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In This Issue:

Filed Lawsuit Challenging DOH Policy Change on Reimbursement Rates for Fiscal Intermediaries

Fiscal Intermediaries (FIs) in the Consumer Directed Personal Assistance Program (CDPAP) recently filed a lawsuit challenging changes to the FI's administrative reimbursement rates in Managed Care Policy 19.01 issued by the State Department of Health (DOH). Following the DOHs decision to revise the fee

for service Medicaid rate, MLTC Policy 19.01 changes FI's administrative reimbursement from an hourly rate to a fixed tiered "per member-per month" structure, and is scheduled to go in effect on September 1, 2019. MLTC Policy 19.01 was ostensibly issued by DOH in accordance with savings included in the enacted SFY 2019–20 Budget which reflected changing reimbursement methods for FI services under the CDPAP. The "PMPM" payments are based upon the number of authorized hours of direct care services for the member.

The Petitioners claim that the new methodology will lead to reimbursement which is insufficient to meet the administrative costs incurred by reasonably efficient FIs, and significantly below the costs incurred by individual FIs within CDPAP. The Petitioners argue that the new reimbursement methodology will cause many FIs to exit the industry. The Petitioners have requested a preliminary injunction to stay MLTC Policy 19.01 from taking effect.

DOH (i.e. the State) has made a motion to dismiss the case and the Petitioners have filed reply papers in response. The Petitioners argue that health care providers affected by a Medicaid rate change have standing to challenge the change in payment methodology. They also argue that a shift to a "PMPM" structure is required to be conducted through a regulatory rule change, and strongly oppose claims that the shift in methodology may be conducted as an explanatory statement or interpretation of the State budget.

The State has stated in their briefings filed last week, that the Petitioners are relying on the incorrect regulation (18 NYCRR 505.14), and point out that under 18 NYCRR 505.28, DOH has the ability to establish the rates for FIs providing services under the CDPAP. Additionally, DOH continues to emphasize the lack of standing by the Petitioners, as the CDPAP regulations are intended to protect consumers' interests, and not the FIs. The State continues to support that Managed Care Policy 19.01 implements the necessary provision of the Enacted Budget set to reduce spending within the program's targeted budget.

The Petitioners' motion for a preliminary injunction and DOH's motion to dismiss are now fully submitted, and the case has been assigned to Justice Christina Ryba for consideration.

DOH has posted the following template notices for implementing MLTC Policy 19.01 on its website:

- FI Cease Operations: MCO/LDSS to Consumer
- FI Cease Operations: MCO/LDSS to Consumer 2nd Notice
- FI Cease Operations: FI to Consumer
- FI Cease Operations: FI to PAs
- FI Cease Operations: FI to MCO/LDSS
- CDPAP Consumer Service Authorization Transfer Consent Form
- CDPAP Medical Record Authorization Transfer Consent Form

A list of FAQs by consumers regarding changes to FI services under the CDPAP is also available on the DOH website.

Public Health and Health Planning Council (PHHPC) Meetings

The Public Health and Health Planning Council (PHHPC) recently held a full council meeting in New York City. A link to the full PHHPC agenda materials can be found here.

Prior to the full Council meeting, there was a Special meeting of the Codes, Regulations and Legislation Committee (CRLC) in which the CLRC considered one motion for adoption and three topics for information.

Motion for adoption:

- Regulation that will require nursing homes to advise a resident as well as provide information about, the availability of home and community based services as well as community transition programs, upon admission. This regulation would expand on the current practice of nursing homes.

The CRLC recommended the motion for adoption, and the Full Council subsequently recommended the motion for approval.

The Council also discussed three regulations "for information" only, of which will:

1. make updates to diagnostic and treatment centers (D&TCs) Patients' Bill of Rights and requires D&TCs to provide patients a list of the health plans and the hospitals that the center participates with as well as to receive an estimate of the amount they will be billed after services are rendered;
2. remove the minimum one year experience requirement for nurses serving in specialty areas including emergency departments and would replace the one year minimum experience requirement with completed training and education specific to the specialty area, along with ongoing education and competency maintenance; and
3. establish maximum contaminant levels (MCLs) in drinking water for measurement of PFOA, PFOS and 1,4-dioxane.

Other highlights from the full Council meeting included presentations by Department of Health Staff including:

- ***Executive Deputy Commissioner, Sally Dreslin*****,** presented updates on the Department's activity, particularly related to measles outbreak tracking and progress including promotion of vaccinations with schools beginning classes in September, DOH's acceptance of water quality standard recommendations, the recent announcement of the first round of Statewide Health Care Facility Transformation – III funding awards, State's efforts to protect Title X funding, along with the preparations for the NY State of Health's - 2020 Open Enrollment Period.
- ***Deputy Commissioner, Office of Public Health, Brad Hutton,*** presented on the Department's progress and efforts in childhood lead poisoning prevention, lead line replacement in public drinking water, collaborative work with local health departments and FDA to identify suspected food born contaminants stemming from imported basil, and the State's pioneering work of the Health Across All Policy Workgroup.

The full Council also endorsed revised policy changes presented by the Department regarding the assessment of impact on the local healthcare delivery system, particularly the impact to Critical Access Hospitals and Sole Community

Hospitals, upon Certificate of Need (CON) approval of Ambulatory Surgery Centers (ASCs).

The full Council also discussed several CON applications on their agenda of which all were recommended for approval.

The next PHHPC Committee meetings are scheduled for Thursday, September 26, 2019 in NYC and the next PHHPC Full Council meeting is scheduled for Thursday, October 10, 2019 in NYC.

Department of Health Announcements

Approval of Federal Medicaid Waiver to Improve Access to Care for Children with Complex Health Needs

The State Department of Health announced that a proposal for a new Medicaid model of care serving children throughout the state with complex health needs has been approved by the federal Centers for Medicare and Medicaid Services (CMS). The new streamlined care model will improve access to Medicaid services and expand Medicaid coverage to home- and community-based care for more than 6,000 youth under age 21 who are faced with an array of serious health issues and otherwise could be forced to live in hospitals and other institutionalized settings. The approval of this waiver will allow for maximized efficiencies in the management of care coordination by authorizing managed care plans to provide home and community based services to a unique population of medically fragile children. The aim of the project is to improve clinical outcomes, reduce health care costs by reducing unnecessary emergency room visits, promote a preventative health approach, integrate behavioral care, health services and community supports, and increase network capacity of community-based recovery oriented services. Expanded home- and community-based services will now billable to the Medicaid program.

Community-Based Organization Directory and Engagement Survey

The New York State Department of Health (DOH) has released a new statewide Community Based Organization (CBO) directory and engagement survey. The survey has been simplified based on feedback from stakeholders and designed to capture information about CBO service provision for the purpose of making connections with Managed Care Organizations (MCOs) and Value Based Payment (VBP) contractors. This survey is replacing last year's CBO survey and is open to all non-profit, community-based organizations. Information gathered through this new survey will be used to generate a new CBO directory.

The CBO survey can be found at: https://www.surveymonkey.com/r/SDH-CBOSurvey.

Please direct any questions to SDH@health.ny.gov.

Managed Care Policy and Planning Meeting

The Department of Health recently held the monthly Policy and Planning Meeting with the State's Medicaid Managed Care plans.

Highlights from the meeting include:

- Mainstream Enrollment: Statewide enrollment for July was 4,299,897, a decrease of .37% since June (4,315,739). Enrollment in NYC decreased .53% and is now 2,486,735, compared to 2,500,068 one month ago. Upstate, enrollment was 1,813,162, a decrease of .14% since June (1,815,671). In the past, Jonathan Bick has attributed the modest decline in enrollment to mainstream migration to HARP plans.
- MCO Provider Enrollment in FFS Medicaid: The State has seen an increase in the average number of new provider enrollment applications received weekly since managed care plans started notifying network providers that have not enrolled in FFS that they would be terminated from 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. DOH clarified that Fiscal Intermediaries are not currently an enrollable provider type.
- MLTC Enrollment: MLTC enrollment through the month of July is 270,306, an increase of 3,321 since June (266,985). Overall, the MLTC program has grown by 15.87% since last July. The majority of this growth continues to be in the MLTC partial cap program, which is currently at 239,014, compared to 235,945 one month ago. Thus, the MLTC partial cap program was responsible for 3,069 new enrollments out of the 3,321 increase observed. FIDA and MA continued their monthly enrollment declines (FIDA: 2,705 vs. 2,812; MA: 5,085 vs. 5,175) while the PACE program also experienced a modest month-over-month decline (5,736 vs. 5,776). Enrollment in MAP continues to grow at the fastest clip as a percentage of total enrollment, with enrollment now at 16,442 compared to 15,977 one month ago, and 13,904 in January. Overall, the program has increased by 46.72% since last July.
- Children's HCBS Waiver Transition: CMS approved the 1115 waiver amendment to transition Children's HCBS waiver services into mainstream Medicaid managed care beginning October 1, 2019. Voluntary Foster Care Agency services and population will be carved-in beginning February 1, 2020.

OMIG – Medicaid Managed Care Program Integrity Reviews

As part of the 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 (the Matrix) identifies the contract sections OMIG will review and how performance shall be measured. The Matrix pertains to MMC Model Contracts and is valid for reviews conducted within the Review Period covering 1/1/18 – 12/31/18.

Update: OMIG will evaluate MCO performance under each line of the Matrix and assess a score for that line (between 0% and 100%), and then take the average score for all Matrix Lines ("ML"). Where OMIG has determined an MCO is not meeting its program integrity obligations under the contract, OMIG may recover as much as 2% of the MCO's administrative component, depending on the MCO's average scoring.

OMIG will issue an Audit Notification Letter to MCOs identified for review, to include details of 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

eMedNY: Medicaid Managed Care Network Provider Enrollment PowerPoint Updated

eMedNY recently provided an update of the Medicaid Managed Care Network Provider Enrollment PowerPoint. The updated version is now available on the website found at https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/MMC_Childs_Health_Insurance_Program_-_8-15-2019.pdf

For questions or assistance, contact the eMedNY call center at (800) 343-9000.

Senate Majority Announces Madison County Roundtable On Opioids, Addiction & Overdose Prevention

Senate Majority Leader Andrea Stewart-Cousins recently announced that the Joint Senate Task Force on Opioids, Addiction & Overdose Prevention is holding a roundtable discussion in Madison County that will be focused around the challenges faced by rural communities.

The Madison County roundtable will be on Monday, August 26 at 11:00 AM in the Madison County Board of Supervisors Chambers in Wampsville, NY.

If interested in participating in the hearings or roundtables conducted by the Joint Senate Task Force on Opioids, Addiction & Overdose Prevention, RSVP to: nysoverdosetaskforce@nysenate.gov

State Announces Opposition to Federal Proposal of Non-Discrimination Protections

Governor Cuomo recently announced the multi-agency opposition to the federal government's proposed revision to non-discrimination protections of healthcare included in the Affordable Care Act. The State Department of Financial Services (DFS), Division of Human Rights and the Office of Children and Family Services submitted comments urging the federal government to abandon the U.S. Department of Health and Human Services (HHS) proposal that would undermine discrimination protections for transgender and gender nonconforming individuals and limit the types of insurance that must comply with the Affordable Care Act's nondiscrimination protections. Superintendent of DFS, Lina Lacewell, issued a letter to HHS Secretary, Alex M. Azar II, arguing that the proposed rule makes significant rollbacks to healthcare protections for the LGTBQ community, particularly transgender and gender non-confirming individuals. The State Department of Health, the Office for People with Developmental Disabilities and the Office of Mental Health are expected to also submit comments in opposition to the proposed rule within the week.

ALP Expansion and Funding Opportunities

The New York State Department of Health (DOH) has issued a Request for Applications (RFA) to award up to 1,000 Assisted Living Program (ALP) beds (Component A). The RFA is open to eligible entities that are new to the delivery of adult home or enriched housing program services and to currently-licensed adult homes or enriched housing programs new to the delivery of ALP services. This initiative will allow for the addition of up to 1,000 ALP beds in those counties where there is currently no more than one ALP provider and/or where the county's current ALP capacity exceeds 85.0%.

The expansion initiative also includes a second component, ALP Capital Projects (Component B), to provide grants in support of capital projects directly related to the establishment of an Adult Home (AH) or Enriched Housing Program (EHP) with an Assisted Living Program (ALP) or to increase the number of available ALP beds located in an existing facility within specific counties. The funding for ALP capital projects is intended to improve financial sustainability, preserve or expand health services to ALP residents, modernization of facilities, and to promote participation in alternative payment arrangements such as managed care organizations and accountable care organizations. The State will provide up to $20 million in capital awards through this component.

Letters of Intent are due by September 13, 2019 and applications are due by November 14, 2019 at 4 pm for Component A, and Letters of Intent are optional for Component B. All questions are due by September 13, 2019.

Regulatory Update

Department of Financial Services

Charges for Professional Health Services

The Department of Financial Services ("DFS") has issued a notice of adopted rulemaking to delay the effective date of the Workers' Compensation fee schedule increases for no-fault reimbursement.

Background: The Worker's Compensation Board had issued a notice of proposed rulemaking in December of 2018 intended to update and incorporate fees for medical services provided to injured workers. This proposed rule would impose costs on insurance carriers and self-insured employers, as the proposed rule increases the emergency room services reimbursement rate and establishes a fee schedule for clinic services and private psychiatric hospitals.

This rule will postpone the effective date of the fee schedule to 10/1/2020 rather than 4/1/2019. This will allow additional time for insurers effected by the updated fee schedules to evaluate and make adjustments needed to operationalize the new fee amounts.

Minimum Standards for Form, Content and Sale of Medicare Supplement and Medicare Select Insurance, et al

DFS has issued a notice of proposed rulemaking to establish a framework for the form, content and sale of Medicare supplement insurance as required by federal law. States must have a regulatory program that provides a minimum level of coverage, which is equal to or more stringent than the standards set forth in the National Association of Insurance Commissioners ("NAIC") Model Regulation, as established by 42 U.S.C. Section 1395ss.

In accordance with the federal Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), the NAIC adopted a revised model regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act ("the Act"). The Act sets forth the model standards for all states, providing "grandfather" protections including the option to continue coverage for those individuals insured under a Plan C who carry coverage up to January 1, 2020, and requires Medicare supplemental plans to offer either a Plan D or G in addition to Plans A and B to all individuals newly eligible for Medicare. Additionally, a new high deductible Plan G has been created for offering beginning January 1, 2020. The changes included in the proposed regulations reflect those required by MACRA. An appendix providing additional details was filed with the notice of proposed regulations.

This regulation will be open to public comment for 60 days from August 7, 2019.

Minimum Standards for Contraceptive Coverage

DFS has issued a notice of revised rulemaking to establish regulatory framework for the provision of broad contraceptive coverage by health insurers. This regulation is being revised in order to comply with Chapter 25 of the Laws of 2019 and Part M of Chapter 57 of the Laws of 2019 which requires every policy or contract that provides medical, major medical, or similar comprehensive type coverage to provide broad contraceptive coverage, to include all FDA approved contraceptive drugs, devices, and other products, as well as requires the DFS Superintendent to promulgate regulations establishing a method for insured

individuals (or their designee or health care provider) to request coverage for a non-covered contraceptive drug, device or product.

The regulation allows for a request to be submitted on behalf of the insured individual to the insurer for the coverage of a non-covered contraceptive drug, device, or product. This request must indicate whether the covered contraceptive drug, device, or product is not available or is medically inadvisable for the insured. The health care provider may warrant the use of a non-covered equivalent contraceptive, and the insurer will be required to provide coverage for a non-covered contraceptive within 72 hours for a standard request, or within 24 hours in the event of an expedited request. An expedited request would be based on "exigent circumstances" as described in the regulation to include circumstances of jeopardy to the health or life of the insured individual.

This regulation will be open to public comment for 45 days from August 14, 2019.

Workers' Compensation Board

Updating the Prescription Drug Formulary

The Worker's Compensation Board has issued a notice of proposed rulemaking to update the prescription drug formulary newly established under regulations posted in the June 5, 2019 issue of the State Register which includes high-quality and cost-effective pre-authorized medication. This rule would make changes to the most recently established prescription drug formulary, noting the changes as a "second edition" which identifies the list of drugs into three categories.

This rule will be open to public comment for 60 days from August 7, 2019.

Related Articles and Other News

New York State Department of Health Issues Health Advisory on Vaping-Associated Pulmonary Illness

Home Health Care Drives Job Growth – 32% of the Jobs Added Between 2016 and 2019

Attorney General James Joins 38 State Coalition Urging Congress To Remove Federal Barriers To Treat Opioid Use Disorder

HealthCare.gov and State Obamacare Insurance Exchanges to Publish CMS Star Quality Ratings for Health Plans

Governor Cuomo Directs Department of Health to Apply for Federal Waiver to Provide Medicaid Services to Incarcerated Individuals Leaving Prisons and Jails

Calendar

Wednesday, August 21, 2019	Lead Poisoning Prevention Advisory Council Meeting Empire State Plaza, Concourse Level, Meeting Room # 1 10:30 a.m. - 3:00 p.m., Albany, NY
Thursday, September 26, 2019	The Public Health and Health Planning Council – Committee Meeting Day 10 a.m. 90 Church Street, 4th Floor, Rooms 4A and 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**

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