Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Dear Health Plan Administrator:

New York State's Fiscal Year 2018-2019 Enacted Budget includes several changes that will impact Managed Long-Term Care (MLTC) Plans. Changes affecting covered benefits, plan and provider policies and procedures were scheduled for implementation as early as practicable in order to realize the greatest possible program benefits. These changes, along with implementation dates and impact to the specific products are detailed below.

In many cases, the changes in law adopted with the 2018-2019 State Budget require additional guidance from the Department to plans. This will be forthcoming. This letter will provide plans awareness of changes that will impact both plan operations and membership. Changes are summarized below and member materials are forthcoming.

The terms of the existing contracts stipulate that plans must comply with any applicable State or federal statute, plans must put policies and procedures in place to implement the following statutory changes as of the effective date indicated. Future contract amendments will be developed to address these proposals and reflect the specific product type impacts.

Until such time as changes can be made to Member Handbooks, plans may notify enrollees of these changes through member letters and handbook inserts.

I
Limit the Nursing Home Benefit in Partially Capitated MLTC Plans for Permanently Placed Enrollees to 3 months

Presuming CMS' approval of the technical amendment to the State's 1115 Demonstration Waiver, partially capitated MLTC plan enrollees who have been permanently placed in a nursing home for a period of 3 calendar months will be disenrolled from the plan and returned to fee for service (FFS) Medicaid. There will be no impact to the member, who will remain in the same nursing home. The permanent placement designation is recognized as a mutual agreement between the enrollee, his or her physician, the nursing home, and the plan. The period of 3 months will commence once any available Medicare coverage has been maximized. Generally, those who were permanently placed in the nursing home in April 2018 will be disenrolled to FFS as of July 2018. This limitation only impacts the NH benefit for Partial Capitation plans. There is no impact to the nursing home benefit for MAP, PACE, FIDA, or Medicaid Managed Care.

Limitation of the permanent nursing home benefit will be carried out as a State administrative action. Further guidance, along with template notice to affected members will be provided shortly. The State will also provide model Member Letter language to address the limitation of the NH benefit.

Effective May 3, 2018, the mandated enrollment of newly identified permanently placed Dual Eligibles moving into MLTC plans will end and those consumers will stay in FFS Medicaid. The Department is developing a model notice to members regarding this change. In addition, disenrollment notification and processes are under development.

Please note: Consumers who are disenrolled due to 3 months of permanent placement in a nursing home will be deemed eligible for CBLTC services for a period of 6 months, should they wish to revert from permanent placement and return to a community setting with CBLTC services from a MLTC plan. Those consumers will not be subject to a CFEEC evaluation prior to plan enrollment. Consumers may elect to rejoin their previous MLTC plan or choose another plan but in either event, remain subject to the selected plan's assessment prior to approval of enrollment.

Further information regarding impact to capitation rates will be provided by the Division of Finance and Rate Setting (DFRS).

Addition of 'continuous period' of 120 days of CBLTC Services
to Eligibility Criteria – *Effective 4/12/18*

The addition of 'continuous period' to the eligibility criteria of 120 days of CBLTC services is applicable to all MLTC product types: Partially Capitated, PACE, MAP and FIDA. The intent of this addition is to provide clarification of criteria's intent, as applied upon enrollment into plan. The need for a period of 120 days is to be applied on a continuous forward looking basis, not retrospectively. This should not be calculated as cumulative throughout the first year of enrollment. Plans are expected to amend all enrollee materials and policies and procedures accordingly. Model member notices and handbook notice insert as developed by the State will also reflect this clarifying statement.

Restrict MLTC Partial Capitation Members from Plan Transfers
Within a 12-month Period – *Effective 10/1/2018*

Individuals who enroll in a partially capitated MLTC plan will be prohibited from transferring to another available MLTC plan more than once a year unless good cause is demonstrated. Each member will be allowed a grace period of 90 days from point of enrollment, during which time they may elect one transfer for any reason. For the remainder of a twelve-month period beginning with the effective date of their enrollment, enrollees may pursue transfer if good cause is demonstrated.

This change is intended to mirror Lock-in provisions currently in place for New York's Medicaid Managed Care plans. It is expected to provide MLTC plans with more opportunities to foster continuity of care, engage members with effective care management strategies and improve health outcomes. In addition, the change is expected to facilitate plans' participation in Value Based Payment arrangements by providing a consistent timeframe to provide services and evaluate their effectiveness.

The Department will provide guidance to plans outlining good cause exceptions to allow members to transfer between plans during the 12-month lock-in period, and describing the process for identification of enrollees that have moved and their period of lock-in. Template Model Member notices and insert for Member Handbooks will be developed.

Utilization and Authorization Adjustment – *Effective 10/1/18*

Enrollees in all MLTC products who do not use the CBLTC services or supports outlined in their plan of care during a calendar month without prior notice to the plan will be disenrolled.

While all MLTC product lines are contractually required to follow this practice presently, this change in law is intended to ensure that all MLTC plans develop or use systems to better track utilization and immediately disenroll members who are not utilizing authorized services and supports.

Members disenrolled under this change in law will be considered involuntarily disenrolled using the existing process and will receive a notice from the MLTC plan with Fair Hearing rights issued by New York Medicaid Choice (NYMC). The Department will provide plans with guidance and exceptions to the directive that members must use the services for which they are authorized each calendar month. The Department will also develop a model member notice and Member Handbook insert. Once finalized, all MLTC plans will be required to update their policies and procedures accordingly.

II

Restrict the Number of LHCSA Contracts Partially Capitated MLTC Plans May Hold -- *Effective 10/1/18*

Partially capitated MLTC plans will be limited in the number of Licensed Home Care Services Agency (LHCSA) contracts it may hold. This change will limit the number of contracts these plans may hold based on a methodology approved by the Department.

MLTC plans operating in the City of New York and/or the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per seventy-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per one hundred members enrolled in the plan within such region.

MLTC plans operating in counties other than those in the city of New York and the counties of Nassau, Suffolk, and Westchester may enter into contracts with licensed home care services agencies in such region at a maximum number calculated based upon the following methodology:

1. As of October 1, 2018, one contract per forty-five members enrolled in the plan within such region; and
2. As of October 1, 2019, one contract per sixty members enrolled in the plan within such region.

In instances where limits on contracts may result in the enrollee's care being transferred from one LHCSA to another, and in the event the enrollee wants to continue to be cared for by the same worker(s), the MLTC plan may contract with the enrollee's current LHCSA for the purpose of continuing the enrollee's care by that worker(s). These types of contracts shall not count towards the limits mentioned above for a period of three months.

The Department will be providing guidance to affected plans. Plans may be required to provide evidence of their compliance on an annual basis. Plans that must reduce their number of LHCSA contracts will have to consider continuity of care and adequate workforce in addition to quality and value in selecting their contracted plans.

Monitor FI Marketing – *Effective 4/1/18*

Effective April 1, 2018, Fiscal Intermediaries must submit all advertising to the Department for review and prior approval. The Department will issue guidance to Consumer Directed Personal Assistance Service (CDPAS) Fiscal Intermediaries on advertising. This change does not require member notification or inclusion in the Member Handbook insert.

Social Adult Day Benefit Efficiency Savings – *Effective 10/1/18*

Social adult day care should be carefully planned and prioritized for those who would otherwise need constant personal care coverage in their home, those who require supervision due to advanced dementia, and those who have no other opportunity to be integrated in the community (e.g.- social isolation). All MLTC products will be incentivized to more efficiently provide this service to enrollees most in need of this level of care through a rate cut in their premium.

The Department will provide further guidance to plans that distinguishes between adult day health care and social adult day care, indicates how plans can prioritize this benefit to those who need it most, and suggests characteristics of quality and value that may help plans contract with appropriate social adult day care providers through Value Based Payment arrangements.

III

The following changes were also included in the enacted 2018-2019 State Budget.

Nursing Home Transition and Diversion (NHTD)/Traumatic Brain Injury (TBI) Managed Care Carve Out

The NHTD and TBI waiver populations will continue to be exempt/excluded from mandatory enrollment into Medicaid Managed Care until January 1, 2022.

Increase the Physical Therapy Limit to 40 Visits/Year – Effective 4/12/18

The Budget increases the limit on Physical Therapy from 20 to 40 visits. The Department will be providing additional guidance on this change in the MLTC benefit package. Member notice and Member Handbook inserts will have to be updated.

Establish Report Requirement for Plans Receiving Members Due to Acquisition, Merger or Other DOH Approved Arrangement – Effective 4/1/18

Any MLTC plan that accepts members as a party to an acquisition, merger, or other similar DOH approved arrangement must submit a report to the Department within twelve months of the transaction. The report shall include, but not be limited to, enrollee information and services authorized and utilized by the enrollee before and after the transaction. The Department shall make a summary of such report available to the public.

The Department will release guidance to plans affected by the budget provision prior to any such transactions. This provision does not require member notification.

The State's contracted Enrollment Broker, New York Medicaid Choice (NYMC) has been notified of all the changes which impact those operations. Applicable processes will be altered, as will all impacted Enrollment Broker educational materials and notices. Further guidance will

be provided to MLTC plans with regard to NYMC Enrollment Broker operations in respect to these budget initiatives.

Additional information related to the implementation of these actions, along with frequently asked Questions and Answers, will be forthcoming. MLTC plans may submit questions regarding implementation to the Department at DLTCEB19@health.ny.gov.

Sincerely,

Andrew Segal, Director
Division of Long Term Care
Office of Health Insurance Programs