Hinman Straub Highlights of December 10, 2015 Managed Care Policy and Planning Meeting

Last Thursday, the Department of Health held the monthly Policy and Planning Meeting with the State's Medicaid Managed Care plans. Some highlights from the meeting include:

- FIDA: The State announced changes to the FIDA demonstration that have been approved by CMS that include relaxing some of the IDT and Marketing requirements. In addition, CMS previously announced that it would make an upward adjustment to the Medicare Part A and B portion of the premium rates. The State and CMS have also agreed that the quality withhold from plans that dropped out will be distributed to those plans remaining in the program. FIDA passive enrollment is suspended until at least mid-2016 as is the implementation of FIDA in Suffolk and Westchester counties.
- Behavioral Health Transition: The Office of Mental Health (OMH) provided an update on the behavioral health transition in New York City. Enrollment through December is meeting the State's expectations, with 39,484 enrollments and 4,502 opt-outs. OMH also announced that they are delaying the submission of the readiness review tool responses beyond January 8th. A new due date will be announced shortly.
- Nursing Home Data Request: Due to reports from plans regarding significant delays in getting indicators on rosters for members who are residents of nursing homes, DOH will be surveying plans regarding their members who are in permanent placement status in nursing homes.
- Enrollment Reconciliation Process: DOH has begun the reconciliation process to reconcile enrollment information between plans, the Exchange, and WMS. DOH is starting with the largest plans. Enrollment rules regarding duplicate CINs and duplicate enrollment are applicable so plans might have to reconcile claims with other managed care plans as membership is resolved.
- Access and Availability Survey: DOH discussed the results of the 2014 Access and Availability Surveys conducted by IPRO. Every region and specialty type failed the surveys as results continue the downward trajectory. Plans questioned the reliability of the survey and whether the surveys are actually measuring access to care and DOH even acknowledged that they have not received many consumer complaints that would indicate access to care is an issue. DOH said they would explore some of the specific concerns that the plans raised and are open to reforming the survey.
- MLTC: Mandatory enrollment in MLTC is up to 154,099 members as of the November enrollment reports. Since the last meeting, DOH has posted an FLSA information letter and FAQ to the MRT website, along with policies (15.05(a), 15.06, and 15.07) related to CDPAS FI Q&As, CFEEC UAS requirements for nursing home transitions, and potential security exposure with the UAS.
- Community First Choice Option State Plan Amendment: DOH provided a brief overview of CFCO, which provides enhanced FMAP for existing benefits and will

add supervision and cueing as a state plan service. The CFCO services will be available through all Medicaid programs including mainstream MMC, HIV SNP, MLTC, FFS and the OMH and OPWDD systems. More information on CFCO will be forthcoming.

DSRIP Update

VBP Early Innovator and Pilot Programs

Marc Berg from KPMG discussed the VBP early innovator and pilot programs. The early innovator program is intended for providers with level 3 or "significant risk" level 2 VBP arrangements for total cost of care for a total population or a sub-population. Managed care plans would be required to contract with these providers and pay 90 to 95% of the premium depending on the services the providers are able to perform. The VBP pilot program is much broader and intended to incentivize providers to reach level 2 VBP arrangements in 2016 or 2017. Plans that participate in early innovator and pilot program arrangements will receive some form of "bonus" payment for their involvement. The State hopes to have 2-3 pilots and/or innovators per VBP arrangement type operating in 2016, with selection dependent on geography, provider type, etc.

PPS Meeting in Albany

Last week representatives of the 25 statewide PPSs met in Albany. The focus of the meeting was on workforce strategy development. The State has agreed to give PPSs additional time to expend funds earmarked for workforce development as many PPSs have yet to finalize their plans.

PPS Performance

Jason Helgerson said PPSs have performed well thus far, with none identified as being in "red" status or failing. He said the majority of PPSs hit most of their achievement values and thus will receive the majority of incentive funding available for recent quarterly payment. The biggest complaint the State has received thus far from DSRIP has come from downstream providers and community based organizations who have not received their DSRIP incentive fund payments from PPSs.

PPS Legal Structure

Twelve PPSs are pursuing new corporate structures to oversee their PPS systems. Under the DSRIP STCs, all non-safety net providers must receive CMS approval and qualify under the "vital access provider" exception to become eligible to receive DSRIP incentive funds. The majority of the "New Co's", as they are being called, are Limited Liability Corporations.

In addition, Mr. Helgerson noted that so far, only one PPS is looking to become an ACO (Adirondack Health Institute), while another one is interested in becoming an IPA (Mt. Sinai). This is significant as a PPSs must be either an ACO or an IPA to contract with a managed care plan for a network of service providers.

PPS Enhanced Oversight

There are three PPSs receiving "enhanced oversight" from the State and KPMG. This means KPMG staff attend all of their DSRIP meetings, offer assistance, and report back to the State on developments. These PPSs are Advocate Community Partners, Refuah Community Health Collaborative, and the Adirondack Health Institute.

DSRIP Network Changes, Midpoint Assessments

Mr. Helgerson discussed that there will be a program mid-point assessment at the start of year 3. CMS must approve all changes to a PPS network, meaning that any partner drop-outs will have no impact on PPS valuation and attribution, though attribution for performance purposes will be updated annually. Under CMS rules, a PPS is prohibited from dropping a provider, though mutual agreement to part ways is allowed.