

Appendix C

Summary of Medicaid Managed Care Benefit and Program Changes Resulting from the Medicaid Redesign Team and 2011-2012 Budget

I. Medicaid Managed Care Benefit Changes

The following benefit changes will be implemented by Medicaid managed care plans and, as applicable, FHPlus and MLTC plans as of the effective date indicated below. Managed care plans should notify all new and existing enrollees of these new benefits and benefit limitations via revisions to member handbooks, inserts to member handbooks, member newsletters, the plan's web site and/or electronic communications. The Department will work with plans to ensure the content and timeliness of notices.

Prescription Footwear Benefit — Effective 4/1/11

Prescription footwear means orthopedic shoes, shoe modifications and shoe additions. Medicaid coverage is limited to: 1) children under 21 years of age who require orthopedic footwear to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot, or to support a weak or deformed structure of the ankle or foot; 2) shoes attached to a lower limb orthotic brace; and, 3) as a component of a comprehensive diabetic treatment plan to treat amputation, or pre-ulcerative calluses, or peripheral neuropathy with evidence of callus formation of either foot, or a foot deformity or poor circulation. This applies to all "L" codes listed in the Prescription Footwear section of the DME Provider Manual, as well as the codes for diabetic shoes, which are: A5500, A5501, A5503, A5504, A5505, A5506, A5507, A5512, and A5513. Diabetic shoe codes have been added to the Prescription Footwear section of the DME Provider Manual. These changes apply to Medicaid managed care, FHPlus, and MLTC except that FHPlus does not cover orthopedic shoes. Additional information is available at: <http://www.emedny.org/providermanuals/DME/communications.html>

Compression and Support Stockings — Effective 4/1/11

The following gradient compression stocking codes are covered by Medicaid managed care, FHPlus and MLTC plans only when used in the treatment of an open venous stasis ulcer. These codes are not covered for any other conditions, including the prevention of ulcers, prevention of the reoccurrence of ulcers, treatment of lymph edema without ulcers, varicose veins, or circulation disorders:

- ® A6531 Gradient compression stocking, below knee, 30-40 mm Hg each
- A6532 Gradient compression stocking, below knee, 40-50 mm Hg each

The following code is covered by Medicaid managed care and MLTC plans only for treatment of severe varicosities and edema during pregnancy:

- A4510 Surgical stockings, full length, each

The following codes are *no longer covered* under the Medicaid program:

- Surgical stockings (applies to Medicaid managed care)
 - A 4495
 - A 4500
- Gradient compression stockings (applies to Medicaid managed care and FHPlus)
 - A 6530
 - A6533 — A6541
 - A 6544
 - A 6549
- Miscellaneous DME if used for any type of compression stockings with or without zippers (applies to Medicaid managed care and FHPlus)
 - A 9999

Additional information is available at:

<http://www.emedny.org/providermanuals/DME/communications.html>

Smoking Cessation Counseling — Effective 4/1/11

Beginning April 1, 2011, smoking cessation counseling services will be covered for *all* Medicaid managed care enrollees and FHPlus enrollees who smoke. All enrollees are eligible for up to 6 sessions per calendar year, including any combination of individual and group counseling sessions. Additional information is available in the April and May 2011 Medicaid Updates.

Enteral Formula and Nutritional Supplements — effective 5/1/11

Coverage of enteral formula and nutritional supplements by Medicaid managed care, FHPlus and MLTC plans is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means; and, 3) children under age 21 who require medical formulas due to mitigating factors in growth and development.

Personal Care Benefit — Effective 8/1/11

The Personal Care Services (PCS) benefit will be added to the Medicaid managed care benefit package as of August 1, 2011. The Consumer Directed Personal Care Assistance Program (CDPAP) will *not* be included in the managed care benefit and will continue to be covered under the Medicaid fee-for-service program for Medicaid eligibles until July 2012. The PCS benefit is limited to 8 hours per week for individuals receiving *only* PCS housekeeping (Level 1) services. Medicaid managed care plans will be responsible for medical case management services for enrollees receiving PCS and must also coordinate with appropriate local government programs, such as Adult/Child Protective Services, to address any social and/or environmental issues necessary to maintain the enrollee's health and safety in the home. The Department will work with Medicaid managed care plans on issues such as network development, assessment tools and processes, contracting and transitional care.

To promote continuity of care, the Medicaid Managed Care/FHPlus Model Contract will be amended to require plans to permit enrollees who are receiving PCS through the Medicaid fee-for-service program as of August 1, 2011 to continue their course of treatment, regardless of the network status of the provider, until the plan has assessed the enrollee's needs and an approved treatment plan is put into place. In addition, plans are required to contract with current HRA and other LDSS vendors in order to promote continuity of the worker. The premium adjustment for personal care is based on the current level of payment and will be sufficient to require health plans to reimburse providers at the contracted HRA rate for NYC plans and to negotiate a fair reimbursement rate in other regions of the State. Health plans are not required to contract with entities unwilling to accept the HRA rate or the Medicaid fee-for-service rate as long as they have an adequate network of providers available to treat members. PCS is a non-covered service under FHPlus.

Personal Emergency Response Systems (PERS) will be included in the Medicaid managed care benefit package as of January 1, 2012 to allow time for plans to establish contracts with PERS vendors. Until that time, when the plan authorizes PERS, completed PCS and Home Health Services assessment forms should be submitted to the local district for processing and arrangement of PERS services. PERS is available only to enrollees receiving home health and/or personal care services.

Screening, Brief Intervention and Referral to Treatment (SBIRT) — Effective 9/1/11

SBIRT is a screening and referral program that is intended to identify individuals potentially at risk for substance use problems and provide early intervention to prevent the development of serious substance use problems. SBIRT services are currently available to individuals aged 10 years and older in emergency rooms, hospital outpatient departments and diagnostic and treatment centers. Effective September 1, 2011, the settings in which SBIRT will be covered will be expanded to include physician offices for both Medicaid managed care and FHPlus. The Department expects to issue guidelines for the provision of these services by July of this year.

Pharmacy — Effective 10/1/11

The pharmacy benefit will be included in the Medicaid managed care and FHPlus benefit package beginning October 1, 2011. Plans may establish formularies, utilization management controls and a mail order pharmacy benefit. A pharmacy benefit manager or utilization review agent may administer the benefit. The plan's prescription drug benefit must be comparable to the Medicaid fee-for-service benefit and include internal and external review processes for coverage appeals and medical exceptions. Use of mail order pharmacies is allowed, but not required. However, if utilized, plans must allow enrollees to use retail pharmacies if the enrollee desires and the pharmacies agree to accept the mail order reimbursement rate.

For a period of 90 days after October 1, 2011 for existing enrollees and for new enrollees enrolling on or after October 1, 2011, plans will be expected to provide a one-time, temporary fill of drugs for up to a 30 day supply of medication as long as the medication is covered under the Medicaid fee-for-service formulary. This would include claims for drugs that are not on a plan's formulary and/or require prior authorization or step therapy under a plan's utilization management rules, or have been filled at or written by a non-participating provider. However,

transitional fills for new prescriptions must be filled at a participating pharmacy. The Department had previously indicated that the submission of pharmacy encounter data would be required nightly. Resulting from industry concerns on this issue, the Department will require the plans to submit weekly encounter data during the initial six months after implementation. After which, we will have a discussion regarding the frequency of data submission. Please keep in mind that the end goal is to require nightly submissions of pharmacy data in order to support and promote quality improvement initiatives. However, in light of the various implementation issues, we will allow weekly submissions. Below are further clarifications on the pharmacy benefit.

- The Medicaid managed care pharmacy benefit includes medically necessary prescription and over the counter (OTC) drugs, medical supplies, hearing aid batteries and enteral formula.
- The FHPlus pharmacy benefit includes medically necessary prescription drugs, insulin and diabetic supplies, smoking cessation agents (including OTC smoking cessation products), select OTC medications covered on the Medicaid Preferred Drug List (Prilosec OTC, Loratadine, Zyrtec and emergency contraception), vitamins necessary to treat an illness or condition, hearing aid batteries and enteral formula. Medical supplies, other than diabetic supplies and smoking cessation agents, are not included in the FHPlus benefit package.
- Clotting factor products for hemophilia will temporarily remain carved out of the Medicaid managed care and FHPlus benefit package, whether obtained by prescription or provided during an outpatient or home care visit.
- Risperidone micro spheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) will remain carved out of the benefit package for SSI/SSI-related enrollees in mainstream Medicaid managed care plans.

Additional information on MRT pharmacy initiatives, including frequently asked questions, is available on the Department's web site at:

http://www.health.state.ny.us/health_care/medicaid/redesign/does/additional_information_andiaqs.pdf

Limitations on Therapies — Effective 10/1/11

Outpatient physical, occupational and speech therapy will be limited to 20 visits each per calendar year for Medicaid managed care, FHPlus and MLTC. Restrictions do not apply to enrollees under the age of 21 or to the developmentally disabled population. As the FHPlus benefit package already restricts physical and occupational therapy to 20 visits per year, this change will apply only to the FHPlus speech therapy benefit. CMS approval is required before the limits can be implemented.

Emergency and Non-emergency Transportation — Effective Date TBD

The Department will implement regional transportation management vendors to handle non-emergency transportation services for both fee-for-service and Medicaid managed care beneficiaries. Transportation managers will initially cover services for fee-for-service beneficiaries, only, within their particular region. Medicaid managed care beneficiaries residing in the same region will begin receiving non-emergency transportation services through the manager a minimum of 60 days after the manager begins operations in the region. As the non-emergency transportation vendor assumes responsibility for managed care enrollees, the emergency transportation benefit will be removed from

the managed care benefit package. In order to promote a smooth transition, the Department will provide at least 60 days advance notice to affected plans and enrollees before implementation. This change does not apply to FHPlus.

A summary of the new benefits, including effective dates, is enclosed as Attachment A.

II. Medicaid Managed Care Program Changes

Marketing

As previously discussed, effective April 1, 2011, funding is eliminated for direct marketing to Medicaid beneficiaries by Medicaid managed care plans. With the elimination of the face-to-face interview for new Medicaid applicants, the implementation of the SDOH Enrollment Center, 12 month continuous enrollment and the high penetration of managed care enrollment, SDOH does not believe direct marketing provides a substantial benefit to the program. We recognize that many plans have concerns regarding the elimination of this activity as it relates to their overall enrollment base. We will provide a more detailed response on this issue based on the numerous questions we have received. However, effective July 15, 2011, plans will be prohibited from conducting direct marketing activities in counties where the State's Enrollment Broker is operational. For non-Enrollment Broker counties, the SDOH will allow the LDSS, at their discretion, to allow facilitated enrollers at the LDSS to educate and enroll Medicaid fee-for-service consumers. The Model Contract will be modified to direct plan outreach efforts toward enrolling uninsured consumers. Additional correspondence will be provided that will further delineate the activities that health plans will be allowed to conduct and the role of facilitated enrollers.

It should be noted that only a few states allow plans to conduct direct marketing of Medicaid members. The Department will continue to monitor the impact this will have on enrollment and future initiatives and will adjust as needed.

Enroll Non-dually Eligible Individuals into Mainstream Medicaid Managed Care

Quality of care data, including enrollee satisfaction measures, indicate that vulnerable populations, such as disabled and chronically ill individuals, are receiving better quality care through a managed care plan than they did in the Medicaid fee-for-service program and are highly satisfied with their providers and health plans. Based on this track record, the State will require additional high need populations that were previously exempt or excluded to enroll in Medicaid managed care. This expansion will be phased in over the next three years and requires CMS approval.

Many of the new populations targeted for enrollment have complex health needs, and health plans will be expected to follow transitional care requirements to minimize potential disruptions in care related to the transition from Medicaid fee-for-service to Medicaid managed care. As you know, under State statute, managed care plans are required to allow new enrollees to continue seeing their current provider for 60 days after enrollment if the enrollee is in an ongoing course of treatment and their provider does not participate in the plan. Also, the law requires managed care plans to allow all women in their second trimester of pregnancy to continue to see their prenatal care provider through

post-partum care. Transitional care policies for new enrollees seeing a participating provider, as described in the Department's May 28, 2009 letter, will also apply. Finally, the State will retain a 6 month limited chronic illness exemption to further promote a smooth transition into managed care and minimize any disruption in care.

A schedule of populations who will be required to enroll in Medicaid managed care, including the effective date of mandatory enrollment, is enclosed as Attachment B.

Choice Period for Selecting a Medicaid Managed Care Plan

The Medicaid managed care enrollment process will be streamlined by standardizing the period within which a beneficiary may select a managed care plan. New applicants for Medical Assistance (MA) will be required to indicate their choice of plan at the time of application, and if they do not choose a plan, they will be automatically assigned to a plan. Persons already in receipt of MA will have 30 days from the day the local district or State indicates to choose a plan. If they do not choose a plan within that 30 day window, they will be automatically assigned to a plan. Pregnant women will be required to choose a plan when they apply for presumptive eligibility and will be automatically assigned after 30 days if they fail to do so. Enrollees who are unhappy with the plan they chose or were assigned to will have 90 days to switch to another plan of their choice. The State's current auto-assignment methodology will continue to apply.

These changes are intended to promote and encourage managed care enrollment and the selection of a primary care provider and medical home. In the case of pregnant women, expedited enrollment promotes early entry into prenatal care leading to improved birth outcomes. All efforts will be made by the local districts and the State to inform and educate beneficiaries concerning their options and rights through training, community outreach, and the State's enrollment broker. While the State is proposing implementation of these changes in October 1, 2011, CMS must approve the State's 1115 waiver amendment prior to implementation.

Enrollee Restriction Program

Effective August 1, 2011, contingent upon CMS approval, beneficiaries in the Medicaid fee-for-service Restricted Recipient Program (RRP) will be required to enroll in Medicaid managed care, unless otherwise exempt or excluded. Medicaid fee-for-service program restrictions will continue to apply *to carved out services* after enrollment. Concurrent with this change, Medicaid managed care plans will be required to establish an Enrollee Restriction Program for plan covered services. Beginning August 1st, Medicaid managed care plans must restrict enrollees to one or more providers when the enrollee's utilization or abusive behavior meets the NYS Medicaid criteria for the RRP. Individuals who are in the RRP upon enrollment, as well as enrollees in the RRP for pharmacy, when the pharmacy benefit is assumed by managed care plans, must continue to be restricted. After the initial restriction period, the health plan may reassess the need for continued restriction. In addition, enrollees not in the RRP but whose behavior while enrolled in the health plan meets the criteria for RRP, must be restricted. It is expected that plans will establish policies and procedures to notify the enrollee, and all appropriate providers, of an enrollee's restriction. Neither a provider nor an enrollee may be held liable for the cost of services when the provider could not have reasonably known that the enrollee was restricted to another provider. As you know, we continue to share information and meet with plans regarding the enrollment of this population.

Notices of Benefit Denials

As more chronically ill populations are mandated into managed care plans, it becomes more critical that enrollees understand what services are available to them through their managed care plan, what services are available through Medicaid fee-for-service or another payor, and what their rights are when a benefit is denied. Effective October 1, 2011, benefit denial notices must include information concerning alternative means of accessing the denied service, to the extent this information is known to the health plan. Therefore, if the health plan knows that an enrollee has coverage for a denied service through Medicaid fee-for-service or an alternate payor, the plan will be required to provide that information to enrollees in the Notice of Action and inform enrollees of what steps must be taken to access the alternate coverage. For example, if a request for dental care is denied because the plan does not provide dental in the enrollee's county of residence, the Notice of Action should deny the service as non-covered, include the reason that the service is not covered by the plan, inform the enrollee that the service may be covered by Medicaid fee-for-service. Similarly, when a request for coverage of a permanent stay in an RHCF is denied, the Notice of Action should deny the stay as non-covered, inform the enrollee that the stay may be covered through Medicaid fee-for-service.

We continue to have discussions with the Office of Administrative Hearings regarding the fair hearing process. We are encouraged by our most recent discussions and will provide further clarification and guidance in the future.