Medicaid Managed Care Policy and Planning Meeting

Last Thursday, the Department of Health held its monthly Medicaid Managed Care Policy and Planning Meeting in Albany.

Jason Helgerson, the State’s Medicaid Director, called the “number one issue” of the day the problems plans and the State were experiencing with respect to the pharmacy benefit.

Plans have reported sizeable losses thus far, and while some have pointed to inadequate PM/PM premiums as being the culprit, there have also been issues with the pharmacy encounter data, as many plans have reported seeing inconsistencies between the data received by the Department and their own approved encounter data.

During a conference call earlier in the week to discuss pharmacy encounter data reporting issues, John Ulberg, the Department’s CFO for Finance and Rate Setting, noted that a workgroup of DOH staff and plan representatives are working to determine if there are any glitches in the reporting system, or if there are issues with respect to the PM/PM payments currently being paid.

Greg Allen, the Department’s Director of Program Development and Management was also on hand to urge the plans to sign contracts with Health Homes as soon as possible using the Department’s boilerplate language. Jason Helgerson specifically requested that plans do this “within the next two weeks”. Greg Allen explained that Health Homes have incurred a lot of upfront costs, and are experiencing “great anxiety” without the volume of members being referred by the plans. Mr. Allen indicated that a town hall meeting in New York City has been planned to walk through the issues impacting patients, Health Homes, and the plans.

Valencia Lloyd, the Director of Health Plan Contracting & Oversight discussed the New York State Academic Dental Centers, and noted that provisions in law and in the State’s model contract with plans that allow members to directly access “routine” services (even if the clinic is
non-par and if the plan formerly did not offer dental benefits) at these clinics would continue. However, non-routine services would be subject to prior approval by the plans. The definitions for “routine” and “non-routine” services have not yet been provided, but examples of “non-routine” services would include orthodontia and crowns.

MLTCP Implementation Update

The Department of Health intends to release next week a Q&A on the Continuity of Care policy for Managed Long Term Care Plans providing personal care services in New York City as well as final enrollment materials from Maximus, the state’s enrollment broker.

The Department is still welcoming comments on draft marketing guidelines for MLTCPs. However, the Department will not be issuing further guidance on the transition plan it is requiring MLTCPs to submit for review detailing the plan’s strategy for insuring the continuity of care of the transitioning fee-for-service population. MLTCPs have been advised to use “best judgment.”

Approval from CMS is reportedly “very close,” and the Department and CMS has been engaging in regular discussions in order to safeguard the current July 1 auto-enrollment date.

Federal Report Cites Medicaid Overpayments to New York State for Developmental Disability Services

Last Friday, the New York Times reported that a U.S. Inspector General Report found that in 2009, the federal government made over $700 million in payments above and beyond what New York State actually needed to care for individuals with developmental disabilities residing in institutions. No penalties were recommended because the payments were approved by federal regulators, but federal officials are planning to scale back reimbursements to the state over a period of several years.

New York spends approximately $10 billion a year on care for those with developmental disabilities—more than California, Florida, and Texas combined.

OMH Training Session on APG Reimbursement for Mental Health Clinics

Last Tuesday, staff from the Office of Mental Health held an informational training session and webinar to provide assistance in complying with legislative mandates set to go into effect July 1, 2012, which will require Medicaid managed care and family health plus plans to reimburse Article 31 clinics the APG FFS rate for a specific list of Mental Health services. The mandate applies for reimbursement payments made to both free-standing and hospital-based Article 31 clinics, and excludes Child Health Plus plans from the mandate.

During the meeting, many stakeholders indicated that there was simply not enough time to update their systems to include the new APG rates in order to be operational by Staff from OMH and DOH indicated that the idea had been floated to hold off on the implementation to address these concerns. During Thursday’s Medicaid Managed Care Policy and Planning
Meeting, John Ulberg noted that a temporary delay was “likely”, though it is not clear whether the Department will establish a temporary average reimbursement rate or continue with current reimbursement in the interim.

**Request for Proposals Issued for Prevention of Chronic Diseases**

New York’s Department of Health (“DOH”) has issued a Request for Proposals in search of a contractor to administer the financial incentive allocation of the Medicaid Incentives for Prevention of Chronic Disease Initiative. The contractor will also be responsible for collecting data related to participant participation in the program.

The Center for Medicare and Medicaid Services awarded DOH a significant grant under the federal Affordable Care Act that will be used to give incentives to Medicaid enrollees in order to encourage the management and prevention of certain chronic diseases. These incentives will be awarded to individuals who participate in preventive activities, therefore encourage the utilization of preventive services among Medicaid recipients.

The RFP, along with the set of required contractor qualifications, can be viewed [here](#).

**Regulatory Updates**

**DOH**

- Last week the Department published a notice that it has adopted an emergency rule to implement a statewide pricing methodology for the non-operating component of Medicaid nursing home reimbursement rates. The 2011-12 SFY Budget authorizes the Commissioner to promulgate emergency regulations with respect to Medicaid reimbursement rates for residential health care facilities.

  The statewide pricing methodology changes would be limited to the non-operating component of the nursing home rates, and would include adjustments for differences in regional labor costs and a patient’s case mix index. The non-capital component of the rate—which is not subject to the new reimbursement methodology, will be the rates in effect for such facilities on January 1, 2009. The emergency rule also includes a multi-year transition plan inclusive of a per diem transition rate adjustment to allow for a smooth transition to the new methodology.

  The statewide pricing methodology is effective May 1st, 2012. The new methodology is intended to transform what was formerly a cumbersome and administratively complex system of rate setting into a stable, predictable system that rewards efficiencies and incentivizes quality outcomes. The revised system is also intended to provide a good foundation for nursing home providers to prepare for the transition of nursing home residents to Medicaid Managed Care.

  The Department has also adopted on an emergency basis amendments that would extend the statewide base price reduction for Medicaid hospital inpatient rates, such that total Medicaid payments would be decreased by $19,200,000 for the period May 1, 2012 through March 31, 2013.

  The statewide base price reduction is related to an MRT adopted proposal that called for a
reduction to unnecessary cesarean deliveries to promote quality care and reduce unnecessary expenditures. Under the proposal, the MRT earmarked $24.2 million in gross savings that needed to be obtained from July 1, 2011 through March 31, 2012. However, in light of concerns raised by provider groups that a more clinically sound method was needed, an obstetrical work group was created to develop a more clinically sound approach to achieving the savings, though in light of the need to comply with the global cap, the $24.2 million (state share $12.1 million) total Medicaid payment reduction remained in effect. Following these work group meetings, a new proposal was ultimately developed; however, this proposal failed to achieve the savings required, missing the mark by $5 million. As a result, this emergency amendment continues the base price reduction at $19.2 million ($9.6 million state share) for the period May 1, 2012 through March 31, 2013 to account for $19.2 million shortfall between the actual savings and the savings needed to be obtained.

• The DOH released the long awaited regulations relating to limits on administrative expenses and executive compensation for both not for profit and for profit entities which receive state funding. In general, the regulation applies to those entities in which, as a result of a contract or other agreement with the state or other government entity, receive at least $500,000 from, and at least 30% of their revenues are attributable to, “State funds from the department or payments of funds that are not State funds but which are distributed or disbursed upon approval of the department or by another governmental entity upon such approval or by virtue of the provider having approval to operate from the department”. In those cases, beginning 1/1/13, entities must spend at least 75% of “covered operating expenses” (which excludes capital, property rental and equipment rental and depreciation) must be spent on “program services”, which is defined as “those services rendered by a covered provider or its agent directly to and for the benefit of members of the public”. The 75% threshold is increased annually until it reaches 85%. Likewise, such entities may not spend greater than $199,000 in such government revenue on executive compensation.

There are waiver provisions and numerous exemptions and limitations relating to these rules which will be explained in detail in a separate memorandum.

DFS

The Department of Financial Services has adopted a rule that amends the minimum standards for the New York State Partnership for Long Term Care Program. The amendments were the result of an MRT recommendation and were formerly effective on an emergency basis. There are no changes in the final rule from the prior emergency adoption.

In essence, the rule modifies the New York State Partnership for Long Term Care Program to entice more NY residents to purchase long-term care insurance by providing that purchasers of qualifying policies would become Medicaid eligible without spending down their assets once the benefits from the policy expire. The rule allows policies to offer a minimum of two years of nursing home coverage and four years of coverage for home care services at half the nursing home benefit rate (referred to as the 2/4/50 Plan), as well as optional inflation protections. Once the benefits under the 2/4/50 Plan expire, the insured individual would become Medicaid eligible.

Legislative Spotlight

Legislative Committee agendas continue to grow exponentially in both Houses as the remaining weeks in the 2012 Legislative Session quickly dwindle. Many contentious bills are beginning to gain steam as the end of Session approaches.
Upcoming Calendar


May 23, 2012 - Meeting of the Establishment Committee of the Public Health and Health Planning Council (DOH Metropolitan Office, 90 Church St., Manhattan)

May 24, 2012 - Meeting of the Committees on Codes, Rules, and Legislation, Public Health, and Health Planning of the Public Health and Health Planning Council (DOH Metropolitan Office, 90 Church St., Manhattan)

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