During the public comment period representatives from Atlantic Dialysis raised concern over the impact that the proposed change of operators would have on the dialysis services market in the area.

The applications did not receive approval at the full PHHPC meeting. The PHHPC elected to approve all other applications on the EPRC agenda.

During the special meeting of the Committee on Codes, Regulation and Legislation, the Committee heard reports from the Department of Health on two regulatory proposal for adoption ("Hospital Policies and Procedures for Individuals with Substance Use Disorders" & "Public Water Systems - Revised Total Coliform Rule"). Both proposals received a recommendation for approval from the Committee on Codes and full Council.

Immediately following the full PHHPC meeting, a special joint meeting of the Health Planning Committee and Project Review Committee was held to discuss a demonstration program proposed by the Department of Health that would establish observation beds at cancer care centers located at hospital extension clinics. The demonstration program would allow for the establishment of "observation beds" in hospital extension clinics to provide observation services for patients with a primary diagnosis of cancer. The department indicated that the demonstration would be used to inform the efficacy of such models in extending the continuum of care and improving outcomes for patients with limited access to main hospital sites. The proposal was presented to the Committees only to obtain feedback and recommendations, as required by NYCRR Part 705. Following the meeting, the Department will be developing a RFA for demonstration projects. Demonstration projects selected by the Commissioner for approval will be then be subject to full PHHPC review.

The next PHHPC meeting is scheduled for Thursday, May 17, 2018 in NYC.

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VBP Update

MLTC Partial Cap VBP Level 2 P Change

Erin Kate Calicchia, the Bureau Director of the Division of Long Term Care, shared that the Department is revising its VBP Level 2 strategy for MLTC partial cap plans in response to comments received following the contracting strategy webinar held February 20. DOH said it will formulate a new approach for VBP Level 2 for partially capitated plans which will require an update to the VBP Roadmap and CMS approval. This change only affects partially capitated plans and does not impact the Department's VBP requirements for MLTC integrated plans (PACE, MAP, and FIDA).

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Service Authorization Appeals, Grievances, and Fair Hearings Webinar

The Department of health held public webinars to discuss new requirements in managed care related to service authorization requests, appeals, and complaints. The new requirements go into effect May 1, 2018 and incorporate changes required by the CMS Mega Rule (42 CFR Part 438) that apply in MMC, HARP, HIV SNP, MLTC Partial Cap, Medicaid Advantage, and Medicaid Advantage Plus plans. More information about service authorization and appeals is available here.

Notable changes discussed include:

Beginning with service determinations made on May 1, 2018, in order to get a Fair Hearing, Medicaid managed care plan enrollees will be required to first request a Plan Appeal of an

adverse determination, and must either receive a Final Adverse Determination, no response, or a late response from the plan in order to be eligible for the Fair Hearing. This is a notable change as enrollees may currently request a Fair Hearing without first exhausting Plan Appeals.

Medicaid enrollees continue to have 60 days from the date of the Initial Adverse Determination of a service authorization request to ask for a Plan Appeal, but beginning May 1, 2018, will have 10 days from the Initial Adverse Determination or the effective date of the plan's decision, to request aid to continue. Aid to continue allows the enrollee to continue to receive services that a plan seeks to reduce, suspend, or stop, up to the Fair Hearing determination.

Other notable changes include that those Service Authorization Requests and Plan Appeals that must be "Fast Tracked" due to the health needs health is at risk, must be decided within 72 hours instead of the current "3-day" standard, and for outpatient pharmacy, a decision must be made within 24 hours. Plans are also required to authorize services within 72 hours of an enrollee's successful Plan Appeal or Fair Hearing.

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Regulatory Modernization Initiative ("RMI") Update

Future of the Patient Review Instrument (PRI)

The Post-Acute Care Management Models workgroup recommended eliminating the use of the Hospital and Community Patient Review Instrument ("H/C PRI"). The Department has issued a Request for Information ("RFI") to determine the implications of eliminating the H/C PRI and to seek recommendations for a replacement assessment tool, if necessary. The RFI is available on the Department's website, here.

Responses should be sent to ALTCteam@health.ny.gov no later than 5:00 p.m. on **April 30, 2018**.

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OMIG Issues 2018-2019 Work Plan

The New York State Office of the Medicaid Inspector General ("OMIG") recently released its Work Plan for fiscal year 2018-2019 ("2018-19 OMIG Work Plan").

Unlike prior years, where OMIG updated its Work Plan once a year and identified all agency priorities for the upcoming year in the Work Plan, starting this year, OMIG intends to make its Work Plan more fluid, and update priorities over the course of the year to "adapt to the changing Medicaid landscape." Thus, the Work Plan for 2018-19 is no longer a finalized document but a website containing ongoing agency priorities that will be updated over the course of the year. These updates will be communicated via email to the OMIG listserv.

OMIG's priorities identified so far are consistent with the priorities identified in the 2017-18 Work Plan. However, one notable new addition is the creation of a new Medicaid Managed Care Project Team: the Value-Based Payments (VBP) Project Team. The VBP Project Team will work with DOH to gain an understanding of how value-based payments will be reflected in the Medicaid data; discuss ways of ensuring integrity within the data; and ensure access to information is readily available to OMIG to be able to audit and investigate in a VBP environment.

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December 2017 Global Cap Report

The December 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 2017 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 December resulted in total expenditures of $15.9 billion, which was $23 million *above* the $15.877 billion target.

Medicaid spending in major Managed Care categories was $43 million *over* projections. Mainstream Medicaid Managed Care was $30 million *over* projections through December. Long Term Managed Care spending was $13 million *over* projections. Medicaid spending in major fee-for-service categories was $39 million (.6%) *over* projections.

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Managed Care Policy and Planning Committee Meeting

The Department of Health recently held the monthly Policy and Planning Meeting with the State's Medicaid Managed Care plans. Some highlights from the meeting include:

- Mandatory Provider Enrollment into FFS: DOH provided an update on the enrollment of MCO providers in FFS. Enrolled and pending provider lists are updated bi-monthly and posted online for plans to access to identify the network providers with which follow up is necessary.
- Mainstream Enrollment: Statewide enrollment for March was 4,434,781 with 2,603,306 in NYC and 1,831,475 Upstate. This resulted in a .98% statewide increase.
- MLTC Enrollment: Now at 222,828, an increase of 1,968 from last month, as MLTC enrollment continues to outpace projected enrollment. Virtually all new enrollment continues to be in the partially capitated program, which has 202,513 members compared to 200,799 members one month ago and 199,442 two months prior. Both FIDA and PACE experienced enrollment declines for the second consecutive month (FIDA: 4,037 vs. 4,117; PACE (5,670 vs. 5,685) but all other programs saw enrollment increase (MLTC partial cap: 202,513 vs. 200,799; MAP: 9,812 vs. 9,495; and FIDA IDD: 796 vs. 764). As the numbers illustrate, FIDA enrollment continues its decline, with 470 less members than November 2017, which equates to almost a 10% drop in total program enrollment just over the last six months.
- FIDA: More information on the future of the integrated care product in NYS will be given in May 2018.
- Division of Long Term Care Budget Updates:
    - Require 120 days of Continuous CBLTC for MLTC Plan Eligibility: The purpose of this Budget provision is to clarify that effective April 1, 2018, the need for 120 days or more of community-based long-term care (CBLTC) must be "continuous" for an individual to remain enrolled in an MLTCP. DOH indicated that the statutory change was keeping with existing policy with respect to determining eligibility. Erin Kate Calicchia, the Bureau Director of the Division of Long Term Care, also clarified that this requirement does not mean that enrollees must require a service each day within the 120 day period.
    - Limit the Number of LHCSAs that Contract with MLTC Plans: The Department clarified that they will not accept single case agreements in perpetuity despite the fact

that the enacted Budget language expressly permits them in certain circumstances, but said they would permit a three-month extension of an agreement for continuity of care purposes if an individual wishes to remain with a specific LHCSA aide. DOH also stated that LHCSAs included in an Independent Practice Associations (IPAs) are counted individually for purposes of the LHCSA cap. Thus, according to Erin Kate, if an IPA contracts on behalf of a group of 10 LHCSAs, the Department considers that to be 10 LHCSAs contracted with an MLTC.

  - Fiscal Intermediary Marketing: All FI marketing materials must receive prior approval from the Department before they can be used by an FI. If an FI receives two findings from DOH that their materials are false or misleading, their FI authorization will be revoked and they must stop providing services.
  - FI Authorizations: The Department continues to review FI authorization applications but has yet to authorize any FIs. Plans asked the State to provide a list of authorized FIs when authorization occurs. DOH is working on "messaging" for an update related to FI authorizations.
- Restrict MLTC Members from Transitioning Plans for 12 Months after Initial Enrollment: The MLTC "lock-in" will operate like the Mainstream MMC lock-in. MLTC enrollees that choose a plan or are assigned to a plan have 90 days from notification of enrollment or the effective date of enrollment into a plan, whichever is later, to change plans. After that, they have to wait 12 months after the initial enrollment to switch plans unless they switch to an "integrated plan product" (PACE, MAP or FIDA).
  - Authorization vs. Utilization Adjustment for MLTC: DOH clarified that the purpose of this provision is to require disenrollment from an MLTCP if an enrollee does not utilize services within one calendar month if the enrollee did not provide advanced notice that they would be foregoing services for the month. DOH will involve OMIG in future discussions to ensure a consistent policy between the two agencies.
  - Limit MLTC Nursing Home Permanent Placement Benefit to Three Months: This change is expected to impact approximately 20,000 MLTCP enrollees currently residing in a nursing home. DOH said they have had conversations with Maximus and are confident they can handle the volume of expected disenrollments. CMS has yet to approve this benefit change, but if approved, disenrollments from MLTC plans would begin July 1, 2018 for "permanent placement" enrollees who were enrolled in MLTC as of April 1, 2018. New permanent placement auto-enrollments into MLTCPs will end May 1. Additional information and guidance will be forthcoming, including information about when someone's permanent placement status officially begins, and other potential disenrollment timeline scenarios. Plans recommended creating a small workgroup with the nursing home associations to discuss how disenrollments will occur. The State said they would schedule a meeting or call for the end of this week.

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DOH Issues New Adult Care Facility DALs

Submission of Part II licensure documents

The DOH Division of Adult Care Facility and Assisted Living Surveillance recently issued a Dear Administrator Letter (DAL#: 18-06: Guidance related to the submission of Part II licensure documents) outlining the processes for the receipt and review of Part II licensure documents.

Effective **April 2, 2018**, documents previously reviewed onsite during the pre-opening or first scheduled survey must be submitted as part of the complete Part II application package. The Department has revised Schedule 6 to reflect this change. The revised Adult Care Facility

Common Application, specifically Schedule 6, will be posted to the Department's public website within the next several weeks.

Nursing Services in an ALP Q&A Document

The DOH Division of Adult Care Facility and Assisted Living Surveillance recently issued a Dear Administrator Letter (DAL#: 18-04: Q&A Regarding the Provision of Nursing Services in an ALP) to provide clarification to questions received by the Department regarding the provision of nursing services in an Assisted Living Program ("ALP"). The associated Q&A document (here) should be reviewed by ALPs to ensure compliance with home care contracting and nursing services requirements.

1st Quarter Statistical Information Report

The DOH Division of Adult Care Facility and Assisted Living Surveillance recently issued a Dear Administrator Letter (DAL#: 18-08: 2018 Adult Care Facility 1st Quarter Statistical Information Report) reminding ACF operators that they are required to complete the 2018 ACF 1st Quarter Statistical Information Report, encompassing the time period from **January 1, 2018** to **March 31, 2018**. The DAL also specifies additional requirements for facilities with a certified bed capacity of 80 beds or more, in which **20%** or more of the resident population are persons with serious mental illness.

The 2018 ACF 1st Quarter Statistical Information Report (and Roster of Adult Home Residents, if applicable) must be submitted to the Department no later than **April 30, 2018**. Operators will be able to access and complete these reports on the HCS effective April 1, 2018. The survey forms can be accessed by logging onto HCS, here.

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Long Term Care Planning Council Issues Survey to Providers

The Department of Health and the Office for the Aging recently issued a letter requesting participation in a survey on barriers and gaps for New York's long term care system.

The survey is designed to assist the newly created Long Term Care Planning Council in its stated mission to prepare for the emerging needs of New York State's growing aging population.

Survey responses are due no later than **June 18, 2018**.

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HARP/BH HCBS Educational Materials

NYS has released the following Educational Materials for Behavioral Health Medicaid Managed Care:

- Adult Behavioral Health (BH) Home and Community Based Services (BH HCBS) Brochure
- Health and Recovery Plan (HARP) Brochure
- HARP Poster
- HARP Palm Card
- Behavioral Health Medicaid Managed Care Video Series

These materials are available for use in outreach and education to individuals eligible for and/or enrolled in Medicaid Managed Care Health and Recovery Plans, and Behavioral Health (BH) Home and Community Based Services.

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eMedNY Training Seminars and Webinars

The eMedNY Training Schedule for April - June is available and registrations for seminars and webinars are currently being accepted.

Some of the topics offered include:

- ePACES for Dental, DME, Free Standing and Hospital Based Clinics, Institutional, Nursing Home, Professional (Real-Time), Physician, Private Duty Nursing, and Transportation
- eMedNY Website Review
- New Provider/ New Biller

eMedNY training seminars are being held at the following locations:

- Canandaigua
- Poughkeepsie
- Rensselaer
- Cortland
- Hauppauge
- Williamsville
- Watertown

eMedNY also offers training webinars. Click here to view the training schedule and register.

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Legislative Spotlight

The Legislature will be in session on Monday, April 16 through Wednesday, April 18. The Senate Finance Committee will meet on Tuesday, April 17. The Assembly Codes Committee will meet on Tuesday, April 17.

Bills of potential interest include:

- S.517/A.1425 (Young/Jenne)**:** This bill would authorize individuals over the age of twenty-one with traumatic brain injury (TBI) to participate in programs that provide essential services to developmentally disabled individuals, in areas with limited traumatic brain injury service capacity. This bill is on the Senate Finance Committee Agenda.
- A.4738/S.4840 (Gottfried/Rivera)**:** This bill would provide for establishment of the New York Health plan (i.e. "single payer"), a proposal to establish a universal health care plan in NYS. This bill is on the Assembly Codes Committee agenda.

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Upcoming Calendar

Wednesday, April 18, 2018	NYS Board of Examiners of Nursing Home Administrators 10:30 a.m. Department of Health, 875 Central Avenue, Main Conference Room, Albany, NY
Thursday, April 19, 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. ESP Corning Tower Building, 2876A Conference Room, Albany, NY
Monday April 23, 2018	Assembly Hearing on Medical Aid in Dying (A.2383-A (Paulin)) 10:00 a.m. Legislative Office Building, Hearing Room B, Albany, NY
Friday, April 27, 2018	New York State Transplant Council 10:00 a.m. to 4:00 p.m. DASNY, 1 Pennsylvania Plaza, New York, NY
Thursday, May 3, 2018	Assembly Hearing on Medical Aid in Dying (A.2383-A (Paulin)) 11:00 a.m. Assembly Hearing Room, 250 Broadway, 19th floor, New York, NY
Wednesday, May 16, 2018	NYS All Payer Database Stakeholder Forum Meeting 11:00 a.m. to 3:15 p.m. Empire State Plaza, Concourse, Meeting Room 6, Albany, NY

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