NEW YORK STATE | Department of Health | Office of Health Insurance Programs

# MRT "Boo-Yah!" Report

March 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

PHASE 2

## #5101 *Create Risk / Bearing Managed Care Entities for High / Need Behavioral Health Populations (OMH)*

The goal of this project was to integrate behavioral health and physical health in a Medicaid Managed Care environment. New York State took a multipronged approach to achieving this goal by qualifying mainstream managed care organizations and creating Health and Recovery Plans (HARPs). In order to address the unique needs of adults with serious mental health conditions and serious substance use disorders, the State developed a new managed care product called a Health and Recovery Plan (HARP). HARPs administer the full continuum of physical health, mental health, and substance use disorder services covered under the Medicaid State Plan, as well as additional rehabilitative services, called Behavioral Health Home and Community Based Services (BH HCBS).

New York State's Medicaid Managed Care plans, including HIV Special Needs Plans went through a qualification process to ensure that they had developed the organizational capacity and culture necessary to effectively administer the adult behavioral health benefit. The qualification process consisted of a document review, onsite interview, and a corrective action process requiring Plans to address gaps identified.

As of October 2015 in NYC and July 2016 in the rest of the State, New York began transitioning behavioral health services for adults into managed care. New York is committed to the careful and responsible transformation of the current behavioral health system to Medicaid managed care and has taken an aggressive approach to monitoring behavioral health provider networks and payment of claims. In addition, NYS has built in contract provisions that support access and removes barriers to mental health treatment and recovery services so consumers are not negatively impacted by this transition.

The transition has proceeded smoothly. As of February 2017, almost 88,000 people are enrolled in Health and Recovery Plans (HARPs) throughout NYS. Approximately 85% of claims submitted by behavioral health providers to Medicaid managed care plans have been paid. Almost no behavioral health services have been denied due to medical necessity. New York State has been engaged in numerous behavioral health stakeholder activities with MCO, providers, local government, and enrollees to swiftly address identified issues.

PHASE 3

## #6402 *Enrolling Children into Health Homes (DPDM)*

The Health Home program provides comprehensive care management for Medicaid members with chronic conditions with the goal of reducing unnecessary costs and improving health outcomes for Medicaid members with the highest needs. The program was initially launched in 2012 to serve adults. In April 2016, New York received approval from the Centers of Medicare and Medicaid Services (CMS) to expand and tailor its Health Home care management program to serve children. Of note, New York State is the first in the nation to request and receive approval to make complex trauma in children a single qualifying condition for Health Home.

Efforts to tailor the Health Home model for children was a collaborative process between the Department of Health, its State Agency Partners (Office of Mental Health (OMH), the Office of Children and Family Services (OCFS), the AIDS Institute (AI), the Bureau of Early Intervention (EI), the Office of Alcohol and Substance Abuse Services (OASAS), and the State Education Department (SED)), as well as Health Homes, Managed Care Plans, care management agencies, children's specialty providers, stakeholders, advocates and consumers. The overall goal of the collective stakeholders was to tailor the Health Home program to recognize the important differences in the approach to care management and planning for children and adults. In collaboration with stakeholders, the State developed standards, guidance and protocols for children's Health Homes; conducted readiness reviews of designated children's Health Homes to ensure network adequacy – including care managers and providers with expertise in serving children; and performed systems readiness to ensure compliance with Health Information Technology related to care planning and billing systems requirements.

In December 2016, New York began enrolling children in Health Home designated to serve children. Fifteen Health Homes are now operational, and one is completing readiness activities and is expected another one will be operational this Spring. To date more than 6,000 children have been enrolled and more than 5,000 are in outreach.

For more information on Health Homes Serving children, please visit:
https://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm

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### #6403 *Guidance for Hospitals to Refer Patients to the Health Homes Program*

This project addressed the requirement stipulated in the federal Affordable Care Act (ACA), Section 1945 [42 U.S.C. 1396w-4] of the Social Security Act, Section (3)(d) Hospital Referral, and within NYS's Health Home State Plan Amendment (SPA # NY-13-006), that calls for hospitals to refer Medicaid recipients to Health Homes.

The result was the issuance of DAL 17-04 "Hospital Requirements for Making Referrals to Health Home", notifying NYS Hospitals and providing guidance to assist hospitals in meeting this requirement.

PHASE 4

### #7401 *Facilitating the Transition of Behavioral Health Services for Adults and Kids into Managed Care (OMH)*

The goal of this project was to assist providers, consumers, and other stakeholders in the transition of behavioral health services into managed care. New York State stakeholder engagement activities include a comprehensive training program for providers and MCOs on Medicaid Managed Care and behavioral health, development of outreach strategies focused on informing enrollees about changes to their health services, and creation of the Regional Planning Consortiums.

Some of the major behavioral health provider readiness and stakeholder engagement activities include:

- Funding the Managed Care Technical Assistance Center (MCTAC) to assist OMH and OASAS agencies with an extensive array of training to prepare for the adult transition to managed care.
- Training began in April 2016 and technical assistance is currently underway for providers to prepare for children's managed care transition.
- Distribution of tens of millions of dollars to assist adult behavioral health home and community based services providers to build the necessary infrastructure needed to delivery these services. Funding was made available through HCBS start-up grants and health information technology supports.
- Launching Regional Planning Consortiums throughout New York State. 11 RPCs were established to provide stakeholders an ongoing opportunity to relay feedback and recommendations related to the transition of behavioral health services to Medicaid Managed Care.

### #7106 *Expand and Improve Independent Senior Housing Opportunities*

This project sought to address concerns about independent senior housing by:

- clearly defining independent senior housing in regulation;
- streamlining regulatory barriers to improve outcomes and achieve efficiencies;
- identifying resources to develop and preserve quality independent affordable housing for seniors that can serve as a platform for services to maximize their ability to be maintained in their homes and communities;
- and identifying new funding sources and new services from best practices in the supportive housing industry to support independent senior housing.

PHASE 5

### #8001 *Cost-Sharing Limits for Medicare Part B Claims*

Effective July 1, 2015, a change to New York State Social Services Law placed cost-sharing limits on Medicaid reimbursement of Medicaid Part B coinsurances for practitioner claims.

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) #15-0038 on December 9, 2015; and Evolution Project #2026, Cost-Sharing Limits for Medicare Part B Cross-Over Services (Professional Claims) was implemented on January 1, 2016.

With implementation of this change (January 1, 2016 retroactive to July 1, 2015), the total Medicare/Medicaid payment to the provider no longer exceeds the amount that the provider would have received for a Medicaid only patient. Under the new reimbursement methodology:

If the Medicare payment is greater than the Medicaid fee, no additional payment will be made.

If the Medicare payment is less than the amount that Medicaid would have paid for that service, then Medicaid will pay the lower of the difference between the Medicaid rate and the Medicare payment, or the Medicare coinsurance amount.

New York State Medicaid continues to reimburse the full Medicare Part B deductible. In addition, there is no change to the current reimbursement methodology of Medicare Part B coinsurance for the following: Ambulance providers; Psychologists; Article 16 clinics; Article 31 clinics; and Article 32 clinics. Medicaid will continue to reimburse these providers the full Medicare Part B coinsurance.

MRT#8001 provides State savings of $9.6 million for fiscal year 2015-2016 and an ongoing annual State savings of $12.9 million beginning with fiscal year 2016-2017.

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## #8001 *continued*

For more information on MRT #8001 – Cost-Sharing Limits for Medicare Part B Claims, go to the July 2015 Medicaid Update Newsletter article entitled, *Clarification on Medicaid Reimbursement of Medicare Part B Services Including Pharmacy Items* at:
https://www.health.ny.gov/health_care/medicaid/program/update/2015/jul15_mu.pdf

## #8005 *MLTC Technology Demonstration*

The New York State Department of Health (the Department), Office of Health Insurance Programs (OHIP), Division of Long Term Care (DLTC), recently solicited applications to contract services for a twenty-four month Managed Long Term Care (MLTC) Technology Demonstration. The Department awarded two contracts to Visiting Nurse Association of Central NY and Hamaspik, Choice Inc. A total amount of $1,000,000 will be used to conduct the demonstration from January 1, 2017 through December 31, 2018.

The overall goal of the MLTC Technology Demonstration is to see if technology in a home and community based setting can keep individuals in their desired setting longer. Through this demonstration, the awardees will propose the use of various emerging technologies to enhance community based long term care for participating MLTC plan enrollees. Utilizing these technologies may provide opportunities to decrease safety risks in the home and increase enrollee independence. The findings of this demonstration will provide the Department with a baseline for future policy direction related to assistive technologies.

For more information on the MLTC Technology Demonstration, please follow the link:

http://www.leadingageny.org/?LinkServID=4C926C7D-ADB9-9D64-CB4C8EBF97D3AE0B

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## #9303 *Health Homes for Children Startup Costs*

In April 2016, New York received approval from the Centers of Medicare and Medicaid Services (CMS) to expand and tailor its Health Home care management program to serve children (please see project 6402, Enrolling Children into Health Homes, for more information). Sixteen Health Homes were designated to serve children – 12 of those Health Homes have been serving adults since 2012 or 2013; one of those Health Homes has been serving adults in one county and significantly expanded its service area for children only by 25 counties; and 3 are new Health Homes that began operations in December and are designated to serve children only.

The 2016-17 Enacted Budget included $7.2 million resources to provide start-up funds to four Health Home Serving Children that did not benefit from $190.6 million of MRT Waiver Health Home Development Funds distributed prior to December 2016 or significantly expanded their service area to serve children. The four Health Homes Serving Children that met this criteria were: The Children's Collaborative for Children and Families, Catholic Charities of Broome County (Encompass), Children's Health Homes of Upstate New York LLC, and Oishei Health Kids. Each Health Home received a base distribution of $500,000, with the balance distributed according to their share of projected enrollments across the four Health Homes.

## #9305 *Opioids Hard Cap Division*

OHIP pharmacy staff worked with the Medicaid Managed Care plans to develop and implement prior authorization requirements for opioid analgesics prescriptions in excess of four in a thirty-day period. This was a result of the enactment of Social Services Law section 364-j(26-a), which was effective October 1, 2016. The Medicaid Update Newsletter article can be found at:

http://www.health.ny.gov/health_care/medicaid/program/update/2016/aug16_mu.pdf

## #9308 *New Ambulette Ambulatory Fee*

Building on the success of an earlier demonstration in 15 upstate counties, the Medicaid program expanded the ambulette-ambulatory level of service to the rest of the State. This initiative established the ambulette-ambulatory fee at 80% of the ambulette-wheelchair fee in each county, including New York City, for a significant cost savings. The initiative aligns Medicaid reimbursement more closely with the transport mode of service being provided. The new ambulette-ambulatory mode is appropriate for those enrollees who can ambulate, therefore do not require a wheelchair, but still require personal assistance door-through-door from the ambulette driver.

This level of service will not be applied to enrollees being transported to certain specialty care medical services. Accordingly, it was determined that excluding trips to: dialysis, cancer treatment, hospice services, mental health/mental retardation, nursing homes, residence, surgical centers, transplant centers, and OPWDD enrollees getting transportation to various Medicaid covered service would be consistent with achieving the 15% of total ambulette level trips that we have previously identified as being appropriately eligible for the new ambulatory fee.

Because of the volume of enrollees who may be eligible for this service level, upstate eligible enrollees began transitioning to the ambulette ambulatory mode in April 2016, and New York City and Long Island were phased in beginning in October 2016. This transition ensured that the Department's local Medicaid Transportation Managers had adequate time to train and educate transportation providers and referring medical practitioners about this new ambulatory level of service.

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## #9309 *Comprehensive Coverage and Promotion of Long Acting Reversible Contraception (LARC)*

The 2016-2017 New York State Executive Budget included an initiative for the comprehensive coverage and promotion of long acting reversible contraception (LARC), including increasing access and improving education and outreach. There were two different approaches for implementing this initiative, one for Medicaid fee-for-service (FFS) and another for Medicaid managed care (MMC).

In April 2016, the Department took a number of actions to promote Medicaid coverage of long acting reversible contraception (LARC). Intrauterine devices (IUDs) and implantable contraception are NY Medicaid covered LARCs. Medicaid reimbursement for LARC to most providers is the actual invoice cost of the device.

Article 28 free standing clinics that are Federally Qualified Health Centers (FQHCs) that do not participate in the Ambulatory Patient Group (APG) are reimbursed though the Prospective Payment System (PPS); these facilities receive the same threshold payment for every clinic visit regardless of the intensity of services provided during the visit. However, reimbursement through the PPS methodology is a disincentive when the clinic provides a medical device for a patient that costs more than the PPS, such as an IUD.

To promote the comprehensive coverage of LARC, NYS Medicaid obtained approval from the Centers for Medicare and Medicaid Services (CMS) for State Plan Amendment (SPA) #16-0028 to allow FQHCs to submit claims for the cost of the LARC device separate from their clinic's PPS claim retroactive to April 1, 2016. The following publications were issued:

- Long-Acting Reversible Contraception Carve-out for FQHC's
- eMedNY Provider Communication January 19, 2017

In addition, Medicaid FFS coverage and payment for post-partum LARC was separated from the inpatient all patients refined, diagnosis related groups (APR-DRG) reimbursement effective April 1, 2014. Effective May 1, 2014, MMC plans were encouraged to accommodate and promote coverage of LARC provided to women during their postpartum inpatient hospital stay. Effective September 1, 2016, the Department of Health requires MMC plans to implement mechanisms to pay hospitals for immediate postpartum LARC separately from reimbursement for the inpatient stay. The following publications were issued:

- NYS Medicaid Comprehensive Coverage & Promotion of LARC