NEW YORK STATE | Department of Health

Medicaid Managed Care Program Update

Monthly Managed Care Policy and Planning Meeting

Topics

- Enrollment Update
- Bureau of Managed Care Fiscal Oversight Updates
- BH Carve In: MAP Status
- Managed Long Term Care (MLTC) Disenrollment Reasons
- Dual Eligible Initiatives Updates
- Update: Home and Community-Based Services (HCBS) Self-Assessments For Social Adult Day Care (SADC)
- SFY 2023 enacted budget: No Surprises Act & Administrative Simplification

Total Medicaid Managed Care Enrollment

Months	Total Medicaid Managed Care
Nov-2021	5,668,864
Dec-2021	5,697,809
Jan-2022	5,736,983
Feb-2022	5,760,225
Mar-2022	5,780,569
Apr-2022	5,775,508

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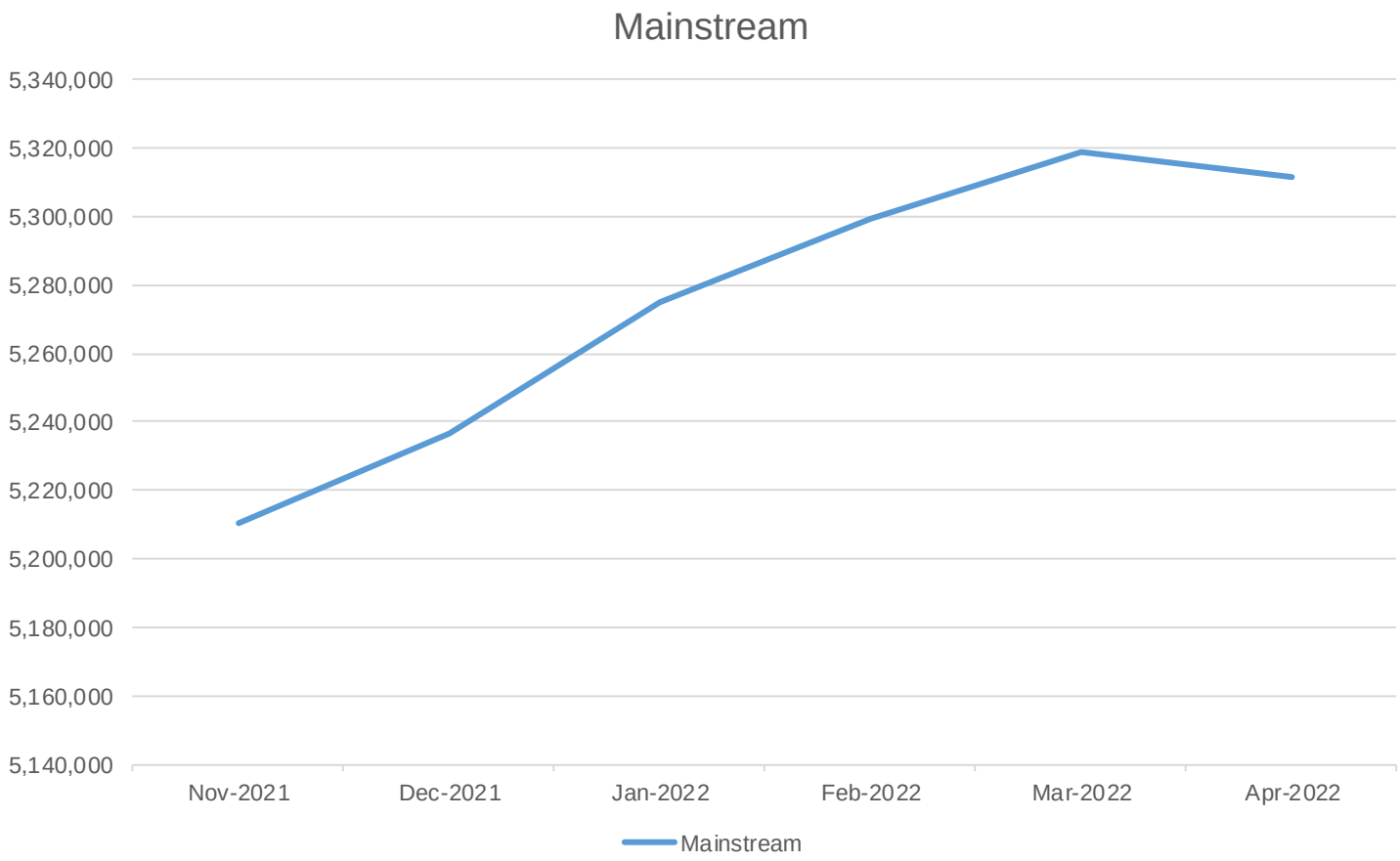
Mainstream Enrollment

Months	Mainstream
Nov-2021	5,210,467
Dec-2021	5,236,827
Jan-2022	5,274,981
Feb-2022	5,299,119
Mar-2022	5,318,944
Apr-2022	5,311,357



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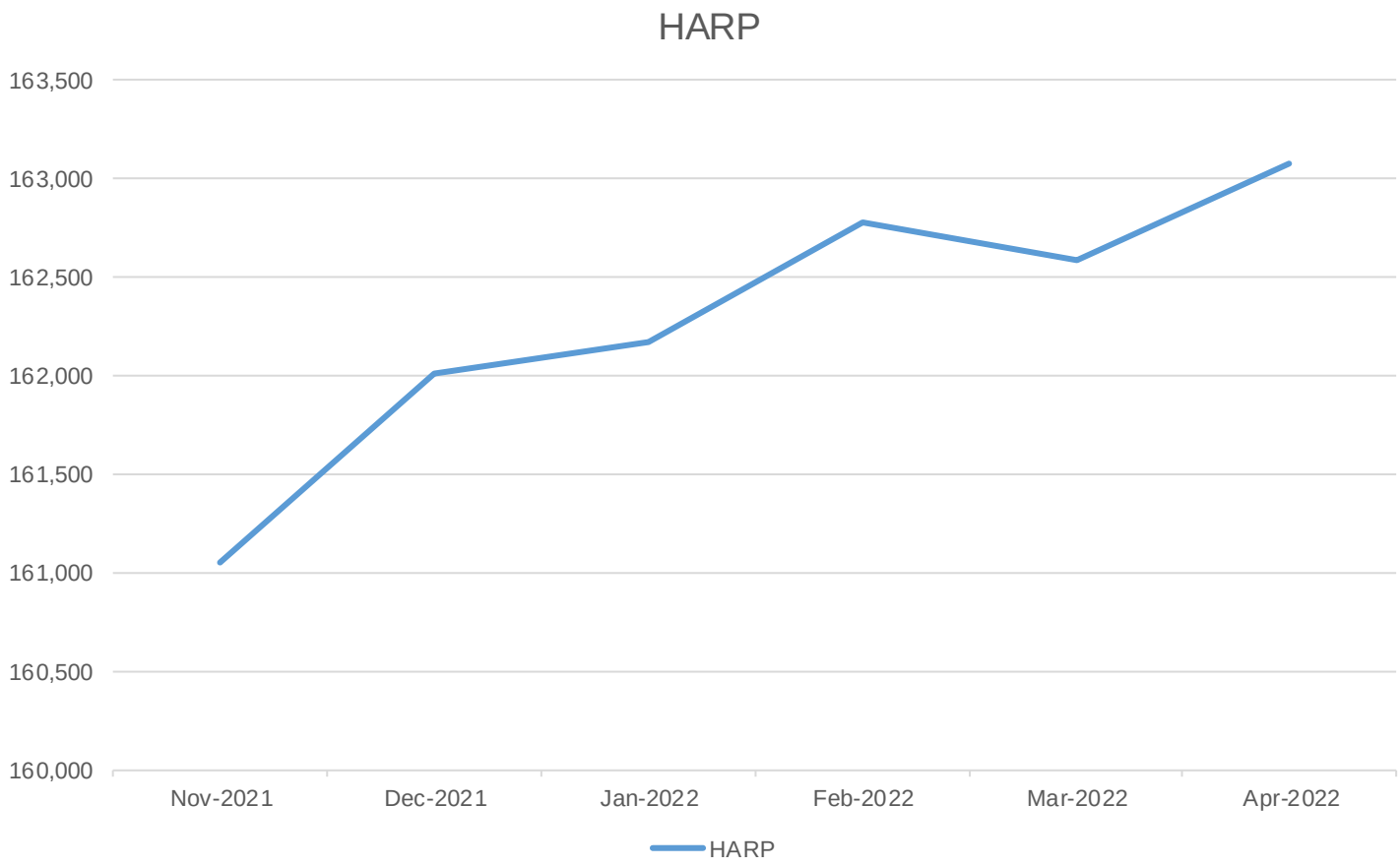
HARP Enrollment

Months	HARP
Nov-2021	161,056
Dec-2021	162,006
Jan-2022	162,170
Feb-2022	162,773
Mar-2022	162,587
Apr-2022	163,076



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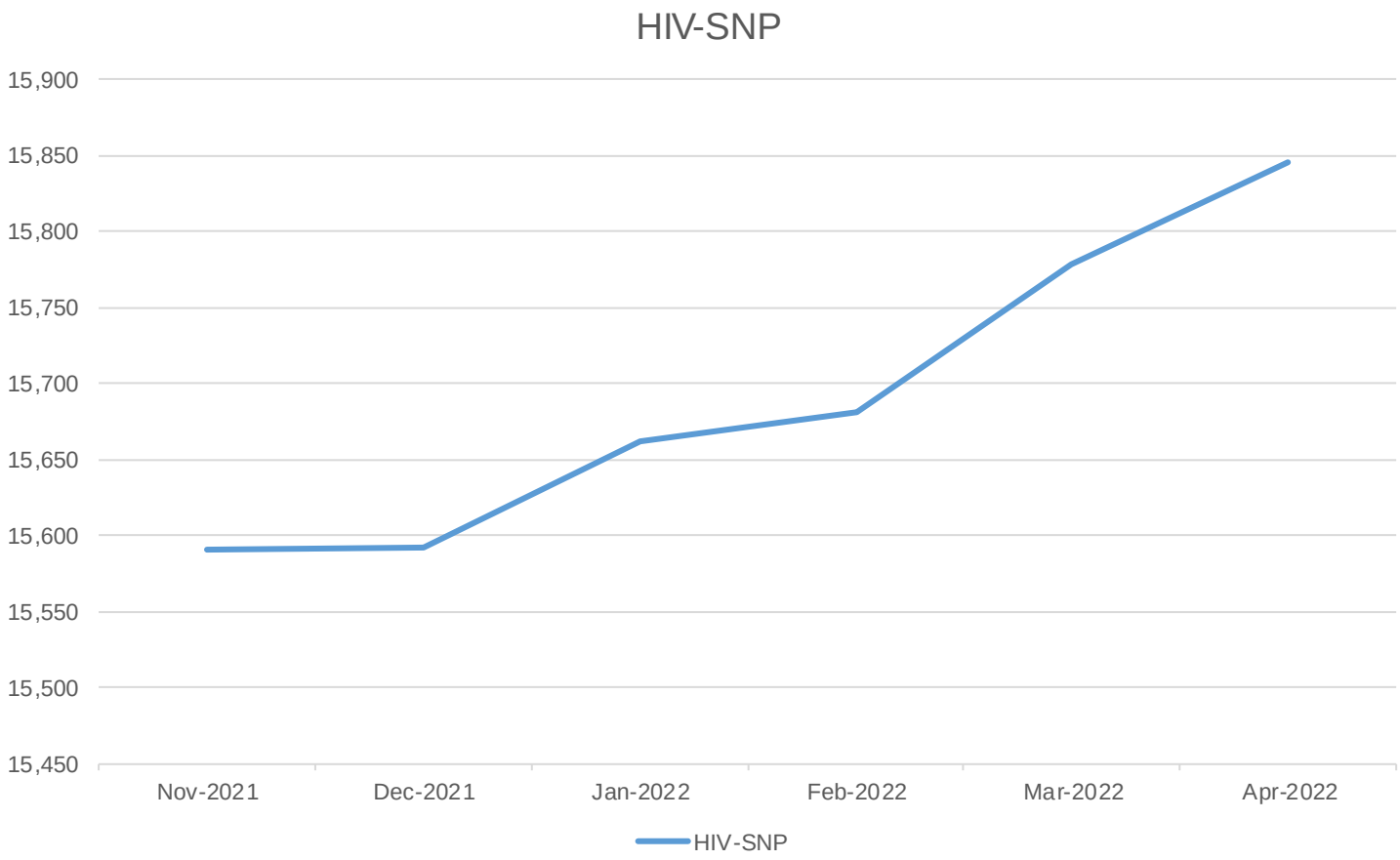
HIV-SNP Enrollment

Months	HIV-SNP
Nov-2021	15,591
Dec-2021	15,592
Jan-2022	15,662
Feb-2022	15,681
Mar-2022	15,778
Apr-2022	15,846



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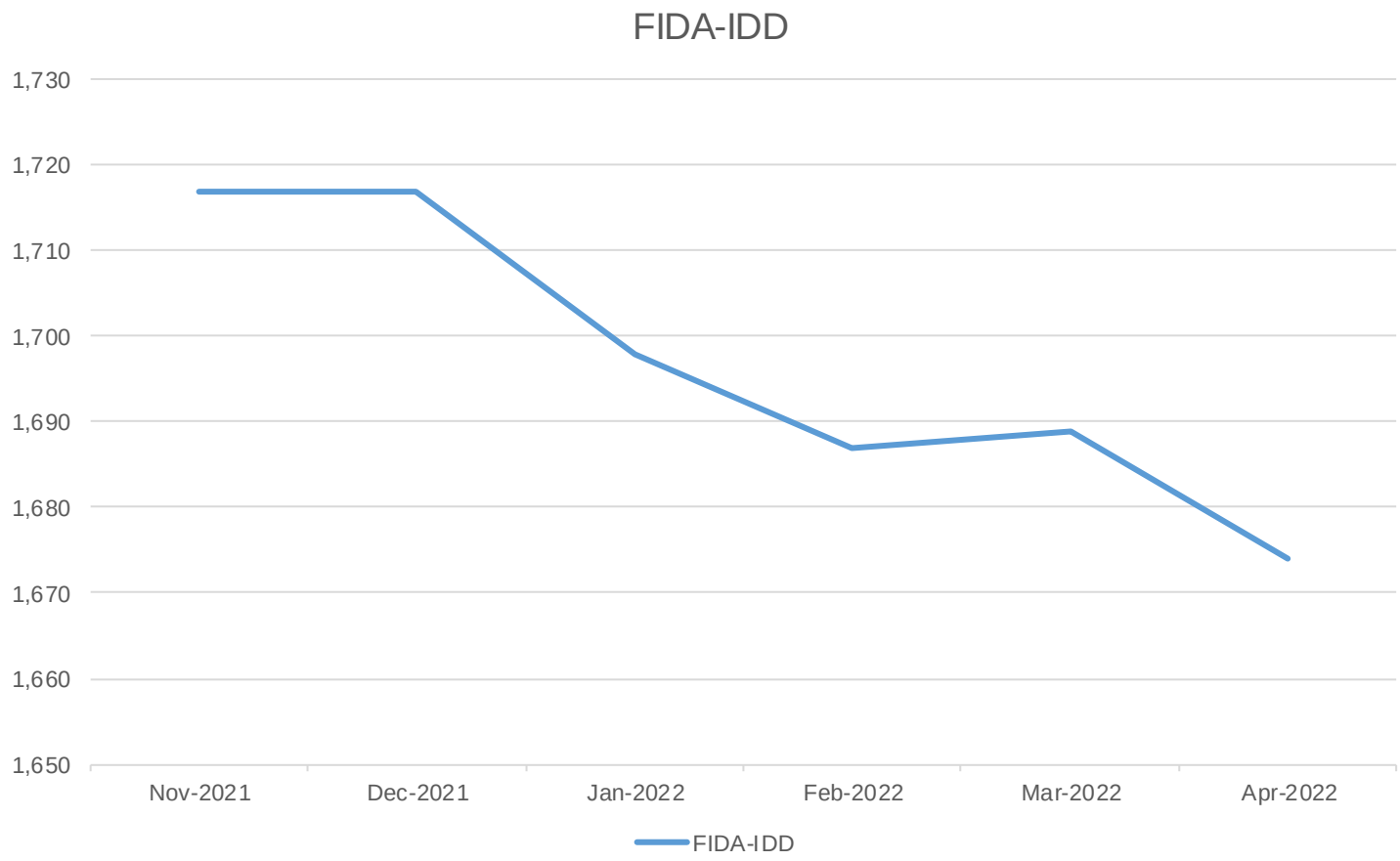
FIDA-IDD Enrollment

Months	FIDA-IDD
Nov-2021	1,717
Dec-2021	1,717
Jan-2022	1,698
Feb-2022	1,687
Mar-2022	1,689
Apr-2022	1,674



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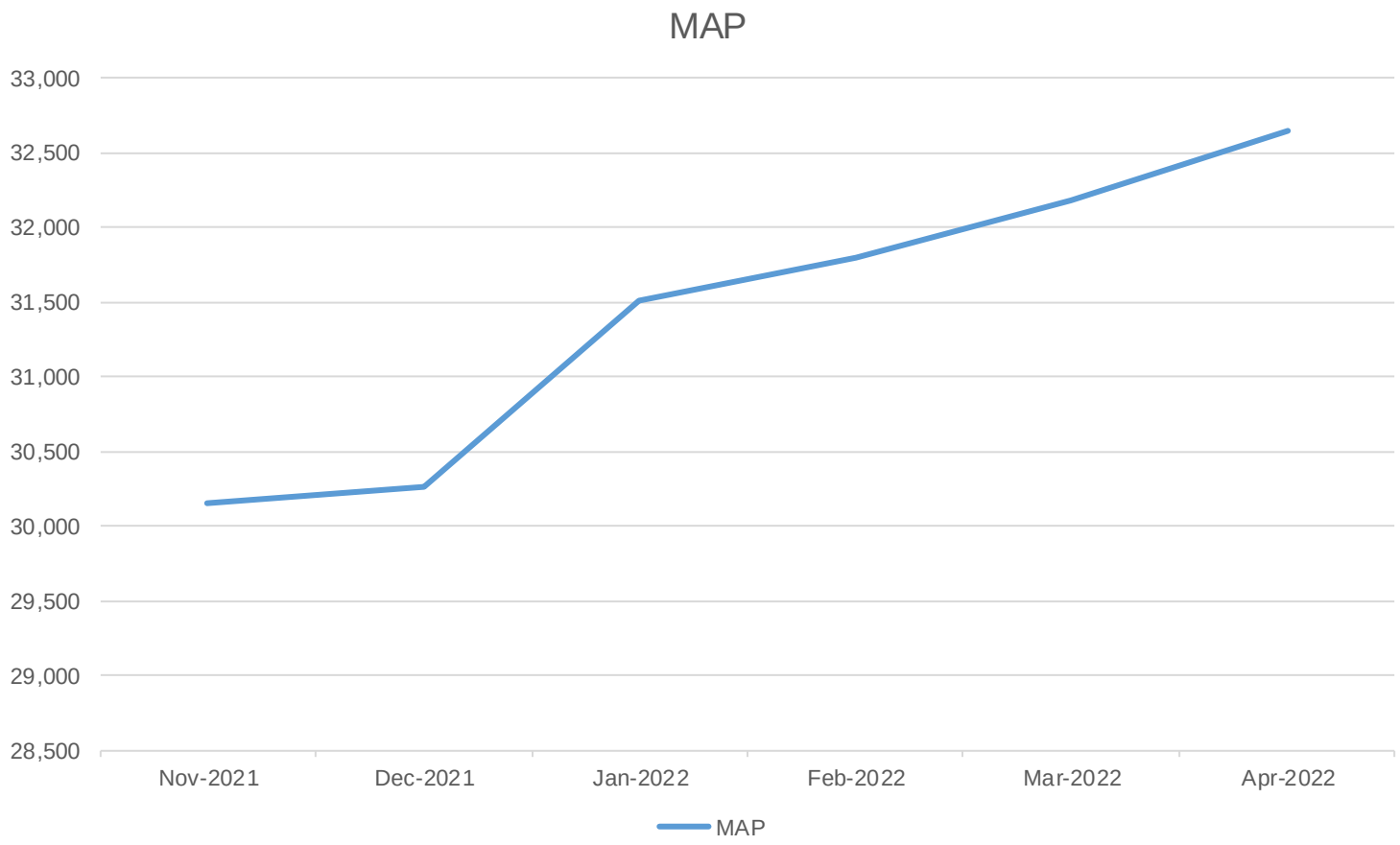
MAP Enrollment

Months	MAP
Nov-2021	30,157
Dec-2021	30,256
Jan-2022	31,516
Feb-2022	31,793
Mar-2022	32,183
Apr-2022	32,649



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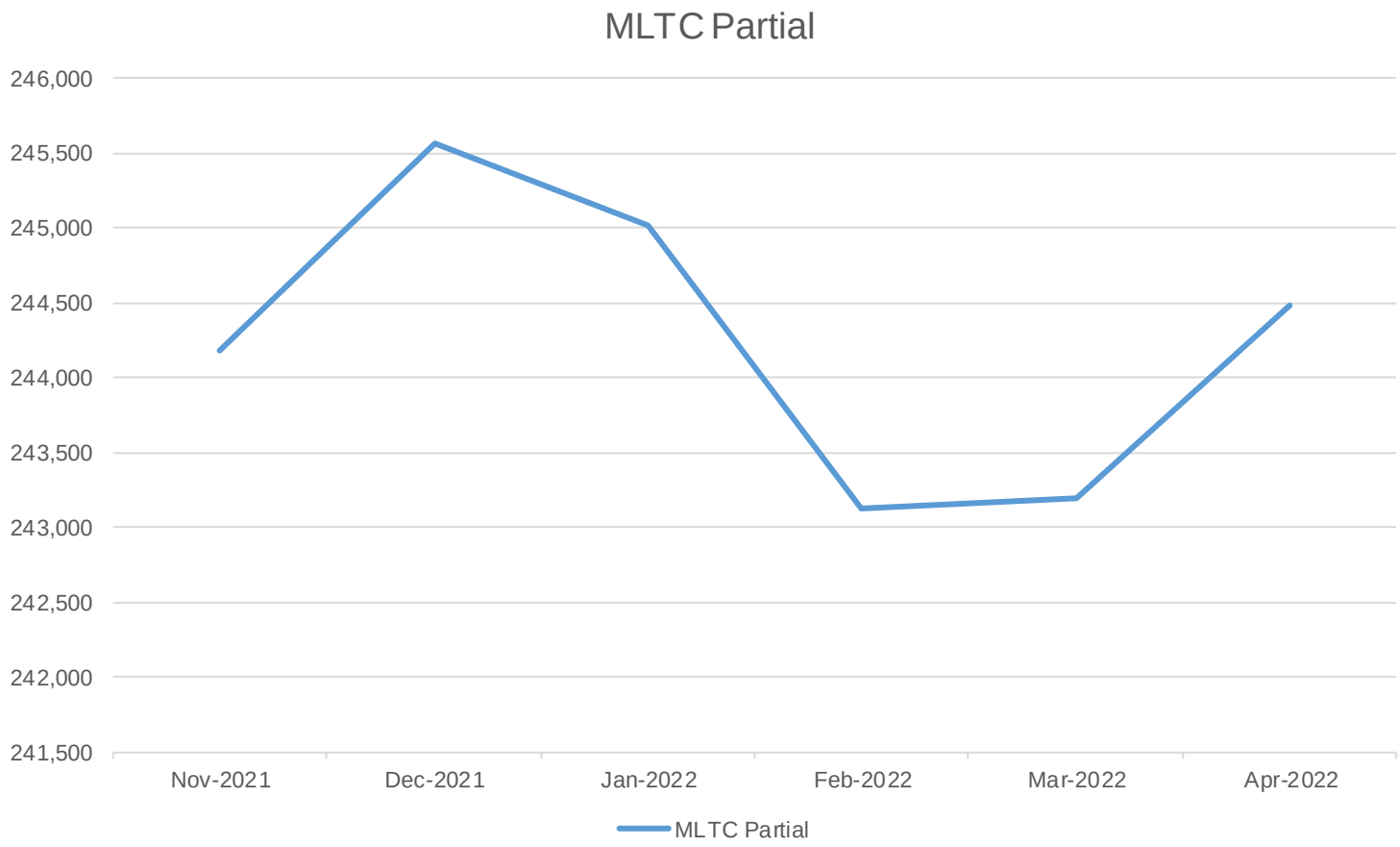
MLTC Partial Enrollment

Months	MLTC Partial
Nov-2021	244,178
Dec-2021	245,571
Jan-2022	245,015
Feb-2022	243,131
Mar-2022	243,193
Apr-2022	244,485



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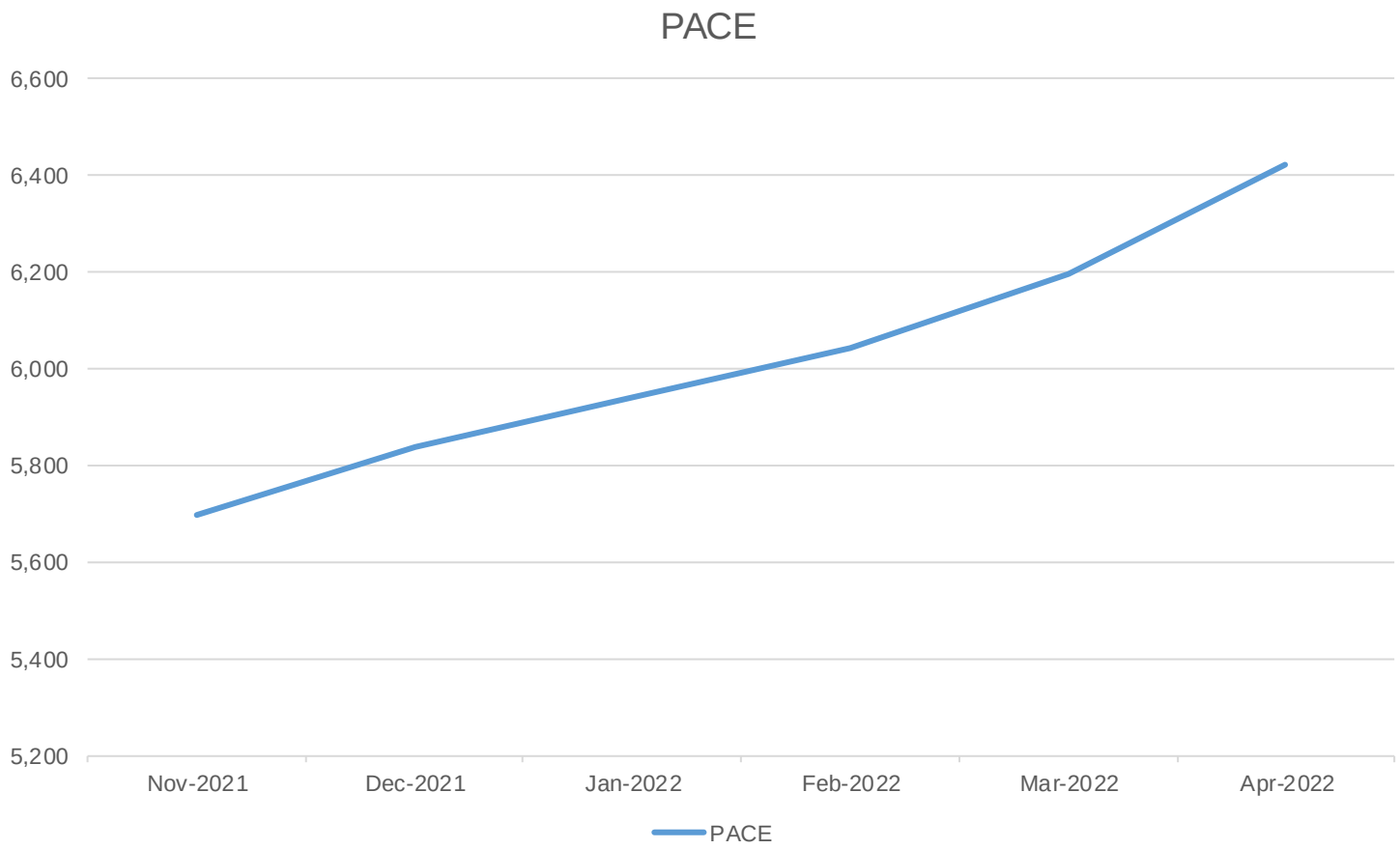
PACE Enrollment

Months	PACE
Nov-2021	5,698
Dec-2021	5,840
Jan-2022	5,941
Feb-2022	6,041
Mar-2022	6,195
Apr-2022	6,421



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Bureau of Managed Care Fiscal Oversight Updates

Upcoming Reporting Due Dates

- **Cost Reports (MMCOR, SNPOR, EPPOR, MLTCCR, MAPOR, PACEOR, FIDAOR) for 1Q 2022 (1/1/2022-3/31/2022) are due May 16, 2022.**
  - ❖ **Please note: The DEMCOR is no longer required in 2022 as the Medicaid Advantage line of business ended 12/31/2021.**

Bureau of Managed Care Fiscal Oversight Updates (cont.)

Reports in Review

- Medicaid MLR Report for SFY 2019-2020 (4/1/2019-3/31/2020) are being reviewed.
  - ❖ Please note that a resubmission of the Medicaid MLR Report for SFY 2019-2020 (4/1/2019-3/31/2020) will be required for plans who received retro-rate adjustments since the initial submission (Medicaid, HARP & PACE). The due date is still to be determined; plans will have 60 days to complete report.
- Medicaid MLR Report for SFY 2020-2021 (4/1/2020-3/31/2021) were due March 25, 2022 and are being reviewed.

Bureau of Managed Care Fiscal Oversight Updates (cont.)

Reports in Review

- Cost Reports (MMCOR, SNPOR, EPPOR, DEMCOR, MLTCCR, MAPOR, PACEOR, FIDAOR) for Annual 2021 (1/1/2021-12/31/2021) were due April 1, 2022 and are being reviewed.

- Value Based Payment Tracking Report (VBPTR) for the 4th Quarter of SFY 2021-2022 (4/1/2021-3/31/2022) were due May 4, 2022 and are being reviewed.

BH Carve In MAP Status

- Desk Review documents were submitted by all 13 active MAP plans on April 1 and collectively reviewed by OMH/OASAS/DOH team.
- Consensus feedback reports will be issued in the coming weeks to each MAP plan.
- Dates for scheduling readiness reviews in August and September have been distributed to each contracted MAP plan.
- Reminder - Plans that have submitted recent MAP applications that are still under review will have BH Carve In readiness reviews conducted as part of the MAP applicant's overall readiness activities when that milestone is reached for each plan.
- Updated May 2022 guidance with CORE services for the January 1, 2023, implementation was issued to MAP plans on Monday, May 9, 2022.
- BH Carve In billing guidance and an instructional billing webinar for MAP plans will be forthcoming.
- Final Readiness Attestations will be due December 1, 2022
- Any questions can be submitted bho@omh.ny.gov or mltcinfo@health.ny.gov.

Resuming MLTC Involuntary Disenrollment Reason for No CBLTSS

Instructional guidance on the resumption of the reason to involuntarily disenroll a member because that member is identified as not receiving CBLTSS was issued April 27,2022 and posted on the link below.

Prospective involuntary disenrollment requests must follow those detailed instructions to outreach the MLTC member before submitting the involuntary disenrollment form and supporting documentation to New York Medicaid Choice requesting a July 1, 2022, effective date or thereafter.

Please see webpage link for more information COVID-19 Guidance for Medicaid Providers (ny.gov) under section titled Guidance Materials

Any questions, please contact mltcinfo@health.ny.gov.

MLTC No CBLTSS Webinar

On Friday, May 20, 2022, from 9:30-11:00 a webinar is scheduled to review the instructions for MLTC plans to submit the involuntary disenrollment supporting documents and form to New York Medicaid Choice (NYMC) related to the members identified and outreached as not receiving CBLTSS services in the previous calendar month.

MLTC plans are encouraged to invite staff that process enrollment, disenrollment and transfer requests, as well as case managers to this instructional webinar.

Please pre-register at: https://meetny.webex.com/meetny/onstage/g.php?MTID=e662b4d3bfea3d7f47f51a46ac2699230.

Involuntary Disenrollment Reasons resumed

- **Enrollee is no longer a member of the plan's Medicare Advantage Program** (Resumed effective October 1, 2021, and thereafter)
- **Enrollee no longer resides in the plan's service area**. (Resumed effective October 1, 2021, and thereafter)
- **Enrollee or family member engages in behavior that seriously impairs the Contractor's ability to furnish services for reasons other than those resulting from the Enrollee's special needs.** (Resumed effective January 1, 2022, and thereafter)
- **Enrollee has been absent from the plan's service area for more than 30 consecutive days.** (Resumed effective January 1, 2022, and thereafter)
- **Enrollee has not been receiving CBLTSS services in the previous calendar month** (Resumed effective July 1, 2022, and thereafter)

Dual Eligible Initiatives -

- **Medicaid Advantage Sunset**
  - The three (3) remaining plans were closed out on 12/31/21.
  - Eligible members were transferred to the IB-Dual program or disenrolled to FFS.

- **Integrated Benefits for Dually Eligible Enrollees - (IB-Dual)**
  - IB-Dual Program effective 4/1/21 has grown to 20K+ enrollees.
  - Additional plan interest for 2022/2023.

- **Medicaid Advantage Plus (MAP)**
  - Behavioral Health carve-in on track for 1/1/2023.
  - Readiness reviews currently underway.

Dual Eligible Initiatives –

- **SMAC 2023 -**
  - Draft SMAC 2023 distributed to Plan Associations for comment.
  - Clarifications to Integrated Medicaid Product submission requirements.
  - Revisions to Categories of Dual Eligibles per enacted budget for MSP.

- **MAP A&G Demo – Beneficiary Survey**
  - CMS conducting survey regarding beneficiary experience under MAP integrated A&G Demo.
  - Sample of MAP participating health plans selected.
  - Surveys to be completed by end of May.

- **PHE Unwind Activity –**
  - Developing guidance for unwind and impact on default enrollment process.
  - Medicaid FFS Pathway: Allow FFS duals to enroll into Mainstream managed care with an aligned D-SNP.

Duals Initiatives -

- **Duals Roadmap – Public Comments**
  - Posted for public comment in March 2022.
  - Outlines DOH strategy for expanding integrated care options for dual eligibles.
  - Public comments focused on the following:
    - Quality metrics to assist consumers in plan reviews.
    - Engage in Medicare savings demo opportunities for integrated care.
    - Evaluating impact of daily care management activities in integrated plans.
    - Encouraging focus on MAP education for consumers and providers.
    - Develop data sharing initiatives with providers to identify and promote integrated plans to their patients.

MLTC Plans HCBS SADC Settings Regulation Compliance - Program Updates

Outstanding Site Self-Assessment Tools

MLTC plans should be finalizing the submission of any remaining outstanding SADC site self-assessment tools to DOH.

This may include general corrections and edits to the self-assessments in Sections 1 or 2, as well as notifying DOH of any SADC sites that have recently closed or will no longer be contracted with the MLTC plan.

SADC HCBS Compliance Self-Assessment submissions should be sent via the Health Commerce System (HCS) Secure File Transfer (SFT)

Link: https://commerce.health.state.ny.us
SFT Contact: HCBSSADCSiteAsesssments

Program Updates

Upcoming 1:1 Meetings and Feedback Spreadsheet

Within the next two weeks, each MLTC plan will also receive a 1:1 meeting invite and a feedback spreadsheet of expected vs. received SADC network self-assessment tools submissions (based on November 2021 PNDS).

Plans will be instructed on due dates for remediation and/or clarification, heightened scrutiny flags, and if that site is also reporting SADC Self Assessment results with another plan.

DOH will continue to collaborate with plans to remediate any discrepancies, prepare sites for public comment this autumn 2022 and validation to remove non–compliant sites from network before March 17, 2023.

Annual Site Visit Tool

MLTC Suggested Annual SADC Site Evaluation Tool and Video Tutorial

(In Development – Expected End of May 2022)

- This new SADC site visit tool and instructional video will provide a suggested template that MLTC plans may utilize while conducting the required annual site visits of each SADC contracted site in the network.

- The purpose of this suggested tool will be to provide all MLTC plans consistent references when conducting each SADC site's annual compliance checks to safety, environmental and HCBS Settings Final Rule requirements and standards.

Reminders

1. MLTC Plan's Annual SADC Site Evaluations

MLTC Plans must continue to conduct annual site reviews prior to the release of this new suggested annual site visit tool. MLTC Plans may leverage the HCBS Compliance Assessment with Guiding Questions for MLTC plan SADC Site Assessors document as a resource for MLTC plans to use in evaluating each SADC site's compliance specifically to the HCBS Settings Final Rule.

2. Temporarily Closed Sites

All actively contracted SADC sites (even if a site is temporarily closed), will need to be in full compliance with the HCBS Settings Final Rule by 3/17/2023 in order to stay in network and to serve members.

This also applies to any new and/or returning sites that are coming back into network. Therefore, MLTCPs will want to ensure all contracted SADC sites meet all the requirements outlined in the HCBS SADC self-assessment, in order to remain in-network after 3/17/2023 for members to receive services at these sites.

Reminder - PNDS SADC Updates

3. SADC sites updated in quarterly PNDS submissions

Plans are required to accurately report SADC sites to PNDS, including SADC sites that remain actively contracted and have met or are remediating HCBS SADC compliance.

Resources

For additional information please see the following resources:

- **CMS HCBS Final Rule**
  https://www.health.ny.gov/health_care/medicaid/redesign/docs/hcbs_final_rule.pdf
- **NYSDOH HCBS Final Rule Website**
  https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm
- **NYSDOH MLTC Policy Documents Website**
  https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm
  - HCBS SADC Fact Sheet & Policy
  - MLTC SADC Self-Assessment Tool
  - HCBS SADC Site Self-Assessment Compliance Webinar Training Recording
- **NYSDOH HCBS Transition Plan**
  https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-11-07_hcbs_final_rule.pdf
- **NYSDOH Person-Centered Planning Library**
  https://www.health.ny.gov/health_care/medicaid/redesign/person-centered_planning/index.htm

Questions?

Please contact NYS DOH, HCBS SADC Site Assessments

Email: HCBSSADCSiteAsesssments@health.ny.gov

No Surprises Act – Alignment in Public Health Law

- The SFY 2023 enacted budget aligns Public Health Law (and Insurance Law) with the federal No Surprises Act.
- Amended state statues achieve consistency of provider and plan responsibilities and consumer protections.
- For Public Health Law Article 44 certified health plans, applies to Medicaid managed care, EP, CHP and QHP.
- DOH will update MCO-Provider contract Standard Clauses to include new requirements for providers.
- DOH will update Medicaid model contracts and issuer contracts to incorporate new requirements for health plans.
- The following slides provide a summary of key changes.

No Surprises Act – Alignment in Public Health Law

Contract Provisions

- PHL 4406-c adds new subdivision (11) -- Contract between a health care plan and health care provider shall include:
  - A provision that requires the health care provider to have in place business processes to ensure timely provision of provider directory information to the health care plan.
  - A health care provider shall submit such provider directory information to a health care plan, at a minimum:
    - when provider begins or terminates its network agreement;
    - where there are material changes to the content of the provider directory information; and
    - at any other time as determined appropriate, including at the health care plan's request.

No Surprises Act – Alignment in Public Health Law

Contract Provisions (continued)

- Provider directory information shall include:
  - name, address, specialty, telephone number, and digital contact information;
  - whether the provider is accepting new patients;
  - for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the OMH or OASAS, and any restrictions regarding availability of the individual provider's services; and
  - for physicians, board certifications, languages spoken, and any affiliations with participating hospitals.

No Surprises Act – Alignment in Public Health Law

Contract Provisions (continued)

- PHL 4406-c adds new subdivision (12) -- Contract between a health care plan and health care provider shall include:
  - A provision that states that the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the Commissioner in accordance with 42 U.S.C. Section 300gg-139(b), for services obtained by the enrollee based on inaccurate network status information provided by the health care plan in a provider directory or in response to a request that stated the provider was participating.
    - If the inaccurate information was provided by the health care plan, the health care plan shall reimburse the provider for the out of network services regardless if the enrollee's coverage includes out of network services.
    - The health care provider may require in the terms of the contract that the health care plan remove the provider from the health care plan's directory at the time of termination and that the health care plan will bear financial responsibility for providing inaccurate network status information to an enrollee.

No Surprises Act – Alignment in Public Health Law

Disclosure of Information

- PHL 4408 amended to add digital contact information to provider directory
- PHL 24 adds new subdivision
    - A health care professional, group practice of health care professionals, a diagnostic and treatment center or a health center rendering services at the group practice, D&TC, or health center, and a hospital, shall make publicly available, and if applicable post on public website, and provide enrollees with one page written notice in clear and understandable language
        - Information contained in 41 U.S.C. sections 300gg-131 and 300gg-132 and Art. 6 of Financial Services Law
            - Relating to prohibitions on balance billing for emergency services and surprise bills; and
            - Information for contacting appropriate state and federal agencies when individual believes provider violated above-referenced laws

No Surprises Act – Alignment in Public Health Law

Continuity of Care

- Amends PHL 4403 to include new requirements to:
  - Provide notice to enrollee when provider leaves network (except for reasons that do not require provider to be given a hearing);
  - Increases the transitional care period from up to 90 days to 90s days from either the date of notice or the effective date of termination, whichever is later;
  - For pregnant enrollees, extends continuity of care for the duration of pregnancy and post partum care directly related to delivery;
  - Requires health care provider to accept reimbursement from health care plan at the rates applicable prior to the start of the transition period and to continue to accept the in-network cost-sharing from the enrollee as payment in full; and
  - Requires health care provider to adhere to the health care plan's quality assurance requirements and to provide to the organization necessary medical information related to such care;
  - Requires the health care provider to adhere to the health care plan's policies and procedures including but not limited to, procedures of referrals, obtaining prior authorization, and treatment plan approval.

Administrative Simplification - SFY 23 Budget

- **Health care facility* applications**
  - Adds new PHL 4406-h
  - Health care plan (upon request) shall make available and disclose to facilities, written application procedures and minimum qualification requirements that facility must meet to be considered for participation in the in-network benefits portion of the health care provider's network
    - Health care plan will consult with appropriately qualified facilities in developing its qualification requirements
    - Health care plan shall compete its review of the facility's application and shall notify the facility within 60 days of receiving the completed application
      - Whether the facility is credentialled ; or
      - Whether additional time is necessary to make a determination
      - Health care plan shall make every effort to obtain missing information and shall make final determination within 21 days of receiving it

*Facility means health care provider entity or organization licensed or certified pursuant to Articles 5, 28, 36, 40, 44, 47 of PHL or Articles 16, 19, 31, 32 or 36 of MHL