



MRT “Boo-Yah!” Report

October 2017

This report is a compilation intended to highlight projects as they are completed and share the many accomplishments of the NYS Medicaid Redesign Team.

For more information about the Medicaid Redesign Team (MRT) visit the webpage at: https://www.health.ny.gov/health_care/medicaid/redesign/.

You can also view a full list of all MRT work plans by clicking on the link below: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_progress_updates.htm.

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#6010 Develop Initiatives to Integrate and Manage Care for Dual Eligibles (DLTC)

Fully Integrated Duals Advantage (FIDA) is operational and serves just under 5,000 individuals who are eligible for both Medicaid and Medicare services, or “dual eligibles”, with Long Term Services and Supports (LTSS) needs in the eight New York City counties and surrounding area. The program is having positive results for those enrolled and for those providers who are engaging in the FIDA interdisciplinary team care management approach. The Division of Long Term Care (DLTC) has completed all deliverables under the implementation grant it received from the Centers for Medicare and Medicaid Services (CMS). Now DLTC is working to grow enrollment and to evaluate the program. Lessons learned will influence the future of integrated care in the state.

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#7403 Targeted Vital Access (OMH)

The Office of Mental Health (OMH) currently has 8 inpatient hospital Vital Access Provider (VAP) projects and 39 outpatient clinic projects underway.

Of the 8 inpatient hospital projects, 3 are scheduled for completion by September 30, 2017. Hospitals have been able to identify areas of fiscal loss and institute systems changes to address the identified problems. The 5 other VAP projects are continuing and projected to end at various intervals through calendar years 2017 and 2018.

The 39 outpatient clinic projects are all underway and slated to end on March 31, 2018. As with the inpatient projects, the initiatives are addressing fiscal issues faced by the clinics. Reports indicate that the clinics are making strides in achieving fiscal stability.

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#8017 Refinancing / Shared Savings

This State Plan Amendment (SPA) proposed to allow facilities that elect to refinance their mortgage loans on or after April 15, 2015 to participate in a shared savings program. Under this program, facilities will retain 50% of the savings generated from refinancing's approved by the department. This program provides incentive to generate savings through the refinancings. Currently, the Medicaid program retains nearly all savings generated.

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#9306 Cost Sharing Limits for Medicare Part C Claims (DPDM)

2016 changes to the Social Services Law* limits Medicaid reimbursement of Medicare Part C co-payments and co-insurances. These changes to the Medicaid payment of Medicare Part C copayments and coinsurances:

- Limit Medicaid reimbursement of Medicare Part C to 85% of the co-payment or the co-insurance;
- Affect institutional and professional claims, as well as pharmacy claims for drugs and supplies when submitted via a National Council for Prescription Drug Programs (NCPDP) transaction or as a professional claim;
- Were implemented on June 1, 2017 and is retroactive to July 1, 2016; and
- Is projected to save New York State \$11.45 million annually.

No change was made to the reimbursement of the Medicare Part C deductible or to inpatient claims. Exempt from the 85% Part C reimbursement are psychologists and ambulance providers.

In the [April 2017 Medicaid Update Reminder: Medicare Part C Providers](#), providers were reminded of this upcoming change and the requirement to accept the Medicare Part C health plan payment and any Medicaid payment as payment in full. The member may not be billed for any Medicare Part C copayment or coinsurance amount that is not reimbursed by Medicaid. For more information, providers are referred to the Centers for Medicare and Medicaid Services (CMS) publication, *Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program* at: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1128.pdf>.

*A new subparagraph (iv) was added to paragraph (d) of subdivision 1 of Section 367-a of the Social Services Law.

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#10010 HARP Evaluation (DPDM)

New York State received Centers for Medicare and Medicaid Services (CMS) approval for the Behavioral Health (BH) / Health and Recovery Plan (HARP) 1115 Evaluation Plan on May 10, 2017. This multi-method evaluation is to be conducted as an end of demonstration period evaluation and is designed to examine the impact of the behavioral health demonstration on:

- health care service delivery
- quality, health outcomes
- cost effectiveness of the HARP

The Evaluation Plan will assess the following goals:

- improve health and behavioral health outcomes for adults in Mainstream Medicaid Managed Care with behavioral health conditions;
- improve health, behavioral health and social functioning outcomes for HARP enrollees and;
- develop Home and Community Based Services focused on recovery, social functioning, and community integration for individuals in HARP meeting eligibility criteria.

Key to the evaluation plan is the identification of program components that have resulted in successes or posed challenges for implementation and goal outcomes.

#10206 Reduce Hospital Quality Pool (DFRS)

The Hospital Quality Pool was established in the State Fiscal Year (SFY) 2015-16 Enacted State Budget for the purpose of incentivizing and facilitating quality improvements in general hospitals. In accordance with the SFY 2017-18 Enacted State Budget, the New York State Department of Health, Office of Health Insurance Programs, Division of Finance and Rate Setting reduced the Hospital Quality Pool distribution by \$30 million. The methodology for allocating the funds to hospitals was similar to prior years except that the minimum floor distribution was reduced from \$75,000 to \$57,800 as a result in the pool value decreasing. Remaining funds were distributed based on a hospital's proportional share of Medicaid days as reported in their 2015 Institutional Cost Report (ICR).

#10209 SUNY Disproportionate Share Hospital (DSH) payments (DFRS)

The additional funding allocated to State University of New York (SUNY) of \$9.3M as part of the Enacted Budget SFY 2017-18 was remit to SUNY in the April-June 2017 quarter. No further action is required.

#10210 Reduction in Mainstream Managed Care Quality Bonus (DFRS)

The Medicaid Managed Care Quality Incentive pool is currently valued at \$315 million in gross annual funding. This reduces the value of the pool to \$275 million gross annual funding. The Department is operationalizing this reduction as an adjustment to the quality award for lower performing quality tiers. Operationalized in the April 1, 2017 rate update.

#10212 Medicaid Restimate / DSRIP Savings (DFRS)

Potentially Preventable Admissions and the Local Acuity Non-Emergency (PPA/LANE) Adjustment to enact budget proposal for Medicaid Restimate / DSRIP savings. Operationalized in the April 1, 2017 rate update.

#10216 Monroe County Special Payment (DFRS)

Reduces Medicaid managed care premium payments to plans for facilitated enrollment by \$20 million gross to reflect the decline in the uninsured rate. Also ensure that those plans receiving the payments have active facilitated enrollers. Operationalized in the April 1, 2017 rate update.

#10301 Ban MLTC Marketing (DLTC)

The Managed Long Term Care (MLTC) Marketing Ban was an Executive Budget action that was intended to limit marketing carried out by MLTC Partial Capitation Plans throughout New York. This action was taken to control a spike in the enrollment that had occurred between 2016 and 2017, and was meant to restrict all new advertisements, referrals, and other methods for marketing carried out by MLTC Plans. This action was effectuated in June of 2017 when official notification of the intended ban, in addition to guidance on what was to be included in the ban, was distributed to all Plans and related plan associations. The ban was reclassified as a “moratorium” rather than a ban within all communications.



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#10304 *BIP Funds to Support FLSA Mandate (DLTC)*

The Balancing Incentive Program (BIP) was able to provide \$43.5 million in Global Cap relief over the past two years by supporting the cost of rate enhancements to implement the overtime and travel time costs of aides providing home and community-based personal and home health care to Medicaid recipients as required by changes in the Fair Labor Standards Act (FLSA). Nearly \$5 million of this was paid to fiscal intermediaries in 2015-2016, and the remainder (\$38.5 million) was provided through rate enhancements that were made to managed care and managed long term care plans that attested to forwarding the funds to providers and aides to comply with the new, unfunded mandate. These changes ensure that aides who worked overtime were paid time and one-half of their rate and that they were compensated for time they used to travel between clients.

#10402 *Implementation of Pasteurized Donor Human Milk (DPDM)*

In accordance with the 2017-18 enacted state budget, pasteurized donor human milk (PDHM) for inpatient use is a covered benefit under the Medicaid program. The proposal was for use of PDHM, with fortifiers as medically indicated, for inpatient use when medically necessary. Use of PDHM is based on a written medical order for infants who have a documented birth weight of less than 1500 grams, are at high risk of developing necrotizing enterocolitis or infection, or who have other conditions as determined by the commissioner of health or his designee.

More information on PDHM can be found in the July 2017 Medicaid Update article:

https://www.health.ny.gov/health_care/medicaid/program/update/2017/jul17_mu.pdf

#10406 *Increase Penalty for Early Elective Deliveries (DPDM)*

In 2016, Medicaid payments for early elective deliveries prior to 39 weeks gestation (C-section and induction of labor) were subject to a 50% reduction in payment. Effective July 1, 2017 and September 1, 2017, respectively, Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will further reduce payment for early elective deliveries. The penalty for early elective deliveries prior to 39 weeks will increase from a 50% reduction to a 75% reduction in reimbursement for claims. This increase in penalty reflects Medicaid's commitment to providing high quality prenatal care. For more information on early elective deliveries please see the [June 2017 Medicaid Update](#) article:
