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In This Issue:

State and Federal Impasse on Health Home Payments - $65.5 M

The U.S. Office of Inspector General (OIG) issued a report that claims New York State (NYS) improperly claimed an estimated $65.5 million in Federal Medicaid reimbursement for payments made to health home providers. The OIG found that for 22 of 100 sample payments reviewed, NYS improperly claimed federal Medicaid reimbursement for payments to health home providers that were not properly monitored by the State for compliance with Federal and State requirements related to billing, documenting, and service requirements. A

comprehensive individualized patient-centered care plan (care plan) is required for all health home enrollees. Of the 22 improperly claimed payments, OIG found that 13 of them were due to lack of a documented care plan.

In the report, State officials strongly disagreed with the sample and extrapolation methodology used to determine the $65.5 million overpayment and indicated that an extrapolation sample over a 5-year period is not a fair representation of payment distributions for the State's 34 health homes or its 400 care management agencies within the health home network. The State had commented that several steps have been taken to ensure health home providers comply with Federal and State requirements and will continue to collaborate with its Office of Medicaid Inspector General to further review the identified payments and determine an appropriate course of action.

HHS Pulls Proposed Rule Eliminating Rebates on Prescription Drugs in Medicare Part D and Medicaid Managed Care

Last Thursday, the Trump Administration withdrew an HHS proposed rule intended to eliminate payment of rebates by drug manufacturers on prescription drugs to Part D plan sponsors, Medicaid Managed Care plans, and pharmacy benefit managers (PBMs) who contract on behalf of these organizations.

The proposal was a signature part of the President's "Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs", but was allegedly pulled due to concerns about the impact the rule would have on Medicare Part D premiums for seniors. According to several news reports, HHS now intends to focus its attention on other initiatives to lower drug costs.

Medicaid Update – June 2019

To view the June 2019 - Medicaid Update in its entirety, click here. Here are a few highlights.

Medicaid Coverage of Limited Infertility Benefit

Effective October 1, 2019, Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) benefits will include medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals 21 through 44 years of age experiencing infertility. This applies to MMC plans, including mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs). FFS and MMC infertility benefits include office visits, hysterosalpingograms, pelvic ultrasounds, blood testing, and ovulation enhancing drugs included in the Medicaid formulary.

The ovulation enhancing drugs included in the Medicaid formulary are bromocriptine, clomiphene citrate, letrozole, and tamoxifen. FFS and MMC

infertility benefits will be limited to coverage for three (3) cycles of treatment per lifetime. The DOH is working with plans to ensure the lifetime limit can be tacked as members change from plan to plan. For Medicaid purposes, infertility is a condition characterized by the incapacity to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse for individuals 21 through 34 years of age, or after six (6) months for individuals 35 through 44 years of age.

Policy and Billing Updates:

***Billing Update for Bacillus Calmette-Guerin Intravesical (BCG)* – Effective for dates of service on and after July 1, 2019**, providers billing for Bacillus Calmette-Guerin (BCG) intravesical must use code "J9030: BCG LIVE INTRAVESICAL,1 MG". Due to the current BCG (intravesical) drug shortage, providers in Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) can use "J9030" to bill for single or multiple patient use of the single-use vial.

Policy Clarification – Medical Marijuana – The Department of Health has issued a clarification that Medical marijuana is not a covered benefit under Medicaid. However, practitioner office visits related to patient evaluation and certification for medical marijuana is a Medicaid reimbursable service. Patient evaluation and certification for medical marijuana is considered a comprehensive array of services and cannot be fragmented. Payment for the practitioner certification is included in Medicaid's payment for the office visit.

Pharmacy Reminders:

Pharmacy Fee-for-Service (FFS) Billing Guidance: Long Term Care and Foster Care (Child Care) Facilities* -** All pharmacy claims included in the facilities' FFS rate must be billed to the facility. The following process is necessary to successfully bill pharmacy claims that are not covered in the FFS rate by identifying and billing the appropriate coverage. The guidance provided must be followed ***prior to sending New York State Medicaid requests for retroactive claim overrides.

- Third-Party Liability (TPL) and Medicaid Eligibility Coverage – TPL and eligibility coverage should be checked at least twice monthly, and if applicable providers must bill third party insurers first, and must fulfill prior authorization requirements prior to submitting the claim to Medicaid.
- Medicare - Providers will bill Medicare Part B for Part B covered drugs or Medicare Part D for other prescription drugs and if the member has Medicare Parts A or B (or both) and does not have Medicare Part D, providers will bill Part D covered claims to Medicare Limited Income Newly Eligible Transition (LINET).
- Billing Claims That Require Medicaid Prior Authorization (PA) – For retroactive billings where the notification of eligibility date is within 90 days of the date of service, contact Magellan Health, Inc., and for members whose notification of eligibility is after 90 days of the date of service, LTC/FC facility pharmacies may send the claim information for retro-PA consideration to the Medicaid Pharmacy unit, within 30 days from the date

of notification of eligibility. All Retro-PA Claims submitted beyond the 30 days will be denied for payment by Medicaid.

All Providers:

Reminders **-** The Department has issued reminders regarding the following:

- Safeguarding Electronic Prescribing Credentials-Practitioner Responsibilities: Federal requirements in Title 21 of the Code of Federal Regulation (CFR) §1311.102 require the practitioner to retain sole possession of the hard token, knowledge factor, or biometric information and must not share this information, and must notify designated individuals within one business day of discovery that the hard token has been lost, stolen, or compromised or the authentication protocol has been otherwise compromised.
- Authorized Agents for Prior Authorizations of Prescription Drugs: Authorized agent requests must be made by an authorized agent which is defined as an employee of the prescribing practitioner who has access to the patient's medical records (i.e. - a nurse or medical assistant). Pharmacists can only initiate PAs for an emergency 72-hour supply (5-day supply for medications to treat substance use disorders) when an emergency condition exists where the health or safety of the person afflicted with such condition or other person(s) in serious jeopardy. Third party requests are prohibited.

Department of Health Announcements

DOH Issued a "Dear Administrator Letter" (DAL) Regarding Recent Adopted Regulations Relating to Reimbursement of Reserved Bed Days

The Department of Health recently issued a DAL providing information relating to recently adopted Regulations on May 29, 2019 which, for dates of service provided on and after May 29, 2019, eliminates Medicaid reimbursement of reserved bed days due to hospitalization leaves of absences for persons over age 21. The Regulation also eliminates the requirement for the nursing home to hold the bed for the resident while hospitalized; federal law, however, does require the facility to offer the next available bed to the returning resident. The statutory limitation of bed hold payments to nursing homes shall not apply to instances of temporary hospitalizations with respect to recipients under age 21 or recipients receiving hospice services in the nursing home. The DAL states the following regarding the bed hold reimbursement policy:

- Patients under 21 will be reimbursed at 100% of the Medicaid rate for hospital, therapeutic and hospice leaves of absences. There are no day limits for patients under 21 years old.
- Patients 21 and over on hospice will be reimbursed at 50% of the Medicaid rate otherwise payable to the facility for services provided. Payments cannot exceed 14 days in any 12 month period.
- Patients 21 and over on therapeutic leaves of absences will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided and payments cannot exceed 10 days in any 12 month period.

Any questions regarding the implementation of reserved bed days, contact the Department at 518-473-0045 (Laura Rosenthal) or email questions to nfrates@health.ny.gov.

Office of Health Insurance Programs (OHIP) Issues Guidance on FI Rate Structure

Department of Health (DOH) - OHIP has issued guidance to implement changes in reimbursement enacted in the SFY 2019-20 Budget for Fiscal Intermediaries (FIs) providing services under the Consumer Directed Personal Assistance Program (CDPAP). *Effective September 1, 2019*, DOH will implement a three-tier Per Member Per Month (PMPM) rate structure for Fiscal Intermediary (FI) services as defined in state law for FI administrative services provided to Medicaid fee-for-service (FFS) members enrolled in CDPAP. FIs will bill a separate rate code for each consumer for each month the FI is providing administrative service to that consumer based on the number of direct care hours authorized by the Medicaid Managed Care Plan or the Local Departments of Social Services (LDSS). Medicaid Managed Care Plans may either adopt the FFS three tiered payment structure or an alternative administrative fee payment, as long as the administrative fee is segregated from the direct care services payment. For details regarding the PMPM rates click here.

New York Medicaid Population Health Symposium

DOH has announced the *New York Medicaid Population Health Symposium*, which will take place in New York City *November 18-19, 2019*. Stakeholders of the New York Medicaid program are invited to engage in two-days of collaborative discussions and presentations with a focus on transition to Value Based Payments, and to share perspectives and insight of the DSRIP Performing Providers Systems, Physical and Behavioral Health Providers, MCOs, and to address social determinants of health through community organizations. The Department is seeking presentations for this event, and requests interested parties to respond by July 17, 2019.

Health Home Supervisory Training

The Department of Health (DOH) and Chapin Hall have announced that they will host CANS–NY introductory and supervisory training across the State in July 2019. These two training sessions will prepare attendees to take their certification examination, or educate care management supervisors on how to supervise around collaborative assessment, care planning, and progress monitoring with the CANS–NY.

Introductory training is offered for providers and health home care managers who are not yet certified in the CANS– NY, and Supervisor Training can participate in a full–day training for an overview of the ways that the CANS–NY has been used to meaningfully manage different service sectors in New York. DOH will soon require that all Health Home care managers and supervisors attend and participate in CANS-NY In-Person training.

To register for these training sessions log on to www.tcomtraining.com.

Updates to Ambulatory Patient Group (APG) Information

The Department of Health has updated the APG website to reflect the following changes:

- APG Rates : Hospitals, D&TCs and ASCs' APG rates by Provider;
- Reimbursement Components: "Never Pay Procedures" and "APG and Px-Based Weights History and APG Fee Schedules" were updated for July 2019; and
- 3M Versions and Crosswalk: 3M APG Crosswalk file for a new version (v3.14.19.3) was posted.

Managed Care Policy and Planning Meeting

On Thursday, the Department of Health held the monthly Policy and Planning Meeting with the State's Medicaid Managed Care plans. There was no MLTC update provided at the meeting.

Highlights from the meeting include:

- Mainstream Enrollment: Statewide enrollment for June was 4,315,739, a decrease of .12% since May (4,320,982). Enrollment in NYC decreased .41% and is now 2,500,068, compared to 2,510,405 one month ago. Upstate, enrollment was 1,815,671, an increase of .28% since May (1,810,577). In the past, Jonathan Bick has attributed the modest decline in NYC enrollment to mainstream migration to HARP plans.
- MCO Provider Enrollment in FFS: The State has seen an increase in the average number of new provider FFS enrollment applications received weekly since managed care plans started notifying network providers that have not enrolled in FFS that they would be terminated from managed care plan networks. DOH expects the number of new applications received weekly to continue to increase. If a provider receives a termination notice and does not submit an appeal or enrollment, the termination will be effective 60 days after the initial plan termination notice is sent to the provider.
- MLTC Enrollment: MLTC enrollment through the month of June is 266,985, an increase of 3,703 since May (263,282). This is the greatest monthly increase in MLTC program enrollment all year. Overall, the MLTC program has grown by 16.12% since last June. The Department of Health attributed the growth to an increasing aging population combined with a mandatory program. The majority of this growth continues to be in the MLTC partial cap program, which is currently at 235,945, compared to 232,418 one month ago. Thus, the MLTC partial cap program was responsible for 3,527 new enrollments out of the 3,703 increase observed. FIDA and MA continued their monthly enrollment declines (FIDA: 2,845 vs. 2,812; MA: 5,261 vs. 5,175) while the PACE program also experienced a modest month-over-month decline (5,804 vs. 5,776). Enrollment in MAP continues to grow at the fastest clip as a percentage of total enrollment, with enrollment now at 15,977 compared to 15,687 one month ago, and 13,904 in January. Overall, the program has increased by 47.89% since last June.

- Voluntary Foster Care Agency (VFCA) Carve-in: The VFCA carve-in date is no longer October 1, 2019. DOH indicated the new date could be February 1, 2020, but this has not been finalized.

State Department of Health Sets New Drinking Water Standards for Chemical Contaminants

The Department of Health Commissioner, Dr. Howard Zucker, has accepted the New York State Drinking Water Quality Council's (DWQC's) recommendations for maximum contaminant levels (MCLs) in drinking water for measurement of PFOA, PFOS and 1,4-dioxane. Upon review of the DWQC's recommendation in December 2018, the Department noted that these levels would be the nation's most protective MCLs for PFOA, PFOS, as well as the nation's first MCL for 1,4-dioxane. The Department has initiated the regulatory process by submitting proposed rulemaking expected to be posted in the July 24, 2019 issue of the New York State Register. The proposed regulations will be open to a 60 day public comment period, subsequently subject to possible revisions, or be submitted for adoption by the Public Health and Health Planning Council (PHHPC) with final approval by Commissioner Zucker.

The State has announced the availability of up to $350 million in grant funding to support water quality improvement projects to include those that would combat emerging contaminants with system upgrades, sanitary protections from results of flooding as well as technological innovations. Additional information regarding the State's Water Infrastructure Improvement Act grant funding opportunities can be found here.

OMIG – Medicaid Managed Care Program Integrity Reviews

As part of the SFY 2019-2020 New York State Budget, the Office of the Medicaid Inspector General (OMIG) will commence reviews of managed care organizations (MCOs) to evaluate compliance with program integrity sections of the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Contract (Contract). These reviews are authorized by Social Services Law Section 364-j (36) and 18 New York Codes Rules and Regulations Part 517.

Newly enacted Social Services Law section 364-j(36)(b) requires that OMIG publish on its website a list of contractual obligations subject to review. The Matrix of Contract Obligations and Performance Standards identifies the contract sections OMIG will review and how performance shall be measured.

OMIG will issue an Audit Notification Letter to MCOs identified for review detailing the review process, timeframe, document submission instructions, and OMIG contact information.

Questions regarding OMIG's Medicaid Managed Care Program Integrity Reviews should be emailed to: mmcreporting@omig.ny.gov

Office of the State Comptroller Releases Analysis of the State Budget Financial and Capital Plans

The Office of the State Comptroller (OSC) recently released an analysis of the State's Financial and Capital Plans, with the State Division of Budget (DOB) projecting a growth in tax receipts and federal aid for the SFY 2019-20 along with monetary settlements allowing for deposits to its statutory reserves. Despite DOB's expected growth in receipts, the Comptroller's Report (the Report) speaks to the uncertainty behind several of the factors in predicting for the future. The level of uncertainty associated with federal trade policies and the federal funding levels which include one-time funding sources could present for a challenge to achieve structural balance. The Report notes:

- **Federal funding**: Federal receipts are projected to increase nearly $3.5 billion, or 5.6 percent, in SFY 2019-20. Two-thirds of federally funded disbursements is for local assistance payments for Medicaid programs.
- **Structural Imbalance**: DOB estimates that the state's General Fund budget gap would total $3.9 billion in SFY 2020-21 and rise to $4.7 billion in SFY 2022-23 before actions to limit spending.
- **Capital Spending**: The Capital Plan projects capital spending of $66.8 billion over the current and next four fiscal years, including increases in housing, transportation and education. The total represents an increase of $327.9 million from the previous Capital Plan.
- **State-supported Debt**: State-supported debt outstanding is anticipated to increase by $13.6 billion, or 25.6 percent, over the five-year Capital Plan, with capacity under the state's debt cap projected to decline to $107 million in SFY 2023-24.

The Comptroller's message is clear that the sensitivity to both tax receipts and federal aid, along with the challenges to preserve a structural budgetary balance, will require the State to do more to improve its long-term outlook.

Long Term Care Planning Project: Meeting 3

On Tuesday, the State held the third meeting of the Long Term Care (LTC) Planning Project, focused on the topic of Family Caregiver Support. The purpose of the meeting was to discuss existing family caregiver supports and ways to increase awareness of these supports and services for people who don't know how to navigate the system. PowerPoint Presentations provided at the meeting are available here.

The meeting included a collaborative discussion among meeting participants on two questions: (1) what changes in programs, policies, and practices are needed to increase access to respite?, and (2) what new services or models are needed to overcome obstacles/and or build in strengths?

According to the presenters, there are more than 4 million informal caregivers in New York providing $32 billion worth of unpaid care. On average, informal caregivers contribute more than $10,000 of their own income to pay for care provided to a family member.

The LTC Planning Project is a joint effort by the New York State Department of Health (DOH) and the New York State Office for the Aging (NYSOFA) to improve aging and long-term care in New York. The Project is overseen by Mark Kissinger, who is now the Special Adviser to the Commissioner, but was formerly the Director of the Bureau of Managed Long Term Care at DOH.

The time and date of the fourth meeting has yet to be announced.

Regulatory Update

Department of Health

Medical Use of Marihuana

The Department of Health has issued a notice of adopted rulemaking that adds additional serious conditions for which patients may be certified to use medical marihuana. The original proposed rule was posted in the August 1, 2018 issue of the State Register, and revisions to the rule were posted in the April 3, 2019 issue that remove the requirement that a patient be enrolled in a treatment program certified pursuant to Article 32 of the Mental Hygiene Law. This regulation instead requires practitioners certifying patients for substance use disorder and opioid use disorder to hold a federal Drug Addiction Treatment Act of 2000 (DATA 2000) waiver. This rule is effective as of July 3, 2019.

Managed Care Organizations (MCOs)

The Department of Health has issued a notice of adopted rulemaking which amends the contingent reserve requirements for Managed Care Organizations (MCOs). This proposed regulation extends the lower contingent reserve requirements for calendar years 2019 through 2024, and establishes the requirements for calendar years 2025 and beyond. This rule is effective as of July 3, 2019.

Office of Mental Health

Expansion of Telemental Health (Telepsychiatry) Services to Additional OMH Licensed Settings and Programs

The Office of Mental Health (OMH) has issued a notice of adopted rulemaking that expands on the opportunity to offer telemental health services in the New York State regulated mental health system. Originally limited to services provided by psychiatrists and nurse practitioners, these amendments expand the range of services that can be offered by mental health providers approved by the OMH to deliver telemental health services to include services of psychologists, social workers, and mental health counselors. This rule includes non-substantive changes from its original version posted in the January 23, 2019 issue of the State Register. This rule is effective as of as of July 3, 2019.

Related Articles and Other News

DOH and Local Health Departments - Investigation of Cyclosporiasis Cases in the Capital Region

HHS to Transform Care Delivery for Patients with Chronic Kidney Disease

Appeals court appears likely to call for lower court to settle unanswered questions on ACA lawsuit

Calendar

Thursday July 18, 2019	The Public Health and Health Planning Council – Committee Meeting Day 10:15 a.m - Empire State Plaza, Concourse Level, Meeting Room 6, Albany
Thursday, August 8, 2019	The Public Health and Health Planning Council – Committee on Codes, Regulations and Legislation and Full Council Meeting 9:15 a.m. - 90 Church Street, 4th Floor, Rooms 4A & 4B, NYC

Quick Links

NYS Department of Health --- **NYS DOH –Meetings, Hearings & Special Events** --- **Medicaid Redesign Team** --- **Senate Health Committee Website** --- **Assembly Health Committee Updates** --- **NYS Division of Budget**