The Medicaid Redesign Team (MRT II) established by Governor Cuomo in February 2020 opened an online portal for accepting Medicaid redesign proposals from the public. Members of Medicaid Matters New York – the statewide coalition representing the interests of consumers served by Medicaid – submitted dozens of proposals to the MRT II. This is a compendium of the proposals submitted by several Medicaid Matters members.

On behalf of the entire coalition, Medicaid Matters submitted the following proposal:

*Medicaid Matters urges reconsideration of the global cap. The current mechanism is nearly a decade old and has not kept pace with the needs of New York’s Medicaid program. It has functioned like a block grant, the concept New York State has advocated against at the federal level. The cap should be 1) eliminated; or 2) retooled to adjust for enrollment increases and changes to the minimum wage. Other states have found other ways to instill fiscal discipline in their Medicaid financing, including global budgeting, rather than capping. If New York State is to go forward with a global cap or any other financing mechanism, finance reports must be posted regularly, and there must be clear rules about funding the administration considers to have global cap impact or not. We need a Medicaid budget that realistically covers what our program needs to provide for the people who rely on it. The global cap must be reconsidered.*

About this document:
Each item in the table of contents is hyperlinked to the content within the document. There are many submissions in the document that contain hyperlinks to content posted elsewhere.

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Table of Contents

Consumer Directed Personal Assistance Association of NYS (CDPAANYS)

Health Homes Serving Children (HHSC)

Health People (Bronx community-based organization)

Jim Karpe (I/DD parent)

Judy Wessler

Long Island Center on Independent Living

New York Association of Independent Living

New York Association of Psychiatric Rehabilitation Services

New York Legal Assistance Group

New York State Nurse Association

New York StateWide Senior Action Council

PHI (Paraprofessional Healthcare Institute)

Ralph Warren (I/DD self-advocate)

Schuyler Center for Analysis & Advocacy and The Children’s Agenda

Supporting Our Youth and Adults Network (SONYAN) – I/DD group on Long Island

The Legal Aid Society

Urban Justice Center Mental Health Project (MHP)
The Health Homes Serving Children

The Health Homes Serving Children (HHSC) must be excluded from the proposed process that is being derived from the adult HH system. HHSC has not had a stable year of operations since inception given so many changes to our system. With the closure of residential facilities, changes to the juvenile justice system; and the upcoming transition of children in foster care, the need for HHSC care coordination will only increase and any restructuring to this program would further limit children accessing necessary services, in the community.

Currently 28,000 children are enrolled in the HHSC- nowhere near the anticipated 175,000 children originally estimated by NYS. The Health Home program has been identified as needing to be “course corrected” by the MRT II, however, we must distinguish the difference between the ADULT HH from the Kids. We have been operational for less than 3 years and transitioned so many systems to HHSC. Such as OMH-TCM, FFS billing to MMCP, have experienced 2 different outreach rate changes, integrated Early Intervention ongoing service coordination for those dually enrolled in EI/HH, we have taken 6 long standing waiver programs with their own rules, regulations, staff, documentation, not to mention over 5,500 children were transitioned from the former 1915c waiver to HHSC with a new array of services to access and had services converted to another authority and that transitioned just a year ago. The HHSC has been impacted by policy changes in this program that at times, had no value or relevance on the lives of the children we served but were a direct consequence of being treated as one Health Home program. We continue to see that children are a second thought when HH policy is revised with very little regard for trauma informed practices in reality. Kids are not little adults and we cannot continue to have them treated as an afterthought in this program.

I would like to propose that the HHSC continue to work with the Children’s Health and Behavioral Health MRT Subcommittee on implementation of the original recommendations through the first round of MRT that have not yet been completed.

Health People

I. MRT II: The Evidence: Diabetes Education Saves Billions, Improves Outcomes
NY State’s excess diabetes costs of $15,366 per Medicaid patient with diabetes (CDC) are double those of any other state and total $13.4 billion annually. These extraordinary costs are fueled by serious—but often avoidable complications—including amputation (up by 48% since 2009), kidney disease and blindness, as well as the 40% increased Alzheimer’s risk that diabetes causes.

Yet, it is well proven that evidence-based self-care education slashes diabetes costs and complications. One example: Recent large evaluation of the Diabetes Self-Management Program, a 6-session group course for type 2 diabetics, showed $2,220 savings just the first year in all cause medical charges for participants, compared to similar diabetics who didn’t attend the DSMP.

Providing the DSMP to just 20% of some 900,000 Medicaid patients with type 2 diabetes would save almost $400,000,000 just in the first year, with accumulating savings from participants’ better health for years.

Similarly, the National Diabetes Prevention Program, (NDPP) a 22-session group course for pre-diabetics slashes their prospects of developing diabetes by 60%; recent large federal evaluation shows its saves $2,650 per participant in medical costs in the first 15 months. Alas, the state’s claim to be implementing the NDPP as a Medicaid benefit is untrue. Since the state is barely reimbursing half what the NDPP costs, providers aren’t available. Yet, providing the NDPP for even 10% of the state’s some 2 million Medicaid pre-diabetics would save $530,000,000 just the first year—with ongoing savings as thousands more Medicaid patients don’t get diabetes at all. In both cases, the state gets one-third of the savings and localities get 10%!

Medicaid patients want this evidence-based education. Health People, through DSRIP funding, has engaged almost 2,000 Medicaid type 2 diabetics in the DSMP. We have shown these programs can be so rapidly implemented they start to more than pay for themselves within months. The key to rapid implementation is training local peer educators—particularly those who have diabetes, themselves—to facilitate the education groups and placing groups at accessible local sites from senior centers to homeless shelters. The state’s ongoing failure to use this well-documented strategy to massively improve health while massively saving Medicaid $$$ is disturbing.

Jim Karpe  
Father of two young adults with Intellectual and Developmental Disabilities (I/DD)

I. Reduce Administrative Overhead for I/DD

MRT 2 can save money by calling a halt to the transition to Managed Care for services for people with I/DD. This expensive and disruptive transition will cost hundreds of millions over the next few years, and will not save money in either the long or short term.
Plus, there is no evidence that it will improve quality of or access to Long Term Supports and Services. Please call a halt to the next expensive experiment, the creation of SIP-PLs.

II. Transition Most Supervised IRAs to management by Non-Profits

Transition to the Non-Profit providers the majority of State Services Supervised IRAs. Currently six thousand individuals reside in IRAs that are run by State Services, at an average cost that is two-times the cost of the equivalent residences run by Non-Profits. The back-of-the-envelope calculation is that transition to Non-Profits will result in a 40% savings on the $1.5 billion currently spent on these Supervised IRAs. That money should then be re-invested in development of additional residential opportunities, both certified and un-certified. This will reduce or eliminate the current use of hospitals and nursing homes as the "residence of last resort", which is both expensive and inappropriate.

BACKGROUND:

Supervised IRAs (Individualized Residential Alternatives) are a sub-type of Certified Residential Opportunity, administered by OPWDD (Office for People with Developmental Disabilities). The Supervised IRA provides round-the-clock supervision, and is differentiated from Supportive IRAs which are suitable for people who do not need constant supervision. Average annual cost at State Services Supervised IRAs is $233K, while the average rate for Non-Profits for the same service is $133K.

III. Increase budget and rate for Intensive Behavioral Supports

Increase the budget and rate for Intensive Behavioral Supports (IBS), which helps parents keep in the family home their loved ones with Developmental Disabilities. Current annual budget is two hundred thousand dollars for the entire State. Over fifty thousand individuals live at home with a parent care-giver who is age sixty or older– so this is four dollars per individual. Further, the rates for IBS are so low that no providers are willing to take on the cases, so even that paltry budget is likely not spent each year. Changing to a more attractive rate and a larger budget will reduce the burden on costly Certified Residential Opportunities.

Intensive Behavioral Supports help alter behaviors of the individual, and also train parents and other care-givers in how to alter their own behavior and therefore the reactions of the individual with DD. Effective IBS improves the quality of communication and quality of life in the family home. This helps defer placement into costly supervised IRAs, with an average annual cost per individual that is over $133K.

IV. Enhance programs to support less restrictive residential environments

Individuals with Developmental Disabilities have, in theory, a wide variety of Residential supports. In practice, once they enter a Certified Residential Opportunity (CRO) individuals rarely are able to move to a less restrictive setting– regardless of their readiness and their choice.
Further, people who are attempting to start out in a less restrictive setting find that they are stymied a thicket of administrative barriers. Some of those individuals wind up in CROs simply because that is the path of less resistance (and highest cost). Thousands of people have been unable to take advantage of the rental subsidy that they have been approved for, based on the best data available. It appears that only 60% of those approved for the subsidy are taking advantage of it.

Another example: Live-In Caregiver is a program that is intermediate between rental subsidy and a CRO. There are thousands who could take advantage of it. However, the administrative barriers create so much difficulty that at latest count, only 108 people have a Live-In Caregiver.

V. Two Recommendations:

1. New York State should reduce the barriers to entry for Live-In Caregiver and Rent Subsidy, and enhance the wrap-around supports. This will reduce the pressure to expand the use of costly CROs.
2. New York State should create a program to move those who want to, to the least restrictive environment that is compatible with ensuring their reasonable safety. Such a program would require a periodic independently executed survey of individuals who are in CROs, to determine who is expressing a desire to reside in a less restrictive setting. Perhaps on a frequency of every two years. Everyone who "raises hand" would then be assessed to determine their current capability. Those who are willing and able would then be assisted in moving to that less restrictive setting of their choice. This will improve quality of care, and free up CRO capacity.

Proposal written by Judy Wessler

- Integrity of review of proposals by including stakeholder in the process, including consumers and community-based organizations;
- Changing the Indigent Care distribution of funds;
- Reviewing all proposals with an eye to serving underserved populations and ensuring equity;
- Eliminate the Medicaid budget cap and develop new methods.

The Medicaid budget cap is outdated and should be eliminated. Smart people need to figure out a way to control costs and maintain the program as an alternative. There needs to be an oversight review of the Governors' action done outside of public view that rewards friends and donors as has been documented by Bill Hammond.
Any and all proposals considered during the MRT II review and recommendations must be viewed through the lens of impact on underserved communities, and working toward equity based on race, disability and any other handicap.

The state’s distribution of the ICP dollars is not legitimate and needs to be updated. ICP funds are meant to pay hospitals for the care of the uninsured and to target high Medicaid-serving population. New York has been phasing-in toward this goal for 8 years and inappropriately targeting the funds. It is important to meet the medical needs of underserved populations so that funding should be targeted to those hospitals that are serving those populations. It is way past time to change the formula and should be done legislatively through bills sponsored by Assemblyman Gottfried and Senator Rivera in this legislative session.

In order to ensure the integrity of review of all of the recommendations submitted to the MRT II, it is necessary to broaden the number and types of persons reviewing the recommendations submitted. The breadth of views and expertise reviewing the recommendations will work to ensure the integrity of the process. The review process and resultant recommendations of MRT I was tainted by a political process that eliminated and changed important recommendations. Stakeholders, including consumers and community-based organizations, must be involved in the review process.

Long Island Center on Independent Living

I. Reconsider reimbursement changes to the CDPA program

The growth in the Consumer Directed Personal Assistance Program (CDPA) is inappropriately being blamed for the Medicaid deficit. The DOH has put forward a change to reimbursement via proposed regulations that does not sufficiently reimburse the necessary administrative responsibilities and could cause significant disruptions in the system. LICIL urges the state to rescind the proposed regulations and allow for a more thoughtful process that includes consumers, FIs and advocates to identify opportunities for savings to the program, including any changes to reimbursement. LICIL and its colleagues has identified administrative changes to the program that would result in immediate savings to the program and allow for such a process. Specifically, LICIL recommends:

II. Make Consumer Assessment Annual

Before managed care, most counties required assessments annually. Under managed care this changed to semi-annually. Assessments already occur whenever there is a change in need, such as a hospitalization, and managed care organizations (MCOs) must do outreach to consumers monthly. Because of this, the need for a required biannual assessment is not justifiable. Based on CDPAANYS assessments of health care provider costs, and factoring in other factors such as medical transportation to the appointment, we
determined that if the assessment was made annual for CDPA alone, it could save approximately $47 million.

Allow personal assistants (PAs) to provide transport to and from medical visits – DOH allows PAs to transport consumers when tasks may be required on the plan of care; however, it has not allowed PAs to transport consumers to and from medical appointments. While not all consumers have access to vehicles, reducing medical transport utilization by expanding this option, not only makes sense, it improves consumers’ quality of life. The state could save approximately $84 million by allowing PAs to provide medical transportation for CDPA participants.

III. Reconsider the Medicaid Global Cap

Much of the reason for the so-called budget shortfall is due to spending simply exceeding the Medicaid Global Cap. It is important to remember that the Medicaid Global Cap was first established when New York State was in fiscal crisis. And while the Global Cap did succeed in constraining Medicaid growth for a time, essential programs and services have already faced significant cuts in recent years as a result of the cap. Years later, New York’s economy is doing well, and such austerity seems cruel and unnecessary. The State needs to continue in its tradition of providing community-based services to low-income individuals and people with disabilities. In order to do so, the cap should be 1) eliminated; 2) retooled to adjust for enrollment increases and changes to the minimum wage; or 3) raised. Other states have found other ways to instill fiscal discipline in their Medicaid financing, including global budgeting, rather than capping. If New York State is to go forward with a global cap or any other financing mechanism, finance reports must be posted regularly, and there must be clear rules about funding the administration considers to have global cap impact or not. We need a Medicaid budget that realistically covers what our program needs to provide for the people who rely on it.

IV. Preserve spousal and parental refusal for Medicaid recipients

Spousal refusal is a longstanding provision of state law that ensures that individuals can access the Medicaid-funded services and supports they need to live in the community, when the well spouse “refuses” to spend down their resources or income to support their spouse. The reality is that with Medicaid income levels below the Federal Poverty Line, all the couple’s income and resources are vital to meet their living expenses, and to prevent the well spouse from being impoverished and needing Medicaid as well. The alternatives are to force couples to divorce, live separately, or to institutionalize their loved ones purely for financial reasons, creating a discriminatory institutional bias. Part of spousal refusal is also parental refusal, the right of a parent to “refuse” to spend down their income and resources for parents of children with significant disabilities in need of costly services. This provision allows parents to maintain the income and resources they require to maintain a household, while ensuring their children have the services they require.

The State must preserve spousal and parental refusal to prevent unnecessary an unwanted institutionalization.
New York Association on Independent Living

I. Reconsider reimbursement changes to the CDPA program

The growth in the Consumer Directed Personal Assistance Program (CDPA) is inappropriately being blamed for the Medicaid deficit. The DOH has put forward a change to reimbursement via proposed regulations that does not sufficiently reimburse the necessary administrative responsibilities and could cause significant disruptions in the system. NYAIL urges the state to rescind the proposed regulations and allow for a more thoughtful process that includes consumers, FLs and advocates to identify opportunities for savings to the program, including any changes to reimbursement. NYAIL and its colleagues has identified administrative changes to the program that would result in immediate savings to the program and allow for such a process. Specifically, NYAIL recommends:

a) Make consumer assessment annual

Before managed care, most counties required assessments annually. Under managed care this changed to semi-annually. Assessments already occur whenever there is a change in need, such as a hospitalization, and managed care organizations (MCOs) must do outreach to consumers monthly. Because of this, the need for a required biannual assessment is not justifiable. Based on assessments of health care provider costs and factoring in other factors such as medical transportation to the appointment, it is estimated that making the assessment was made annual for the Consumer Directed Personal Assistance Program alone, it could save approximately $47 million. This recommendation derived from and is strongly supported by consumers.

b) Allow personal assistants (PAs) to provide transport to and from medical visits

DOH allows PAs to transport consumers when tasks may be required on the plan of care; however, it has not allowed PAs to transport consumers to and from medical appointments. While not all consumers have access to vehicles, reducing medical transport utilization by expanding this option, not only makes sense, it improves consumers’ quality of life. The state could save approximately $84 million by allowing PA’s to provide medical transportation for CDPA participants. This change can be achieved immediately by updating existing policy guidance and communicating the change to providers.

II. Support Increased Funding for Programs that Assist People to Return to the Community from Institutions

Many people in nursing homes can and would prefer to be served in the community at a lower cost. The MRT II should support increased funding for programs that assist people to return to the community from institutions. According to the national evaluation of MFP, Medicaid expenditures for older adults and people with disabilities are 23% less in the
community than when in a nursing home. Increasing the number of people who transition by 100 people could save $2.2 million in Medicaid funding per year.

Since 2015, the Open Doors program, funded by the Department of Health, has helped over 3,500 New Yorkers transition from nursing homes. The program is currently funded at $5.4 million per year and staffs over 98 Transition Specialists and Peers across NYS. Since 2015, the program has received over 15,000 referrals. Open Doors currently has over 3,000 active cases, 1,600 of which are in NYC. Additional funding to the Open Doors program would increase staffing particularly in NYC and support increased transitions, ultimately saving the State.

The State should also increase funding for housing programs that support high acuity Medicaid-eligible individuals who are at institutional level of care. The 2011 MRT created the Supportive Housing Allocation Plan, which funds housing subsidy programs for people with significant disabilities in multiple service systems, including the Olmstead Housing Subsidy (OHS), Rapid Transition Housing Program (RTHP) and the NHTD/TBI Housing Subsidies. These supportive housing programs have proven to be incredibly effective at improving health outcomes and stabilizing some of New York’s most vulnerable people. Findings from a 2017 Department of Health-funded evaluation of the initiative demonstrated significant positive outcomes, including substantial reductions in inpatient days, emergency department visits, readmissions for rehab stays to treat substance use disorders, inpatient psychiatric admissions, and overall Medicaid health expenditures. OHS and RTH currently have over 600 individuals housed, with 900 individuals in need pending approval and enrollment. Increased funding for these programs would increase the number of individuals housed and ultimately save the State money.

III. Reconsider the Medicaid Global Cap

Much of the reason for the so-called budget shortfall is due to spending simply exceeding the Medicaid Global Cap. It is important to remember that the Medicaid Global Cap was first established when New York State was in fiscal crisis. And while the Global Cap did succeed in constraining Medicaid growth for a time, essential programs and services have already faced significant cuts in recent years as a result of the cap. Years later, New York’s economy is doing well, and such austerity seems cruel and unnecessary. The State needs to continue in its tradition of providing community-based services to low-income individuals and people with disabilities. In order to do so, the cap should be 1) eliminated; 2) retooled to adjust for enrollment increases and changes to the minimum wage; or 3) raised. Other states have found other ways to instill fiscal discipline in their Medicaid financing, including global budgeting, rather than capping. If New York State is to go forward with a global cap or any other financing mechanism, finance reports must be posted regularly, and there must be clear rules about funding the administration considers to have global cap impact or not. We need a Medicaid budget that realistically covers what our program needs to provide for the people who rely on it.

IV. Preserve spousal and parental refusal for Medicaid recipients.
Spousal refusal is a longstanding provision of state law that ensures that individuals can access the Medicaid-funded services and supports they need to live in the community, when the well spouse “refuses” to spend down their resources or income to support their spouse. The reality is that with Medicaid income levels below the Federal Poverty Line, all the couple’s income and resources are vital to meet their living expenses, and to prevent the well spouse from being impoverished and needing Medicaid as well. The alternatives are to force couples to divorce, live separately, or to institutionalize their loved ones purely for financial reasons, creating a discriminatory institutional bias. Part of spousal refusal is also parental refusal, the right of a parent to “refuse” to spenddown their income and resources for parents of children with significant disabilities in need of costly services. This provision allows parents to maintain the income and resources they require to maintain a household, while ensuring their children have the services they require.

The State must preserve spousal and parental refusal to prevent unnecessary an unwanted institutionalization.

V. Access to Home

Access to Home is an important program administered by NYS Homes and Community Renewal (HCR) that provides funding for home modifications to allow individuals with disabilities and older New Yorkers to stay in their homes and out of costly institutions. For many people, the addition of a ramp to their front door makes the difference between being able to leave the house and being homebound.

The 2011 MRT identified Access to Home as an important program that helps reduce Medicaid costs and committed funding to the program specifically for Medicaid-eligible individuals, however the general program targeted at low-income individuals has remained severely underfunded. According to data from HCR, only 34% of counties were served at all by the program. As a result, the program is unable to ensure that people are safe in their homes and prevent falls that can lead to hospitalization or nursing home placement. Institutional care is a major cost driver in the Medicaid system, on average it costs Medicaid $86,596 per year to keep someone in a skilled nursing facility in New York. These costs can be avoided if access modifications are made available statewide to facilitate aging in place and enabling people with disabilities to live at home before they end up needing Medicaid services.

Access modifications through New York’s Access to Home program can fund essential fall prevention measures and ensure that people with disabilities remain independent. Simply removing doorway thresholds that create a hazard, replacing inaccessible door handles, building ramps to avoid the dangers of pushing a wheelchair upstairs, and installing bathroom safety features like grab bars or benches that can prevent serious injuries that lead to hospitalizations and eventually institutional care. These home access features also help to safeguard paid and family caregivers from injury in the home by avoiding dangerous situations that might lead to institutionalization if there aren’t available caregivers.
Increased funding for Access to Home at $10 million will increase availability of the program statewide, prevent people from needing Medicaid, and reduce hospitalizations and institutionalizations.

New York Association of Psychiatric Rehabilitation Services

I. Increase Enrollment to Health Homes and HCBS

Category of Proposal: Outpatient

Medicaid Redesign Goals: Improves quality of care; Improves or expands coverage; Improves care management and care delivery; Advances the State's successful healthcare reform strategy.

The following strategies will improve system effectiveness and result in Medicaid savings.

- Simplify and Speed Access and Enrollment: review the usefulness of current procedures and forms across Health and Recovery Plan to Health Home to Home and Community Services pathways.
- Incentivize and Increase the Use of Peer-Delivered Outreach, Engagement, Crisis Management, Wellness Coaching and Relapse Prevention Services. Certified behavioral health peer providers are especially adept at engagement, retention and improved wellness self-management of people with complex needs who frequently make use of costly and avoidable emergency and inpatient services. The state should incentivize and expect plans to make greater use of these critically important, effective and efficient approaches.
- Fund Consumer and Provider Education about HARPs, Health Homes and HCBS. NYAPRS' experience in this area has made clear how little understanding there is still of all three of these landmark advances among direct care staff and Medicaid members.

II. Add Peer Services to the State Medicaid Plan

Category of Proposal: Outpatient

Medicaid Redesign Goals: Improves quality of care; Improves or expands coverage; Improves care management and care delivery; Advances the State's successful healthcare reform strategy; Reforms reimbursement

New York should join many other states in including peer-delivered services in our State Plan to permit Medicaid reimbursement for mainstream (non-HARP) beneficiaries with extensive needs (see link below). Some of this population may not currently meet all of the criteria for HARP enrollment but can or will in the near future and access to peer services will allow for preventive work that will decrease costly future relapse and recidivism. Peers can also provide education and encourage enrollment in HARPs and HCBS to eligible mainstream members who have not enrolled due to a lack of awareness or a fear of change.
Peers are experts in outreach, engagement, retention, advancing wellness self-management, relapse prevention, crisis management and diversion and advancing social connection.

III. Enhance and Incentivize the Critical Role of the Social Determinants of Health  
Category of Proposal: Outpatient  
Medicaid Redesign Goals: Improves quality of care; Advances the State's successful healthcare reform strategy; Improves or expands coverage

It is well known that addressing housing and financial instability, food insecurity, social and cultural isolation and avoidable involvement in the criminal justice system will improve health and bring down avoidable and costly use of inpatient, emergency and homeless services.

- The state should speed the validation process and use of Social Determinants of Health-related Measures that will expect and incentivize health plans and providers for fostering these outcomes. For example, the use of social determinant related measures by DOH, OMH and OASAS for HARP enrollees are expected to be at least two years away. Currently, all of the accepted measures are entirely medical, e.g. access to clinicians and medication.

- NYAPRS is strongly supportive of the state’s plan to invest in and incentivize strategies to address the social determinants in DSRIP 2.

IV. Increase Education for Patient Approved (Opt-In) Sharing of Medical Information into the RHIOs and SHINY  
Category of Proposal: Outpatient  
Medicaid Redesign Goals: Improves quality of care; Improves care management and care delivery and advances the State's successful healthcare reform strategy; Improves or expands coverage

The state should engage in a widespread public education program aimed at encouraging patients to knowledgeably and voluntary provide increased access to patient medical information that will facilitate optimal individualized care, especially to ensure access to appropriate treatment, rehabilitation and medicine, while reducing costly and avoidable use of tests, emergency and inpatient use.

- To ensure informed consent, the state should invest in patient, plan and provider education that will increase enrollment via an Opt-In process, as has been recommended by groups of patient and legal rights groups during the VBP Privacy and Confidential work group.

- See NYAPRS paper on Strategies to Encourage Health Information Sharing and Patient-Provider Collaboration that was submitted to the VBP subcommittee on Privacy and Confidentiality on January 9, 2017.

V. Increase the use of Culturally Competent Patient Incentives  
Category of Proposal: Outpatient
**Medicaid Redesign Goals:** Improves quality of care; Reforms reimbursement; Improves or expands coverage; Enhances program integrity; Advances the State's successful healthcare reform strategy

Incentivizing patients for improved self-care will lead to better health outcomes and savings. The state should act on the recommendations of the VBP Advocacy and Engagement subcommittee, as follows:

- Develop a Member Incentive Program
- Establish guiding Principles for Member Incentive Programs
- Creation of an Expert Group for Achieving Cultural Competence in Incentive Programs
- Eliminate the $125 Incentive Cap for Preventive Care
- Implement of Pilot Incentive Programs
- Incentive Program Outcome Measurement
- Develop a Library of Knowledge on Incentive Programs

A key recommendation involved patient education: “consumer rights to know the incentives that affect their care must be considered when developing strategies around what and when information related to VBP and DSRIP more broadly, will be communicated to members.”

**VI. Increase Employment Rates and Decrease Medicaid Utilization by People with Disabilities**

**Category of Proposal:** Outpatient

**Medicaid Redesign Goals:** Improves quality of care; Advances the State's successful healthcare reform strategy

It has been shown that people with disabilities who return to work via participation in the Medicaid Buy-In program cost Medicaid $984 per-member per-month (PMPM) in 2000, almost 40 percent lower than the cost of other Medicaid enrollees with disabilities, whose expenditures were $1,583 PMPM.

Towards those ends, the state should re-convene the Most Integrated Setting Coordinating Council and accelerate its efforts to implement the Governor’s Employment First Agenda, most notably efforts to increase enrollment into the state’s Medicaid Buy-In program.

**VII. Continue and Increase Funding and Programming for Behavioral Health Services.**

**Category of Proposal:** Outpatient

**Medicaid Redesign Goals:** Improves quality of care; improves or expands coverage; improves care management and care delivery; advances the State’s successful healthcare reform strategy; ensures a stable and appropriately skilled workforce

It is critical that behavioral health services remain exempt from any cuts or changes that could reduce funding to behavioral health, in keeping the much appreciate exemption of mental hygiene services from recent 1% across the board cuts.
Behavioral health providers have been chronically underfunded for decades and cannot withstand additional cuts, and individuals around the State with behavioral health needs already face difficulties finding care, as there are not enough providers and many providers have waitlists. In addition, these providers have low workforce retention and high vacancy rates.

In addition, more funding should be invested in the behavioral health service system since access to behavioral health services reduces healthcare costs in the short and long term, since behavioral health providers serve high cost individuals and can help prevent avoidable hospitalizations and emergency room visits for a ‘high cost’ population.

New York Legal Assistance Group

I. Community Based Rate Cells for MLTC – Necessary to counter the perverse incentive for MLTC plans to deny adequate home care for those with the most severe disabilities to remain in the community, and would save money because rates can be reduced if the outlier expenses are funded through a rate cell. We know DOH and CMMS opposed defining the group eligible for the rate cell solely by the number of hours authorized. But they could be identified through the underlying factors – a combination of diagnoses, severity, living arrangements and availability of informal supports that result in being assessed to need 12+ hours x 5-7 days of personal care or CDPAP services. The rate cell reduces costs because the plans don’t receive a higher PMPM rate for ALL 250,000 MLTC members that incorporates those outlier costs. They are paid a lower rate meant to cover the care needed by the majority of people, say up to 10 hours/day. But those who need more than that are OUTLIERS and long-known insurance reimbursement mechanisms such as STOP LOSS or a COMMUNITY BASED RATE CELL would better channel the funds needed to pay for the higher amount of services needed by this small sector AND AT THE SAME TIME counteract the enormous disincentive created by capitation. Using 2017 MMCOR statewide data, in only 2.1% of all Personal Care “member months” and 1.9% for CDPAP were more than 480 hours/month authorized, which is all those receiving 24-hour care.

II. Carve out private duty nursing services entirely or use a rate cell if based on diagnoses/acuity/informal care availability factors need more than 6 hours/day – Unlike PCS and CDPAP, the MCCOR reports do not require plans to report the number of member months in which PDN services are authorized at all, let alone the member months in which different ranges of hours of PDN services are authorized, e.g. 700+ hours. DOH should have encounter data, however, to estimate these costs and to identify the diagnoses and other indicators for needing PDN. We have had clients with ALS who have extensive nursing needs, as much as 2x12 shifts per day. The high hourly cost of these services is too high for the plan to absorb, and because of this disincentive, plans rarely authorize this service without a fair hearing or external appeal decision. We presume the encounter data would reveal this to be a small
outlier cohort – the cost can be better spread on a FFS basis than borne by plans individually, especially the smaller ones.

III. **Plan Accountability** – Rates in part are based on how the plans’ nurses complete the UAS assessment, with higher scores showing higher levels of dependence signifying a higher “acuity.” There are other factors, but this acuity score is central to the rate setting process. The plan receiving a high rate based on that high acuity score, however, is not held accountable for providing more robust services to members with a higher acuity. The plan is rewarded with a higher capitation rate for having members with high “scores” but is not necessarily providing them with the services commensurate with those scores, which they need to live safely in the community. Whether through audits or other oversight, plans should face sanctions for gaming the reimbursement system in this way, and for failing to provide adequate services.

IV. **Adjust or Repeal Global Cap** – The notion that we have a Medicaid deficit is false. Medicaid spending has exceeded the global spending cap, which is outdated and resembles the federal Republican proposals to block grant Medicaid. The global cap must be reconsidered and take into account changes in enrollment, the minimum wage increases that NYS commendably enacted — even if it means raising revenue, and the aging population that is living longer but needing services longer. The Global cap, like block grants, take no account of economic cycles, in which enrollment may increase.

V. **Revisit the projected cost of MLTC in light of removal of nursing home care from the MLTC program** – All of the statistics presented showing growth in MLTC enrollment and costs were presented without identifying what proportion of the growth in both enrollment and costs in the last two—three years is attributable to the 2015 change that required nursing home residents to enroll in or remain in MLTC plans. Syracuse.com reported that Nascentia alone will lose $400 million in capitation since 65% of its members are in long term nursing home placements. The article reported that 42% of MLTC members upstate will be dis-enrolled because of the changes. While consumer advocates fear that this “carveout” of nursing home care will incentivize plans to deny high cost home care to their members – the fact remains that this change will garner big savings for NYS. Before any further cuts are made in Medicaid, the State needs to be transparent about the extent to which the increase in MLTC enrollment costs in the last year was caused by the nursing home carve-in and accordingly how much costs will decrease. The state increased capitation rates when nursing homes were carved in. Presumably those rates will now decrease, resulting in huge savings – which mitigate the need for other cuts.

VI. **Automatic Recertification’s for Aged, Blind and Disabled in MLTC, Medicaid, or Medicare Savings Programs** – Bill A07578/S05485, which passed but was vetoed by the Governor, would automate the cumbersome annual financial renewal process for seniors and people with disabilities. Though they mostly have fixed incomes and assets, New York has continued to require this burdensome and error-prone mail renewal process annually. Stories are legion of consumers who never receive these
mailings, or who submitted them only to have Medicaid discontinued for an alleged “failure to recertify.” Advances in technology have enabled the state and local Medicaid programs to verify many types of income and financial resources of applicants and recipients electronically, without requiring documentation from the recipient, with investigations for potential ineligibility if a red flag appears. With these advances, recipients could “attest” to the amount of their income or resources, without the burden of submitting documentation, with the few red flags checked on the back end. Contrary to the Governor’s veto message, this is allowed by federal law. 42 U.S.C. § 1396w requires states to implement a program for verifying assets for determining and re-determining Medicaid eligibility for aged, certified blind or disabled applicants and recipients. The Medicaid mail renewal process is a shameful example of the old “churning” process in welfare systems. Recipients are cut off Medicaid not because they are not eligible, but because they cannot cope with the archaic mail renewal system. The consequences of being “churned” off of Medicaid are severe. The consumer is automatically dis-enrolled from an MLTC plan – leading to cut-off of home care services. Even if Medicaid is restored, they are not automatically re-enrolled in their MLTC plan without extensive advocacy and resources of the plan, local district, Maximus and State DOH. The annual recertification process for MLTC enrollees is a waste of resources for plans, local districts, State DOH, enrollees, and their families. Allowing deemed eligibility and attestation would not put the State at risk of reauthorizing Medicaid for people who are ineligible. Attestation of resources is already used in many parts of Medicaid, with no reported downside. This would not change enrollees’ obligation to report changes in income or resources.

VII. Auto-Assign Individuals to MLTC Plans after Found Eligible for MLTC in Conflict-Free Assessment - The Governor vetoed with no explanation part of Bill A7578/S05485 that would automatically enroll consumers into a MLTC plan after they have been approved for Medicaid and for MLTC enrollment and after they have been given the opportunity to choose their own plan but have been unable to do so. Currently, those who cannot manage to navigate the many hurdles to timely enroll in an MLTC plan lose their eligibility for MLTC because the Maximus Conflict-Free assessment approval expires after 75 days, and they must begin the entire process again. This change would align the MLTC program with mainstream Medicaid managed care, in which individuals approved for Medicaid have always been auto-enrolled in a plan after a choice period.

This change should reducing the cherry-picking by which plans now discourage enrollment of members who may be perceived as having high needs, since the plan wants to avoid providing high-cost care with the fixed capitation rate. The plans do this by saying that they would authorize only 4 hours/day for someone who clearly needs 12/7. The consumer is then incentivized to shop around for another plan that might approve the number of hours needed. If the consumer is assigned to the plan, the plan must give the necessary services, resulting in spreading high-need members fairly across all plans. Ultimately this should result in lower rates. As in mainstream managed care, auto-assignment would be on a weighted basis and would only occur after the consumer had a chance to select a plan. It would reduce Maximus costs by
eliminating the need for duplicate assessments if the conflict free assessment expires – the CFEEC will be deemed to be in effect – and would not expire – if the auto-assignment is not completed by the 75th day after the CFEEC determination.

VIII. **Eliminate MLTC** – We know this is unlikely with the State being committed to managed care for all, and with the MRT having significant representation by insurance plans. But, the State has not been transparent about the amount of Medicaid rates paid to plans that goes to administration and profit – including the cost of “care management” which in reality is mostly administrative or utilization control and not true care management. Since the need for home care is a requirement to enroll in an MLTC plan, it is not a true insurance model. It is like allowing only people diagnosed with cancer to enroll in a health insurance plan. How could the plan control costs and spread the risk if everyone needs the expensive services? The model and reimbursement structure compels plans to cherry-pick to avoid high-need members, partner with SADC’s and LHCSAs to market to and enroll low-need people, and deny adequate services to members with higher needs. Case in point – the [Daily News story](#) this week of the Bronx woman with advanced dementia and other impairments, who the MLTC plan denied an increase from 5 hours/day and who froze to death, with no aide to provide the vital cueing assistance she needed because of her impairments. It is not an answer to raise the functional eligibility threshold, and carve out the lower acuity applicants as was proposed last year – this will only accentuate the problem, with plans even less able to spread the risk, and high-need members more likely to be denied services. Elimination of MLTC would also eliminate the need for Maximus doing conflict-free assessments, which is a costly and duplicative function. Administrative costs for the local districts would increase but would be far less than the amount saved.

IX. **MLTC Rate Transparency and Accountability, including Additions Needed to MMCOR Reports**

More transparency is needed for how MLTC rates are set and for MLTC delivery of services. The base rate is based on the MMCOR reports filed by each plan, which itemize all expenses (administrative and medical), the types, amount and cost of each service provided, types and amounts of revenue, and profits. For example, MLTC MMCOR reports show the number of members receiving each of 7 different ranges in amounts of personal care and CDPAP hours, from 700+ hours/month to <160 hours/month, the number of members in nursing homes, and much more. The MMCOR data is notably missing from https://healthdata.ny.gov/ - and should be publicly posted for accountability and to enable comparisons between plans – for the public, for consumers, researchers, and legislators. The Medical Loss Ratio can be calculated from these reports and should be made public.

The rates are then risk adjusted based on the plans’ individual UAS assessments, with higher scores showing higher levels of dependence and higher “acuity.” The plan receiving a high rate based on that high acuity score, however, is not held accountable for providing more robust services to members with a higher acuity. The plan is rewarded with a higher capitation rate for having members with high “risk scores” but is not necessarily providing
them with the services commensurate with those scores, which they need to live safely in the community. Plans should face sanctions for gaming the reimbursement system in this way, and for failing to provide adequate services.

MMCOR reports fail to include Private duty nursing services – plans do not report cost of these services, number of member months the services are authorized in the different buckets of hours reported for personal care and CDPAP.

Plans must also be accountable for gaps in services, particularly upstate – advocates have seen consumers authorized for home care services but with no services provided for days and even weeks. Plans are responsible for using out-of-network services if they lack network capacity. No reporting is required for this accountability. Yet they receive full capitation payments.

New York State Nurses Association

See attached document.

New York StateWide Senior Action Council

I. **Ensure proposals don’t create enrollee barriers benefits, access to care.** Too often an unintended consequence of change quickly proposed and implemented by state policymakers results in a negative impact on enrollees. Every attempt must be made when scoring proposals to assess the potential for a positive or negative impact on enrollees. Consumers and consumer advocacy groups should be called upon to review recommendations to help the MRT assess the potential impact on reimbursement or policy changes on consumers. Will a provider reimbursement change reduce hours of care, impact on the ability to see primary care, specialists or shortage practices such as psychiatric services or home health care? Will a policy change result in more or less burden on a consumer to be assessed, have to switch plans, or to find new providers? Will a change to restricting Medicaid enrollment criteria such as spousal refusal rules impact families and promote divorces in order to comply? Will reimbursement cuts further degrade the patient to staff ratio?

II. **The Medicaid Global Cap is now out of date, does not comport with the expansion of Medicaid enrollment under the ACA, the increase in the minimum wage and did not anticipate the needs of a growing older population.** It has outlived its usefulness as a way to bend the growth cost curve and needs to be re-examined to ensure that if it is an appropriate tool it is using realistic factors to cap cost growth.
III. Community spouses must be able to live out their lives with independence and dignity and deserve protection from impoverishment when a spouse applies for Medicaid to meet long term care needs. The state does not take full advantage of federal options to increase the level of income and assets that can be protected to prevent spousal impoverishment. We recommend increasing those to the maximum. States can choose to adopt the “special income rule,” to increase the Medicaid income limit to 300% of SSI. For Home & Community based care, NYS should use a higher monthly maintenance needs allowance of $3,216.00, federally allowable as long as it is based on a reasonable assessment of need and subject to a maximum that applies to all enrollees under the HCBS waiver. NYS should adopt the maximum community spouse resource allowance ($128,640).

NYS must retain the right of spousal refusal at the time of the Medicaid application. The state and local governments still have the right to pursue payments from the spouse that has refused, but this is done after the application process and allows for the start of needed service coverage. It must be noted that this has been re-asserted by the Legislature annually as part of the State budget process and should not be undermined by MRT action. The benefit of spousal refusal is that it improves the Medicaid application process for the spouse in need, and does not compel a couple to advance divorce proceedings or stop co-habitation of the same premises in order to achieve the same result. Critics that suggest those with income above the paltry spousal impoverishment standard should purchase long term care insurance ignore the facts – significant long term care insurance cannot be purchased late in life, many existing LTC insurance policies have reneged on benefits once promised, premiums have escalated and become unaffordable even for those who have had the coverage for decades, and the ability to use the benefit for community based care has been compromised by the lack of home care agencies able to provide personal care services.

IV. Improve the Medicare Savings Program through efficiencies and expanding benefits.

Improve the ability of lower-income Medicare enrollees to qualify for federal help to pay their Part D premiums, deductibles, and other cost sharing obligations through the Medicare Low-Income Subsidy program and through the state/federal partnership in the (MSP) for Part B premiums.

Expand income eligibility for the Medicare Savings Program, currently at the federal minimum. Some added cost to the state share of Medicaid, this results in a significant benefit for low-income Medicare enrollees and reduces the state’s EPIC program costs since MSP enrollees automatically get the 100% federally funded Extra Help without an asset test. Minimally, expanding MSP to 150% of the FPL will automatically match the LIS, streamlining administrative processes. Follow CMS recommendations to reduce and achieve significant administrative savings and reduce the administrative burden for counties, the state and applicant. Use section 1902(r)(2)(A) of the Social Security Act to better align the LIS and MSP income
criteria to achieve substantial efficiencies in the enrollment process, both for applicants and government eligibility workers, and simplify outreach to potential beneficiaries.

Since older New Yorkers who are eligible for these programs live on fixed incomes that rarely change significantly from year to year, there would be much to gain by eliminating annual reapplication requirements.

a) Ease or eliminate documentation requirements (adopted by CT, FL, TX, VT)
b) Increase the standard income disregard (adopted by DC, IL, ME, MS)
c) Offer full Medicaid benefits through QMB (adopted by NE, SC)
d) Raise the income limit to any level (adopted by CT, DC, IN, MA, ME)
e) Share data with Medicare Advantage plans, who can assist enrollees with renewal
f) Make automatic renewal the norm by sending a letter directing the beneficiary to take action only if there was a significant change in circumstances (adopted in ND, OK, TN, TX)
g) Use data-sharing to verify that there is no change in status, obviating the need for action by the beneficiary, ex parte renewal ( adopted by AL, AZ, LA, MD) Louisiana reported saving $1.7 million a year due to instituting ex parte renewal, while also greatly increasing retention rates for the benefits.

V. There is a need for grants to support demonstration projects to show initiatives that will improve personal care worker recruitment and retention and address the workforce shortage. New York will need to fill almost 745,000 job openings for home health and personal care aides between 2016 and 2026 - a number the state is unprepared to fill. In spite of an increase in the minimum wage for Medicaid providers, there is currently still a significant shortage in personal care workers who can be assigned by a home care agency, which in large part has left MLTC plans steering enrollees to the consumer directed model. A Home Care Jobs Innovation Fund would support pilot projects throughout the state that boost the number of home care workers that enter and remain in the field. The findings from these projects can help determine statewide solutions. The awards would include all project-related costs, including administration, implementation, and evaluation. All worker-related costs associated with the projects, such as additional compensation or bonuses, must also be covered by these funds. The awards should include a diversity of regions (including urban and rural), types of grantees (such as home care agencies, organizations that work with consumers in the Consumer Directed Personal Assistance Program, and organizations with experience in home care workforce development), and tiers of grants. The pilots must also address the shortage in the non-Medicaid EISEP (state funded through NYSOFA), since that program can delay or prevent spend down to Medicaid.

VI. Minimum safe nursing staff to patient ratios needs to be established and enforced by the state in order to ensure patients that their needs will be met by the appropriate
**personnel and in a timely manner.** Safe staffing improves quality of care, saves lives and reduces employer cost for sick leave, workers compensation, recruitment and retention and orientation. Hospital safe staffing will lessen discharge to nursing homes (and the likelihood of spend down to Medicaid) due to poor outcomes or facility acquired infections or accidents. Appropriate staffing in nursing homes will improve quality and dignity of care. There has been significant research tying safe patient staffing levels and improved outcome measures. Hospitals that staff one nurse to 8 patients experience five additional deaths/1,000 patients. The odds of patient death increases by 7% for each additional patient assigned to a nurse at one time. Hospitals with higher nurse staff levels had 25% lower odds of Medicare readmission penalties. In nursing homes with safe nurse staffing levels, there are fewer facility deficiencies for poor quality and improved functional status of residents.

VII. **Expand non-Medicaid home care services to reduce dependence on Medicaid.**
Reduce dependence on Medicaid as a source for home care for those elderly NYers with income just above Medicaid by increasing access to the (NYSOFA) non-Medicaid Expanded In Home Services for the Elderly Program (EISEP). Persons currently served by this program have an opportunity to share in the cost of their care. They receive a case managed package of non-Medical in home supports that may include services such as Personal Care Levels I and II, non-Institutional respite, ancillary services, meals, transportation or social adult day services. The cost of services is much leaner than serving the same person within the Medicaid system. The program successfully keeps many functionally impaired elderly (average age is over 80) who are just above poverty level (150% of poverty level) off of Medicaid for long periods of time.

VIII. **Maximize use of Part A Medicare (instead of Medicaid) to pay post-acute SNF rehab.**
Federal policies currently allow Medicare Managed Care providers to cover the cost of post-acute rehab in an SNF, even if a patient falls short of the 3 midnight (in-patient status) rule due to placement into observation status. However, most Medicare MCOs don't use this flexibility. New York State must encourage such MCOs to use this flexibility, especially if they are also Medicaid MCOs in NY. This would prevent such persons from being fully charged for such care in an SNF (persons who don't meet the 3 midnight rule don't qualify for rehab coverage under Part A and many of them are forced to apply for Medicaid because it exhausts their resources). If the state made this a priority and got these MCOs to allow coverage then it would maximize the use of Medicare dollars instead of crushing families to pay for what used to be covered by Part A and often forcing the use Medicaid dollars to pay for this care. When a person falls in this catch 22 the Office of Inspector General has found that the average out of pocket cost to such a beneficiary is $10,000. Our organization has seen costs up to $30,000.

IX. **Require Medicaid MCOs to use more funding on prevention and evidence-based health promotion disease prevention or management programs.** NYS should require
all Medicaid MCOs to spend a minimum amount of funds on evidence-based health promotion and disease prevention programs. Highest Tier Programs like Chronic Disease Self-Management, Diabetes Self-Management, Active Choices and Matter of Balance have a ROI from such programs over $4.00 for every dollar spent.

X. Reduce use of Medicaid for non-health care costs or allowable administrative costs. New York has handed over most of the provider rate setting and bill paying to MCOs and MLTCs. The exponential expansion of this shift in the locus of control for Medicaid has not be accompanied by stringent reviews of MCO/MLTC costs. Other states have used audits to test the allow-ability of many expenses such as contract costs, administrative expenses and non-care related costs (such as advertising through sponsorships and charitable contributions that are really marketing expenses). Given the current Medicaid shortfall New York State should conduct such audits to assure the unallowable costs are prohibited or paid back and that the loss ratio for non-care related expenses is limited, especially among those MCOs with significant reserves and those showing significant financial gains in their Medicaid product line.

PHI (Paraprofessional Healthcare Institute)

I. Maximize the Home Care Workforce to Improve Quality and Efficiency

Drawing on nearly 30 years’ experience promoting the direct care workforce in long-term care, PHI urges the Medicaid Redesign Team (MRT) II to consider modernizing home care workforce regulations to maximize home care workers’ contribution to a coordinated, high-quality long-term care system.

Home care workers—primarily home health aides and personal care aides—provide critical daily supports for older adults and people with disabilities in New York. As noted in the February 2020 MRT II presentation, these personal care services represent a large and growing proportion of Medicaid spending in the state. The challenge, therefore, is to improve the efficiency of personal care services without compromising access or quality. A key solution is to broaden the scope of allowable activities for agency-employed home care workers to better leverage their role. Although this will require parallel investments in training and supervision, upskilling the home care workforce will create savings through improved care coordination, better medication adherence, decreased rates of avoidable emergency room visits and hospitalizations, and other improved health outcomes. Delegating more tasks to home care workers will also enable nurses to practice to the top of their license, generating further savings within the system.

In modernizing nurse delegation rules and other regulations governing the large and growing home care workforce, New York will follow the successful example set by other states, including New Jersey. Modernizing the rules for agency-provided personal care
services will also achieve parity with consumer-directed personal assistance services (CDPAS), where personal assistants—thanks to a decades-old amendment to the nurse practice act—already streamline care provision by fulfilling a range of tasks, from checking vital signs to administering medications, managing medical equipment, assisting with complex diets and tube feeding, and more.

This proposal to raise the ceiling on allowable tasks for home care workers directly addresses three key priorities (among others) within the remit of the MRT II: identifying innovative models of healthcare delivery; modernizing laws and regulations to achieve efficiencies; and ensuring the availability of a stable and skilled workforce to meet the needs of an aging population.

II. Revise the Global Cap to Address Economic and Demographic Realities

PHI strongly urges the Medicaid Redesign Team (MRT) II to reassess the formula for calculating the Medicaid global cap, in parallel with efforts to create efficiencies and strengthen the financial sustainability of New York’s Medicaid program. Otherwise, the MRT II’s recommendations for saving costs will be premised on deeply flawed assumptions about evolving demands on the program and the drivers of Medicaid spending.

By indexing Medicaid spending to a 10-year average of the medical cost-price index, the global cap fails to account for significant economic and demographic realities. First, absolute demand for healthcare services, particularly long-term care services, is increasing rapidly due to population aging and changes in population health. Second, Medicaid enrollment fluctuates according to macroeconomic factors that impact individuals’ economic wellbeing and capacity to pay. These realities help explain why Medicaid enrollment grew from 4.3 million in 2010 to 6.2 million in 2020, as noted in the February 2020 MRT II presentation. Finally, labor costs have risen dramatically in long-term care, especially for home and community-based service providers, due to changes in the application of the Fair Labor Standards Act and the rising minimum wage.

As a Bronx-based organization that promotes job quality for direct care workers, PHI has seen firsthand how efforts to meet the global cap disproportionately impact our most vulnerable populations and the providers and workers who serve them. Shrinking margins make it exceedingly difficult for New York’s home care providers in particular to adequately invest in their workforce, leading to increased turnover and exacerbating the workforce shortage. Paradoxically, these workforce factors lead to higher Medicaid spending, for example on unnecessary hospitalizations and nursing home placements.

PHI fully supports efforts to create efficiencies and maximize innovation in New York’s Medicaid program. However, to ensure that future savings are based on a realistic and comprehensive understanding of the program’s true cost, it is critical to revise the formula for setting the global cap. Going forward, the global cap—and any other cost-saving mechanism—should be designed to account for a range of changes, including but not limited to those described here, that significantly impact funding requirements.
III. Set Baseline Rates to Stabilize and Strengthen Medicaid’s Largest Workforce

PHI strongly urges the Medicaid Redesign Team (MRT) II to advise the New York State Department of Health to set minimum reimbursement rates (“baseline rates”) that managed care plans must pay home care agencies—to enable agencies to cover the full costs of care, including comprehensive labor costs. As the nation’s leading expert on the direct care workforce, PHI attests that smart investment in direct care jobs stabilizes the workforce and helps decrease costly health outcomes caused by disruptions in care and unmet need.

In New York, home care is primarily provided through the Medicaid Managed Long Term Care (MLTC) program. The MLTC program is projected to constitute more than a third of the state’s Medicaid claims in fiscal year 2020, as shown in the February 2020 MRT II presentation, rendering the program a key target for reform.

The rates that MLTC plans pay home care agencies determine how much those agencies can invest in their workforce—and currently, for the most part, fail to cover more than the bare minimum requirements for wages and benefits. While appearing to save money in the short term, this low investment in the home care workforce is inflating costs over time. Inadequate workforce investment is contributing to high staff turnover and a growing workforce shortage across the state, which is raising labor costs (for recruitment and training), undermining access to high-quality services for consumers, and generating a range of costly downstream outcomes, including avoidable hospitalizations and nursing home placements.

The state should therefore establish a baseline amount that MLTC plans must pay home care agencies that accounts for the costs of onboarding, training, and adequately compensating and supporting the Medicaid program’s largest workforce. Further, these baseline rate requirements should be structured to incentivize high-quality employment practices, such as full-time scheduling and career ladder opportunities. With this policy, the state will take a key step toward ensuring the availability of a stable and appropriately skilled workforce to meet the needs of our aging population, while reducing a range of costs associated with high rates of turnover and job vacancies in the home care workforce.

Proposal written by Ralph Warren
Self-Advocate

The Office for People with Developmental Disabilities (OPWDD) has recently released its revised qualifications document for SIPs-PL. This states the requirements for implementing the next two phases of voluntary and mandatory managed care for people with I/DD. There are significant problems with the current first phase of mandatory managed care which is the establishment of Care Coordination Organizations (CCOs). These are health homes for people with I/DD and they are charged with managing the Life Plan (service plan), but the service plan software is under the proprietary control of MediSked, a private company. State agencies do not have a direct contract with MediSked and the state must
establish a contract with MediSked to ensure program integrity, manage costs of care, and improve quality of care. The various problems with MediSked Life Plan software have delayed and disrupted I/DD health home operations. This has led to cost overruns in hundreds of millions of dollars as the state has failed to meet implementation of Life Plans and related care management goals and now faces reduction in federal match from 90-10 to 50-50. The MediSked Life Plan software does not capture basic structured medical data such as diagnosis, medications, and other data that DOH uses in the financial modeling for risk adjustment in managed care and FFS rate setting. This must be corrected before proceeding to the next phases of I/DD managed care (voluntary and mandatory enrollment into SIPs-PL).

DOH/OPWDD have I/DD health home performance measures that only report on and evaluate general population health measures. There are health outcome measures for medical conditions that are specific to I/DD sub-groups. This must be corrected by DOH before proceeding to managed care for I/DD. There is VBP measures work group for I/DD and it is working on a comprehensive set of I/DD measures. However that work group operates with very limited participation by I/DD family/self-advocates. It is critical that DOH convene regional public hearings on the work on VBP measures for I/DD prior to the completion of the work group recommendations.

DOH contracted actuary, Deloitte, has performed an actuarial study (at least) at a preliminary level, as noted by Dr. Kastner, OPWDD Commissioner in November 2019. Stakeholders have not had an opportunity to review the actuarial findings regarding managed care I/DD in the next phase. Deloitte presented a similar actuarial report under contract to Texas in early 2019. Stakeholders need to have a similar presentation made to us in order to have a useful opportunity for public comment on the SIPs-PL. Keeping this information hidden is likely to undermine the implementation of cost-effective quality care for I/DD in managed care.

In a closely related process to the implementation of managed care for I/DD we have OPWDD contracting with Optumas to create a new resource allocation model that will use the new functional needs assessment (CAS) to develop acuity scoring to set program FFS rates, personal budgeting and eventually impact managed care rate setting. The review of Optumas work has been done by a small closed group of stakeholders. All stakeholders need and deserve a public hearing on the new OPWDD acuity scoring prior to the completion of that work. Without this the state sets a course to underestimate true costs of care and undermine quality services and put individual lives at risk of harm.

Schuyler Center for Analysis & Advocacy and The Children’s Agenda
Complex children and families with significant behavioral health issues are generally not effectively engaged by existing systems. This results in children being served, and potentially traumatized, in settings that are not the most therapeutic, and families challenged by how to help their children. In some cases, families are characterized by multigenerational challenges and they are poorly served by our split (adult and child / not family-oriented) service systems. Evidence is clear that stabilizing the child requires stabilizing the family and we need to build systems to do that. NYS could avoid painful and costly emergency department visits, inpatient stays, and foster care and juvenile justice placements by investing in evidence-based and family-oriented interventions (Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are examples), including developing robust reimbursement oriented around families, not just individuals.

We urge NYS to consider opportunities focused on the Governor’s priorities of reducing maternal morbidity/mortality and promoting a healthy start in The First 1,000 Days.

I. Pre-Conception Care: Reproductive Health Counseling and Long-Acting Reversible Contraception (LARC) for Teens to reduce unintended pregnancy, improve maternal outcomes, and decrease low-birth weight and prematurity

Endorsed by CDC, AAP, ACOG, and AAFP as the first-line recommended form of contraception, LARC usage among adolescents remains low. Improving comprehensive options counseling and access to LARC in primary care settings is a proven strategy.

CDC projects 2,000 LARC placements equate to 250 teen births prevented and among teen births, 10% are low birth weight (LBW). Estimated medical savings related to provision of LARC for 2,000 women to avert unintended pregnancy are as follows:

- 2,000 new LARC users = 250 teen births prevented/year with 25 LBW births among those prevented.
- Uncomplicated term delivery costs approximately $13,660; averting 225 uncomplicated births, savings = $3,073,500
- LBW newborn with neonatal intensive care unit (NICU) stay costs approximately $55,547; averting 25 LBW newborns with NICU stay, savings = $1,388,675
- Savings/year of $4,462,175

II. Maternal Smoking Cessation

20% of pregnant Medicaid-enrolled women smoke during pregnancy. Tobacco interventions are cost-effective among pregnant women by reducing the number of low birth weight infants, preterm labor, and perinatal deaths (Lightwood, 1999). Cessation efforts reduce use of newborn intensive care units, decrease hospital length of stay and reduce service intensity (Adams, 2004). Prior data show that for pregnant women who quit smoking, low birth weight infants are reduced 20% and the number of preterm births reduced by 17% (Goldenberg, 2000; Lumley, 2000).

III. Universal Home Visitation for all children and families on Medicaid
The Family Connects model is an evidence-based, universal approach to supporting newborns and their families. Evidence from two randomized controlled trials (RCTs) show fewer emergency room visits in the first year of life among participating families, resulting in cost savings of over $3 for every $1 invested in the program. Additional outcomes include: greater connections to community resources for families to address social determinants of health, improved parenting behaviors, and improved maternal mental health.

Supporting Our Youth and Adults Network (SOYAN) – I/DD group on Long Island

Supporting Our Youth & Adults Network (SOYAN) membership is comprised of over 300 families supporting individuals who receive services through Self Direction with Full Budget Authority (SDWFBA). We have concerns about the objectives of MRT#2 and the likelihood of choosing short-term solutions within the OPWDD system that will create long-term crises. SOYAN’s proposals have been submitted via the on-line portal. Our concerns have been consolidated to facilitate sharing with a wider audience.

I. Include I/DD Self-Advocates and Families in Long-Term Working Groups

During his opening and closing remarks on Day 1 (February 11, 2020), Mr. Dowling, Co-Chair of MRT#2, spoke of the importance of keeping vulnerable people in the minds of the committee members as proposals are considered and rejected. We’ve heard about the planned regional outreach opportunities. We’ve heard about the intent for the MRT#2 process to be transparent. We’ve heard about the creation of long-term working groups. SOYAN leadership wishes to be included with a seat at the table!

II. HCBS Transportation IS critical for I/DD population living in the community

Transportation (non-emergency medical) must remain within the HCBS waiver guidelines for people with intellectual and developmental disabilities. We understand that Non-emergency medical transportation has been identified and addressed as a rapidly growing cost to Medicaid, for a variety of reasons. We recommend creating better guidelines regarding the use of high cost, fee for service transportation for those individuals who are able to travel independently and use public transportation, where available.

Transportation (non-emergency/medical) must be differentiated from HCBS-Transportation (non-medical) provided to individuals with I/DD – transportation that is key to living in the community. Transportation individualized to the needs of the individual, enables them to live, work and be a member of their community, often accompanied by their individually trained Community Habilitation staff. Transportation is built in to the reimbursement rate for agency- provided services (certified residential services, and Day Habilitation services). For those individuals with I/DD utilizing Self Direction with Full Budget Authority, or variations of Community Habilitation, it is critical that transportation continue to be reimbursed through their individual budgets. To deny NON-MEDICAL transportation
funding would deny access to the community, forcing those individuals to be supported in inappropriate and far costlier residential and day programs.

III. Improving Outcomes by Enhancing Self-Direction

For the past 20 years, Self-Direction with Full Budget Authority (SDWFBA) has been meeting a wide spectrum of support needs for people with I/DD. SDWFBA offers cost-efficient access to meet the ever-changing dynamics of living and working a self-directed, community-based life. People with I/DD can live in their chosen communities in integrated settings, satisfying the intention and requirements of the Olmstead Decision. Individuals with minimal support needs as well as those with intense, complex support needs can be supported through this model, with individual budgets adjusted to their need (budgets that are consistently lower than the projected cost to support that person in traditional OPWDD settings). By supporting people in pursing their life goals, with individually designed supports, SDWFBA improves quality of life, which has been shown to improve long-term health while promoting the integrity and sustainability of the Medicaid system.

Long-term supports and services are an investment in people, and cannot be provided within a model of medical-necessity. No state has proven successful in providing these HCBS community-based supports in a Managed Care model. Managed care neither saves the state money nor improves access to the supports and services that enable people to live and work within their communities.

We urge you to leave SDWFBA within the direct oversight and auspices of OPWDD and not combined into the Managed Care Benefit Package. We urge you to promote and enhance SDWFBA which will reduce expenditures and improve outcomes. We urge you to maintain the current definition of Community Habilitation as it appears in the HCBS waiver to permit a wide-range of activities, learning opportunities and individually designed supports necessary to serve people with the full range of support needs, and keep them safe. We urge you to continue providing more integrated community-living opportunities connected with Community Habilitation and Non-medical Transportation. This will save the state money now, and prepare participants with I/DD for their future needs in their communities, when their aging parents are no longer able to support them. SDWFBA is an investment in people’s future, the future of OPWDD, and the fiscal future of NYS!

Self-Direction with Full Budget Authority (SDWFBA) provides people with I/DD with well-integrated community connections that provide a healthier quality of life at a significant lower expenditure. People with I/DD have a spectrum of skills and needs and almost all can achieve more with Self-Direction with Full Budget Authority. SDWFBA is an investment in the future!

The Legal Aid Society

See attached document.
The Urban Justice Center Mental Health Project (MHP)

The Urban Justice Center Mental Health Project (MHP) recommends MRT II develop a path for Medicaid Health and Recovery Plan (HARP) beneficiaries to directly assist the State with improving access to Behavioral Health Home and Community Based Services benefits (BH HCBS). Medicaid HARP formed out of MRT I and is a crucial program for people with serious mental health concerns (including substance use disorders). It is intended to give beneficiaries the recovery supports needed to stay in community and out of institutions like hospitals and jails. Unnecessary institutionalizations are often severely disruptive for the individual’s life, and are also very costly to the State. MRT II must ensure that Medicaid HARP is well-funded and structured in a way that promotes the person-centered wellness and recovery principles upon which it was founded.

MHP has been providing direct legal and social work assistance to Medicaid HARP beneficiaries since 2016. We interact with MCOs, agencies and providers at all levels of the Medicaid HARP workflow to assist our clients accessing the BH HCBS benefits they seek. Since HARP’s inception, the number of HARP eligible person’s actually receiving BH HCBS benefits has stagnated at less than 5%. HARP beneficiaries consistently express significant interest in receiving BH HCBS benefits, but even with legal assistance, they face a multitude of systemic barriers to accessing those benefits. MHP has learned a great deal from listening to our clients, who are also uniquely positioned to assist the State in understanding the minutia of how HARP is actually functioning on the ground level. HARP beneficiaries possess a deep level of experience with the intersection of the multitude of agencies and systems involved in progressing from eligibility to receiving BH HCBS. They are particularly well placed to give specific, person-centered insight and policy recommendations, including identifying systemic inefficiencies and areas for quality improvement. MHP looks forward to MRT II including a system for the State to truly utilize the input of beneficiaries on a systemic level.
CDPA Program Cost-Saving Options
Proposed by CDPAANYS

1. **Make consumer assessment annual** - Before managed care, most counties required assessments annually. Under managed care this changed to semi-annually. Assessments already occur whenever there is a change in need, such as a hospitalization, and managed care organizations (MCOs) must do outreach to consumers monthly. Because of this, the need for a required biannual assessment is not justifiable. Based on CDPAANYS assessments of health care provider costs, and factoring in other factors such as medical transportation to the appointment, we determined that if the assessment was made annual for CDPA alone, it could save approximately $47 million.

2. **Allow personal assistants (PAs) to provide transport to and from medical visits** - DOH allows PAs to transport consumers when tasks may be required on the plan of care; however, it has not allowed PAs to transport consumers to and from medical appointments. While not all consumers have access to vehicles, reducing medical transport utilization by expanding this option, not only makes sense, it improves consumers’ quality of life. The state could save approximately $84 million by allowing PA’s to provide medical transportation for CDPA participants.

3. **Clarify that consumers may only work with one FI** - Some MCOs enroll consumers in multiple FIs with the incorrect assumption that it prevents PAs from being paid overtime. However, because consumers are employers, PAs are owed overtime regardless of how many FIs they work through. This practice not only increases the likelihood of fraud and double-billing, it is wage theft.

4. **Formalize processes for disenrollment and designated representatives** – When FI’s determine they can no longer serve a consumer due to an inability to self-direct his or her services, a MCO is supposed to reevaluate the individual and, if necessary, disenroll them from the program or get another person to fill the role of Designated Representative (DR), who directs the services in the consumer’s stead. Instead, plans often just send consumers to another FI without even a cursory evaluation. The lack of a formal when a consumer is no longer able to self-direct, or when a DR is appointed, creates conditions ripe for elder abuse and fraud. DOH should formalize oversight in these situations, and CDPAANYS is ready and willing to assist in recommending and creating protocols.

**CDPAANYS estimates these oversight measures could save $50 million per year.**

5. **End “referrals”** – Some MLTCs use reimbursement arrangements with home care agencies (LHCSAs) and FIs as incentive to garner referrals from these agencies. This is particularly prevalent among those agencies directly affiliated with MLTC plans. Agencies report MLTCs are unwilling to engage in any discussions on quality improvements, minimum wage adjustments, or other topics without first discussing how many new consumers the agency provides. There are ways to curb the negative incentives this behavior creates without penalizing agencies for conducting legitimate education, including education required under other laws. Such policies would focus incentives on quality and need, not on business generation. If the removal of these incentives reduces Medicaid enrollment by 500 people, it would generate $31 million in savings.

6. **Create a Minimum Direct Services Spending Ratio for CDPA** - FIs in Fee-For-Service must spend at least 82% of revenues on direct care services. By increasing the direct care requirement to 85%, extending it to services provided to MCOs, and using the new cost reports to “clawback” administrative funds in excess of the limit, the State would realize substantial savings while adequately funding the system and avoiding excess profits.

CDPAANYS is the only statewide association solely representing fiscal intermediaries and consumers in Consumer Directed Personal Assistance (CDPA). For more information, please visit www.savecdpa.com or contact us at 518-813-9537 or bryan@cdpaanys.org.
NYSNA MRT II Proposals:
Address the gap in the state Medicaid budget, maintain Medicaid program services with no reductions in access to or quality of care, distribute funding fairly, and maximize the drawdown of Federal matching funds

NYSNA Proposal #1: Assess provider fees on excessive executive compensation

Excessive executive and managerial compensation is an endemic problem throughout the health care delivery system generally and in the State Medicaid program in particular.

Inordinately high compensation rates contribute significantly to state spending to support Medicaid programs and constitute a distortion in the internal distribution of resources within the Medicaid program. Every Medicaid dollar spent on exorbitant salaries and benefit packages is a dollar that is diverted from patient care and vital services.

Proposal

The state should assess a fee on any and all executive or managerial (non-direct care) annual compensation that exceeds a fair established rate. Compensation for the purposes of implementing the assessed fee should include all direct salary, indirect compensation (special/supplemental retirement benefits, executive perks such as housing, cars, drivers, etc.), and any deferred salary or other compensation that is pushed into future years).

The assessed fees should be specifically dedicated to state share Medicaid contributions and shall not be used for any other general fund purpose.

NYSNA recommends setting the salary cap at total compensation of $500,000 per year in any given calendar year. This amount could be adjusted slightly based on regional cost of living assessments (i.e., higher in NY City or other high cost areas and lower in low income rural or smaller urban areas).

All executive/managerial compensation in excess of the cap would be assessed at 100% and the assessed fees would be paid by the provider entity to the State and applied to the local share of Medicaid funding.

The assessed fee would apply to all Article 28 facilities, all other providers, insurers, pharmaceutical producers or distributors, and other providers receiving funding from Medicaid, Medicare, private insurers, and retail providers of health care products or services.

Analysis
We believe that this proposal alone would, depending the final criteria and breadth of its application, generate sufficient funding to fully offset the FY21 gap in state share Medicaid funding.

We reviewed the 2017 IRS Form 990 filings for just four large hospital systems in the NY City area: Northwell, NYU Langone, New York Presbyterian and Mount Sinai.

Our review found that 75 executives in these four hospital systems received compensation in excess of $500,000. The total direct and indirect compensation of these 75 individuals totaled $161,115,047 or an average of $2,148,201.

Applying the $500,000 annual cap to the sample of 75 individual executives of these four systems would result in an excess compensation assessment fee of $123,615,047.

Applying this concept throughout the state would easily generate sufficient money to offset the state Medicaid gap.

This approach is consistent with existing state policy as expressed in the Governor’s Executive Order 38 and related state regulations and with the holding of the State Court of Appeals in Leading Age v. Shah. EO 38 focused more on terminating contracts for providers that exceeded salary caps and did not receive exceptions/waivers, but the Court found that administrative rule making without legislative approval was within the power of the State and not unreasonable or arbitrary.

This proposal would instead assess a fee for excessive compensation and would be incorporated into state law, thus avoiding any serious legal challenge. Providers would be free to set compensation at whatever levels they deem fair and proper at their discretion, but they would pay an assessment for any compensation over the cap.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

We also note that this assessment is not a new tax or revenue source, but instead merely redistributes existing funding away from wasteful executive pay and to direct patient care and services. Over time this would also encourage broader structural reforms by providers to focus resources on patients and community health.

**NYSNA Proposal #2: Assess provider fees on excess administrative and/or managerial costs**

Excessive administrative and managerial costs are a major drain on the Medicaid program and in the broader health care system.

Bloated spending by providers on unnecessary administrative, managerial and other non-patient care costs diverts funding that could be used to provide patient care and other health services and greatly contributes to the State costs of Medicaid and on business and consumer costs of providing health care.
Proposal

The state would set an initial cap on the percentage of spending by providers on non-patient care or direct health services that exceeds an empirically determined rate. The definition of administrative and managerial costs for the purposes of determining the rate should be based on the spending by the provider on central administration, non-core health services, professional service costs (legal, accounting, non-core overhead, advertising and/or marketing, travel, lobbying, dues or fees to industry associations, luxury goods and services, etc.), and excessive costs for middle and lower level management.

NYSNA believes that the initial cap should be set at 20% of total expenses. The cap should then be reduced over time in phased increments to no more than 12%-15% of total costs.

The state should assess a fee on all spending on administrative or managerial costs in excess of the established cap. The assessment would be set at 100% of any spending above the established cap and the assessed fees would be paid by the provider entity to the State and applied to the local share of Medicaid funding.

The assessed fees should be specifically dedicated to state share Medicaid contributions and shall not be used for any other general fund purpose.

The assessed fee would apply to all Article 28 facilities, all other providers, insurers, pharmaceutical producers or distributors, and other providers receiving funding from Medicaid, Medicare, private insurers, and retail providers of health care products or services.

Analysis

According to a review of IRS form 990 data for a sampling of hospitals, managerial expenses account for 20% to 25% of total hospital expenses. We believe that this general rate on expenditure on non-core health care services is similar throughout the health care system.

NYSNA also believes that the IRS and ICR cost reporting data may mask and minimize the full extent to which health care providers waste health care resource to support top heavy administrative and managerial costs at the expense of tax payers and health care service consumers. Current cost reporting mechanisms seem to allow many of these expenses to be mischaracterized as program service costs when they contribute nothing to patient care and services. Advertising and marketing costs are often fully or largely categorized as program service expenses. The reported costs of office space and furnishings do not distinguish between the cost of an executive office suite and those of a patient examination room – the $100,000 cost of oak paneling on the walls of executive suites is lumped in with the $10,000 cost of sheet rock on the walls of patient waiting rooms.

Research data conclusively establishes that administrative costs in the US health care system greatly exceed that of other comparably advanced economies. Hospital administrative costs account for more than 25% of total expenses in U.S. hospitals, compared to 12%-19% in Canadian and European hospital systems.

According to our review of hospital ICR data, for example, New York hospitals revenues are about $80 billion per year. If current administrative, managerial and other non-care spending is 25%, this means that approximately $20 billion per year is being expended for non-care purposes.
If the state imposed a 20% cap on such spending and imposed an assessment fee to support state share Medicaid funding, this would generate approximately $4 billion per year, just from hospitals, and fully close the projected Medicaid gap. Applying this rule to other providers, health insurers, private for-profit providers, etc. would thus would even more resources to be redirected to support that state share funding obligation.

As noted in NYSNA Proposal #1, this approach is consistent with existing state policy as expressed in the Governor’s Executive Order 38 and related state regulations, and with the holding of the State Court of Appeals in Leading Age v. Shah. It is within the authority of the state to enact legislation imposing the cap on non-care costs. Providers would remain free to overspend on these costs at their discretion, but they would pay an assessment for exceeding the established cap.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

We also note that this assessment is not a new tax or revenue source, but instead merely redistributes existing funding away from wasteful non-care expenses to direct patient care and services. Over time this would also encourage broader structural reforms by providers to focus resources on patients and community health.

**NYSNA Proposal #3: Implement minimum quality of care requirements, including direct care staffing ratios**

The MRT II has been assigned the task of identifying $2.5 billion in Medicaid savings (which could lead to more than $5 billion in Medicaid spending reductions when Federal matching share funding is included).

The MRT II directives also include the provisos that there be no reductions the availability of services and that quality of care be maintained or improved.

It is NYSNA’s position that if the MRT recommends spending cuts of that magnitude then there will be necessary and unavoidable impacts on both the availability and the quality of health care services that will affect the 6.2 million New Yorkers who rely on the system for their health care.

**Proposal**

If the MRT makes any proposal that reduce total Medicaid funding, the implemented changes must include provisions to protect and improve the availability and quality of care.

To that end, any legislative changes should include the enactment of minimum nurse to patient ratios for all Article 28 providers as set forth in the currently pending Safe Staffing for Quality Care Act (A2964/S1032).

**Analysis**
Setting a floor on the number of patients that registered nurses, licensed practical nurses, nursing aides, patient care technicians and other direct care staff can be assigned to care for is safer for patients and for direct care workers. We also believe it is a cost effective way to improve patient care.

Research shows that the more patients assigned to a nurse and other direct care staff, the worse the quality of care that is received by those patients. Poor staffing increases patient mortality rates, reduces patient health outcomes, increases the incidence of co-morbidities, complications and length of stay, reduces patient ratings of their care experience, lengthens patient recovery times, and leads to higher rates of readmission and unnecessary health care utilization.

Minimum staffing standards will also reduce costs or increase revenue of providers in the following ways:

- Reduced length of stay and fewer incidences of unreimbursed excess hospitalization days;
- Reduced rates of incidence of uncompensated or reduced reimbursements due to penalties for hospital-acquired complications;
- Fewer unreimbursed unnecessary re-admissions;
- Improved morale and productivity of nursing and other direct care staff;
- Reduced RN turnover rates resulting in lower recruitment, training, and lost productivity costs;
- Reduced penalties for failure to meet quality standards or metrics;
- Lower rates of workplace injuries and illness among staff that are often attributable to short staffing, stress on the job and heavy patient loads;
- Reduced incidence of assaults on nurses and other staff by patients and family members frustrated by long wait times and unmet care needs;
- Lower legal costs of malpractice lawsuits by patients or their survivors; and
- Increased patient satisfaction scores and other metrics that result in bonus payments under new reimbursement models.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

**NYSNA Proposal #4: Adjust the Medicaid cap to account for increased enrollment and implement revenue enhancements**

The underlying problem that has led to the creation of the MRT II is that the current budgetary structure for funding Medicaid is flawed and in need of revision.

Though we have no objection to attempts to reduce unnecessary, wasteful or fraudulent expenses in the Medicaid program and the broader health care industry, we believe that the current Medicaid cap and funding system for Medicaid is in need of revision to account for the demographic changes and increased health care needs of New Yorkers that are the real drivers of the budget gap.

The current Medicaid spending cap is outdated and arbitrary in determining funding needs and must be adjusted. Since its enactment almost 10 years ago we have witnessed an aging of the population, a
medical rate of inflation that exceeds that of other sectors of the economy, and a massive increase in enrollment in the Medicaid program.

It is time to reset the baseline of the cap, increase the annual rate of increase based on an empirical analysis of health care needs and better coordinate Medicaid program spending and services with other payer systems so that the health care system is treated in an integrated fashion.

This will require finding increased sources of revenue.

**Proposal**

We note at the outset that New York has a net loss or outflow of at least $22 billion and as much as $37 billion a year to the federal government. Cutting Medicaid funding will significantly increase this gap because every dollar in local share cuts reduces funding health care of the 6.2 million New Yorkers who use the program by more than one additional dollar, with negative consequences for the health care system and the broader economy.

Focusing on across the board or targeted cuts to Medicaid will only exacerbate this fiscal imbalance.

The state should focus instead on maintaining or increasing Medicaid funding and closing the budget gap through increased taxes, surcharges and fees on economic sectors that have profited from recent changes in federal tax laws and/or from state health spending.

To that end, NYSNA recommends the following measures to address the Medicaid budget gap:

- **Increase corporate tax rates**
  The FY2021 budget projects total business income tax receipts, including corporate franchise taxes, corporate and utility income taxes, insurance and bank fees/assessments, etc., are projected to total $9.9 billion (compared to $57 billion in personal income tax revenue).

  The Trump tax cuts of 2017 sharply reduced the tax rates on corporations, pass through entities like hedge funds and other financial entities, and on the wealthiest tax payers.

  At the same time the ability of individual tax payers to deduct state and local taxes was severely limited in a targeted attack against New York and other states with generous government social service programs and high costs of living (SALT provisions). While individual SALT deductions were severely capped, the new federal tax law not only reduced tax rates on business entities, but it continues to allow corporations and other business entities to *fully* deduct state and local taxes from their federal tax bills.

  Given this dynamic, we believe that the state should increase tax rates on corporations and other financial or business entities as a primary means of closing its budget gap.

  We recommend a 10% increase on the effective state tax rates, which will generate an additional $990 million in revenues.

  This money should be specifically dedicated to funding State share of Medicaid program funding.
In addition, to minimize any adverse effect on these business entities and to minimize or eliminate any incentive to relocate, the tax increases should be structured in a way that delays their collection until after they have filed and received their full federal tax deductions.

The tax collection process can also allow exceptions or limitations to adjust the tax liability to forgo additional tax liability that is greater than the amount deducted from the business entity’s federal tax liability.

- **Increase the millionaire surcharge**
  The state should consider further increasing the tax rates on the highest income individual payers. Numerous studies have documented that wealthiest individuals have received a disproportionate share of the growth in income generated by the broader economy, while the income of the majority of individuals and households has remained largely static.

  Accordingly, NYSNA would support a restructuring of the personal income tax code to reduce tax rates for working people and an increase in rates for those with annual incomes in excess of $1 million.

- **Target taxes and fees at corporate and business entities that make windfall profits in health care**
  Total health care spending in New York is more than $10,000 per person, or more than $200 billion a year.

  Within this broader health care economy, there are numerous market participants that generate high rates of profit from health care services.

  Rather than cutting spending and services for recipients of Medicaid, NYSNA believes that the state should generate new revenues to close the Medicaid budget gap by targeting health care entities that are profiting from the system.

  Accordingly, we recommend that the state should increase taxes, fees and surcharges on the following health care market business entities:

  - Private for-profit health insurers;
  - For-profit corporate providers, including pharmacy chains, urgent care companies, imaging and laboratory companies, large physician practices, medical device manufacturers and distributors, pharmacy benefit managers, and other for-profit entities that generate high profits in health care;
  - Pharmaceutical manufacturers and distributors;
  - Highly profitable hospital systems with low rates of Medicaid and uninsured/charity care services.

- **Reinstitute the stock transfer tax**
  The state of New York currently has a tax on stock transfers (based on the levy of a small tax on the purchase and sale of stock market shares). The New York stock transfer tax was enacted early in the 20th century and remains on the books, but since 1981 the taxes paid on
stock transfers have been subject to a 100% refund. In practice, the tax is filed annually, but the state refunds it in full, meaning that no money is actually collected.

The stock transfer tax generates in excess of $20 billion per year on paper, but the levied amount is fully refunded or rebated.

Given the current speculative binge and run-up in equity markets, which has generated huge profits for traders, the state should consider at least a partial restoration of the stock transfer tax to address the Medicaid budget gap.

The restoration of the stock transfer tax could be initially targeted at “high speed trading” in which large trading companies buy and sell stocks in extremely short time frames, often holding the stocks for only a fraction of a second. This type of trading is highly exploitative in that it allows sophisticated traders employ high tech methods and computer programs to essentially game the market to the disadvantage of institutional and individual investors. These high speed trades are also highly destabilizing of the normal operation of equity markets, and pose a systemic risk by increasing market volatility and contributing to market price gyrations.

Imposing a tax on these or other abusive stock market practices would not only generate revenue to preserve needed health care services, but would also discourage such behavior and allow fairer and smoother stock market operations.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

**NYSNA Proposal #5: Impose statewide drug price schedules and controls on price increases**

As noted in the presentation that accompanied the roll out of the MRT II, New York State Medicaid pharmacy/drug spending is rising faster than general and medical inflation rates, totaling about $6.8 billion in FY19 and accounting for about 8.7% of total spending.

The State has implemented limited efforts to control drug prices and a drug cap, but that effort does not fully control increases and at best merely locks high drug prices into place.

We need to fully control drug prices in Medicaid, and for all other payers and consumers by implementing strict universal drug price schedules and move to actually reduce drug prices.

**Proposal**

The state should enact legislation to set direct price schedules and regulate price levels for all drugs, applicable to the Medicaid program, private insurers, retailers and pharmacy benefit managers.

These price schedules and controls should apply to all drug manufacturers and distributors.
Drug pricing would be determined by a state panel of technical experts with specialized knowledge of the economic and technical issues related to costs of production within the pharmaceutical industry.

Special measures should be considered to address any supply problems or disruptions caused by recalcitrant or obstructive manufacturers or distributors who threaten to withdraw drugs from the New York market.

The technical panel would not only set prices and limit price increases, but would also embark on a sustained long term process to reduce existing price levels.

This proposal will not only reduce state Medicaid expenditures, but will also benefit privately insured, uninsured and all other consumers and providers in New York.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

**NYSNA Proposal #6: Crack down on Medicaid fraud**

Health care fraud, abuse and unnecessarily care are estimated to account for as much as 47% of total health care expenditures in the U.S.

AS is consistently shown in the reports of the Medicaid Inspector General’s and the State Attorney General’s offices, fraud prosecutions and recovery actions are a major concern in the Medicaid system.

**Proposal**

NYSNA believes that the State should continue its current enforcement actions and should also consider new or improved technological or technical methods to identify fraudulent activity. We do not have the technical ability to suggest particular approaches to increase the rates of detection and interdiction of Medicaid fraud.

We propose, however, that once fraudulent activity is identified and acted upon, that the state should have enhanced penalties to (a) increase the recoveries and penalties for such behavior and (b) to increase the incentives of providers to refrain from engaging in fraud.

The state should enact legislation aimed directly at increasing the power of the state and local authorities to pursue full restitution of the proceeds of fraudulent activity in civil or administrative enforcement proceedings, where the standard of proof is generally a “preponderance of the evidence.”

This would include the following enhanced civil/administrative enforcement measures:

- Increased authority to freeze financial or property assets during the pendency of enforcement proceedings;
• Imposition of punitive penalties, including “triple damages” for intentional fraud or abuse (patterned on Federal RICO statutes or NY State regulations imposing triple damages for intentional rent overcharges under the Rent Stabilization and Rent Control Laws, for example);
• Increased statute of limitations periods;
• Enhance requirements to maintain and to produce records for investigative bodies.

In addition to enhanced civil enforcement measures, the state should also modify the penal code to increase the criminal penalties for Medicaid fraud.

Article 77 of the Penal Code currently criminalizes “Health Care Fraud” with five degrees or categories of severity. First Degree Health Care Fraud is for activity that involves more than $1 million in the aggregate and is penalized as a Class B felony. The lowest level of offence is Fifth Degree Health Care Fraud, which applies to knowingly providing false information or failing to apply information to obtain health services or products.

Article 77 of the Penal Code should be amended to increase the level of severity of each of the five categories of Health Care Fraud to increase the penalty by one level if the person involved is a health care provider. For example, 1st Degree fraud would be penalized as a class B felony if the person involved is a recipient of care, but as a class A felony if the person is a provider.

In addition, the threshold for each level of penalty should be reduced. For example, the threshold for 1st Degree fraud is currently more than $1 million. It should be reduced to a significantly lower level for each category.

Finally, the definitions of criminal and civil fraud should be changed to make individual officers, key employees, owners and shareholders more easily liable for both criminal and civil penalties.

These measures will reduce costs to the program, increase disgorgement of Medicaid funds, impose additional penalties and dissuade illegal conduct throughout the system.

This proposal will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, and (d) maintain or increase the existing Federal funding share for health care services.

**NYSNA Proposal #7: Distribute existing Medicaid funding streams fairly and equitably**

In carrying out its functions as directed by the DOH, the MRT II is considering various programmatic changes aimed at reducing Medicaid costs without impacting the availability and quality of patient care.

The Medicaid funding system includes mainline Medicaid programs and reimbursement systems, but also includes or connects with various special the funding distribution mechanisms, including DSH, Indigent Care Pool (ICP) funding, funding for distressed hospitals through VB-QIP, VAPAP, VAP programs, and other provisions to support the vital services provided by safety net hospitals and other providers.
In seeking to address the Medicaid budget gap, the State has already imposed a 1% across the board reduction in reimbursement rates that was applied equally to all providers, regardless of their patient payer mixes, their safety net status and their financial vulnerability.

The MRT II has further identified financial support for distressed hospitals as a category of expense that is growing faster than the Medicaid cap and a target for funding cuts.

NYSNA is opposed to any Medicaid funding reductions on the support for safety net providers and distressed hospitals.

We also believe that any restructuring or cuts in the Medicaid program must also address and correct the imbalances in the current program structure that unfairly and improperly direct Medicaid funding to providers that do not need the financial assistance and do not adequately support safety net providers that do.

Current policies distribute these Medicaid funding pools in a manner that does not fairly account for the needs of the most financially vulnerable safety-net providers and which unjustly enriches providers that provide fewer services for Medicaid and indigent patients.

The MRT II should, accordingly, consider measures to more fairly allocate Medicaid funding, including adjusting reimbursement rates to benefit safety net hospitals and other providers, target the allocation of Federal Disproportionate Share Hospital (DSH) and Indigent Care Pool (ICP) funding based on the needs of providers and their patients.

**Proposal**

To address longstanding inequities in the distribution of Medicaid, DSH, ICP and other funding streams in the context of any effort to reduce Medicaid costs, the state should implement the following additional and complementary reforms:

- **Incorporate the terms of A6677B/S5546A into law in the state budget**
  
  Under the provisions of the federal DSH program, funds are made available to states to distribute to hospitals to compensate for the unreimbursed costs of care for Medicaid and uninsured patients. The reimbursement rates for Medicaid patients are estimated at roughly 70%-90% of actual costs, depending on the kind of health service. With respect to indigent uninsured patients, the reimbursement is generally zero. The federal DSH program is designed to provide additional funding to hospitals with high rates of Medicaid and uninsured patients and allow them to continue to provide vital services to their vulnerable patient populations.

  In New York, the DSH program provides a total of about $3.6 billion in funding, of which $1.8 billion is federal money. New York is required to provide an equal, 50/50 local share of about $1.8 billion.

  The state local share of $1.8 billion comes from two main sources – $1.135 billion in state share funding generated from HCRA fees and $700-800 million in “inter-governmental transfers” (IGTs) most of which are paid by the City of New York to fund the local share in support of DSH allocations to the Health + Hospitals system.
New York distributes the DSH funding in a generally broad manner that allows many profitable hospitals with high percentages of privately insured patients to receive significant DSH allocations. Even though their favorable payer mix allows them to operate at a profit and they serve lower percentages of indigent patients, they continue to be eligible for and receive DSH and ICP funds that they neither need nor deserve.

This problem is further distorted by the state’s continued inclusion of “bad debt” in the formulas for allocating DSH and ICP funds. Bad debt includes unpaid patient co-pays or charges for privately insured patients, for whom the hospital may have received payment from the insurer that exceeded patient care costs and actually generated a profit. By classifying this bad debt as “charity care,” these hospitals were then able to lay claim to charity care funds on top of the direct payments received from private insurers.

Under the terms of Affordable Care Act, bad debt could no longer be counted as charity care for DSH purposes. In 2013, NY implemented a two year phase out of bad debt in its DSH/ICP formulas, but that phase out was subsequently capped or subject to a “transition collar” of no more than 2.5% reduction per year, which means that the elimination of bad debt from the allocation formulas will stretch out indefinitely.

The Executive Budget proposes to abruptly end the “transition collar” on December 31, 2020, but it is unclear how this would affect safety net hospitals.

The proposed legislation would address the distortions in the distribution DSH funding, protect safety-net hospitals from financial harm, increase the allocations of Medicaid funds to those hospitals with the highest rates of Medicaid and uninsured patients, increase matching Federal Medicaid funds available to the state, and increases reimbursement rates for true safety-net providers.

NYSNA strongly supports the inclusion of the provisions of this proposed legislation in the final budget more fairly distribute ICP/DSH funding and protect the continued viability of vital safety-net providers.

- **Maintain Enhanced Safety Net (ESN) Hospital funding**

Pursuant to Public Health Law Section 2807-c(34), Enhanced Safety Net Hospitals, including public hospitals, sole community hospitals, critical access hospitals and private hospitals with defined patient mixes that include high Medicaid and uninsured and low commercially insured patient rates are to be provided with supplemental funding to offset their uncompensated care costs.

The Executive Budget proposes to eliminate the entire allocation of funding for ESN Hospitals that was previously appropriated.

NYSNA strongly objects to the proposed zeroing out of ESN Hospital funding in the budget. Funding for these true safety net hospitals must be maintained or expanded.

- **Apply means testing for determining Medicaid reimbursement rates**

New York currently provides Medicaid reimbursement rates to hospitals based on generic formulas that do not account for hospital profitability.
As a result, many large hospitals systems that generate hundreds of millions in operating profits continue to receive Medicaid funding that they neither need nor deserve.

Medicaid reimbursement rates should be higher for providers with the highest rates of Medicaid and uninsured patients and should be substantially reduced for providers with the lowest rates of such patients.

- **Require minimum levels of Medicaid and indigent care services private providers**
  
  If there are to be cuts to Medicaid spending, the state should institute requirements that profitable providers shoulder a minimum burden of providing care to Medicaid and uninsured patients. These requirements should include minimum thresholds of Medicaid/uninsured patients with financial penalties for failure to meet the target.

These proposals will (a) maintain all existing Medicaid funding, (b) maintain existing services with no cuts, (c) encourage more efficient use of scarce health care resources, (d) reduce disparities in inequities in the distribution of Medicaid funding, and (e) maintain or increase the existing Federal funding share for health care services.
February 24, 2020

Medicaid Redesign Team  
New York State Department of Health  
Office of Health Insurance Programs  
One Commerce Plaza  
Albany, New York 12237

Re: Medicaid Redesign Team Public Proposal Submission

Via email to mrtupdates@health.ny.gov

To Whom It May Concern:

Thank you for the opportunity to submit proposals to the Medicaid Redesign Team II. The Legal Aid Society, Health Law Unit has submitted all of the below proposals on the portal but have included them below as well. The questions on the portal regarding alignment with MRT guidelines are ambiguous and we are not certain if our answers to those questions could prevent proposals from being considered. If we can provide any additional information, please do not hesitate to contact us at RANovick@legal-aid.org or (212) 577-7958.

Creation of Office of Third Party Health Insurance

The Legal Aid Society proposes the creation of a consumer-facing Office of Third Party Health Insurance (OTPHI) in the Department of Health (DOH) to help Medicaid beneficiaries use their third party health insurance in coordination with Medicaid and to ensure that Medicaid does not pay for services that should be covered by other insurance. We frequently represent clients who cannot access crucial services because of problems coordinating third party health insurance with Medicaid. Some of the most common barriers involve difficulty accessing information about third party insurance held by a non-custodial parent or estranged family member, or failure by a private insurance company to issue a timely denial so that Medicaid can be billed.

Problems with coordination of benefits not only threaten Medicaid beneficiaries’ access to care, but also result in unnecessary costs to Medicaid. We have encountered numerous clients who have been advised by providers, health homes, or other entities to discontinue private health insurance because of their difficulty accessing care. Further, it is likely that Medicaid frequently pays for services that have been unlawfully denied by private insurance.

OTPHI should be empowered to work across DOH and with local districts to resolve billing and coordination of benefits issues that prevent private health insurance plans from paying for services. OTPHI’s staff should actively work to resolve issues for consumers, not simply provide advice or educate consumers. Because of the likelihood that a number of cases would involve insurance held
by non-custodial parents, OTPHI staff should be specifically trained in how to address confidentiality concerns in these cases, especially those involving allegations of domestic violence.

OTPHI should also be responsible for training local districts, health homes, managed care plans, and other government agencies and contractors about rules and processes around Medicaid and third party health insurance. It should work to identify systemic issues with the coordination of third party health insurance and Medicaid and propose solutions.

Maximize Medicare’s Covered Benefits for Dual Eligibles

The Legal Aid Society proposes the State takes steps to ensure increased access to Medicare-covered services for Dual Eligibles. Beneficiaries need assistance accessing covered services, and Medicare providers, including hospitals, need a point of contact and education about what Medicare benefits are available for patients, and how to secure them.

There is often a misunderstanding about the limits of Medicare’s home health and outpatient therapy benefits. Medicare provides both skilled nursing and skilled therapy services under Medicare’s skilled nursing facility (SNF), home health, and outpatient therapy benefits. These services are often not pursued by providers because there is a misunderstanding that the Medicare standard for these services is an “improvement standard”, i.e., Medicare will only approve services should there be promise of a beneficiary’s improvement post-care. This is not the standard. Instead, the standard is a “maintenance coverage standard” that provides skilled nursing and skilled therapy services when such services are “necessary to maintain the patient’s current condition or prevent or slow further deterioration”. (See CMS’s Jimmo Settlement webpage: https://www.cms.gov/Center/Special-Topic/Jimmo-Center) When providers do not pursue these services because they are unclear of the Medicare standard, Medicaid pays.

More so, we have seen our clients who transition from hospitals to SNFs encounter billing difficulties that stem from whether or not they were held only in “observation status” in the hospital, versus being admitted, and therefore qualify for an “inpatient hospital stay” (which is inclusive of 3 midnights). Medicare will only cover care in a SNF for the first 100 days, and only if the person was admitted as inpatient. If a person was in Observation Status only, then Medicare will not pay for a SNF, and Medicaid pays. We propose that the state educate hospitals, and work with them to outline clear criteria for what qualifies as an “inpatient hospital stay” versus “observation status”. There is likely money the Medicaid program is losing by a hospital’s unintentional misclassification of patient stays.

The items identified above could fit neatly within The Legal Aid Society’s proposed Office of Third Party Health Insurance outlined above.
Modernizing Medicaid Eligibility and Communication Systems

The Legal Aid Society proposes modernizing the technology systems used to determine and verify Medicaid eligibility. The current systems are antiquated and siloed; their limitations, flaws, and lack of integration lead to extreme bureaucratic waste. For example, a 2019 audit by the State Comptroller found that Medicaid paid more than $100 million in duplicate payments to plans over four years because these systems could not efficiently identify individuals with an open Medicaid case and communicate that information.

In particular, the Welfare Management System (WMS) used by the Local Departments of Social Services (LDSSs) needs updating. LDSSs make millions of eligibility determinations. The Human Resources Administration (HRA) administers Medicaid to 1,516,282 enrollees, which does not even account for the total number of Medicaid applications processed by HRA. The outmoded WMS system causes costly mistakes including improper denials, discontinuances, incorrect budgets, and lost recertification forms, almost all of which lead to Fair Hearings and countless hours of work for various entities, just to make an eligibility determination. We also see costly mistakes when cases are transferred between New York State of Health and the LDSS due to system integration issues.

These systems are also used to determine “backend” eligibility and collect overpayments from individuals who allegedly received Medicaid when ineligible. Modern systems would likely reduce eligibility errors at the outset. But also, mistakes made by the current technology leads to erroneous, costly, and unnecessary investigations which lead to wasted collection efforts and sunk litigation costs. And this flawed “fraud recovery” system, built upon inaccurate technology, targets the working poor, immigrants, and other vulnerable families, often pushing them back into poverty just when they have started to pull themselves out. These recovery actions are not a fix to the deficit, rather, they make costly mistakes for both the State and the communities we live in.

The current Medicaid eligibility technological systems lead to mistakes that cost the State hundreds of millions of dollars. By updating and investing in these systems now, the State can trim bureaucratic waste and improve the lives of beneficiaries.

Managed Long Term Care Oversight and Reform

The Legal Aid Society submits these proposals regarding the Managed Long Term Care (MLTC) program.

Mandatory enrollment in MLTCs was an initiative of MRT I. In order to generate business MLTCs promoted the program, which has contributed to its tremendous growth allowing more eligible people to receive needed home care services. After an assessment conducted by Maximus finds individuals eligible for home care, MLTCs determine authorizations for a certain number of hours.

Justice in Every Borough.
We routinely see unlawful reductions and denials of services and inadequate authorizations that lead to costly avoidable hospitalizations for issues that occur when an individual is without home care, such as falls that occur when an individual is trying to accomplish ADLs without assistance and infections from ulcers that develop when an individual is unable to turn in bed. Additionally, care management services at many MLTCs is minimal to non-existent.

Despite these problems, the state pays plans a high monthly capitation rate to account for the fact that all enrollees in MLTC are by definition higher users of services than the general Medicaid population. This rate is intended to cover the cost of care, care management and administrative costs. However, our clients find that plans prioritize utilization control over care management, which suggests that MLTCs may consider such controls as care management, rather than as an administrative cost.

We propose the following:

The Department of Health (DOH) must take a close look at the MLTC program to determine whether paying MLTCs hundreds of millions of dollars for administration and profit is a good use of Medicaid funds.

DOH must increase oversight of plans and review reductions and denials of care that can lead to more costly hospitalizations and institutionalization. DOH can utilize its oversight role to penalize plans who issue inappropriate denials and reduction of home care.

We propose that DOH create a community based rate cell. This would allow DOH to pay a lower rate to cover the care needed by the majority of enrollees and avoid paying a higher PMPM rate for all MLTC members. It would also help to address the disincentives to providing adequate care created by capitation.

**Independent Assessor for Managed Long Term Care Services**

The Legal Aid Society proposes the creation of an independent assessor to separate the decision-making process regarding the level of care provided to those in Managed Long Term Care (MLTC) from the entity with a financial stake in the determination (i.e., MLTC plans). This would eliminate the inherent conflict of interest from the authorization process in which MLTC plans issue determinations on the level of care their enrollees require.

MLTC plans receive a fixed capitation rate from the State to provide services to enrollees without regard to the number of home care services they provide. Though there are risk adjustment mechanisms intended to account for overall enrollee acuity relative to other plans, the fact remains that MLTC plans have a financial incentive to minimize the numbers of hours of home care they provide to enrollees. A plan that provides less care to a particular enrollee in a given month will earn more money (or lose less money) for the care of that enrollee.
An independent assessor would ensure that MLTC plans are not enticing consumers to enroll with the promise of a certain number of hours of home care only to be subject to home care reductions at later assessments. Not only would this protect consumers, but it would also save the State resources for those reductions that reach the Fair Hearing stage.

Although all MLTC plans must use the same assessment tool to evaluate enrollees’ needs and abilities, they are not required to use a standard tool to determine how the enrollees’ needs translate to a level of service. An independent entity with no financial stake in the determination is better suited to create a plan of care that outlines the type and number of weekly hours of long-term services and supports needed, which the plan can then develop into a full person-centered plan of care with the participation of the enrollee and family members, when appropriate.

### Automatic Recertification for MLTC and Other Populations

The Legal Aid Society proposes automatic Medicaid recertifications for Managed Long Term Care (MLTC) enrollees, those receiving personal care or Consumer Directed Personal Assistance in mainstream managed care, Aged, Blind, and Disabled beneficiaries, and Medicare Savings Program participants. Despite the fact that most seniors and people with disabilities who receive Medicaid have fixed incomes and assets, New York has continued to require enrollees who are Aged, Blind or Disabled to undergo a burdensome and error-prone mail renewal process annually to prove they are still eligible for Medicaid or the Medicare Savings Program. The renewal packages are mailed to recipients who, due to disability, age, and/or language, are often unable to understand and respond on a timely basis.

The Medicaid mail renewal process is shamefully inefficient as a whole, but it is even more difficult for MLTC enrollees. MLTC plans are supposed to help members with renewals, but The Legal Aid Society has observed significant discrepancies in the assistance provided by plans. Certain plans do ensure that the recertification takes place for all of their members. Unfortunately, some plans do very little to ensure that their members recertify, or – even worse, they start the process, such as by providing a recertification form, but then do not complete it, leaving the enrollee to believe it has been taken care of.

When a Legal Aid client with MLTC loses Medicaid as a result of not recertifying, it often involves dozens of hours of work by a variety of entities including the local district, the plan, the Office of Temporary and Disability Assistance, and the Department of Health, just to continue the services the individual was previously receiving.

Allowing deemed resource eligibility and attestation for these groups would not put the State at risk of reauthorizing Medicaid for people who are ineligible. Attestation of resources is already used in many parts of Medicaid, with no reported downside. The Medicaid program already conducts investigations for potential ineligibility and would continue to do so. This would not change
enrollees’ obligation to report changes in income or resources and would not change excess income liability to the plans.

Medicaid Coverage for Dental Care

The Legal Aid Society proposes that New York State expand its dental benefit package in the Medicaid program.

Adequate dental care is critical to overall health and well-being. A lack of adequate dental care can lead to tooth decay and loss, gum degeneration, mouth lesions, infection, and other serious conditions. A person afflicted with these conditions, in turn, is unable to ingest food sufficient to maintain a nutritious diet, which can cause, and exacerbate, other serious health conditions. Individuals with poor oral health can also suffer stigmatization, leading to social isolation and inability to find employment. When patients are unable to access adequate dental care, the State suffers economic burdens including loss of work productivity, increased emergency room use, and higher health care costs.

We urge New York state to expand Medicaid coverage for dental benefits to promote access to employment, address oral health disparities, and avoid medical costs resulting from the lack of dental care.

Eliminate or Adjust the Global Cap

The Legal Aid Society urges reconsideration of the global cap. The global cap resembles and functions as a block grant which runs contrary to New York’s advocacy against block grant proposals at the federal level. The global cap creates a dangerous narrative that Medicaid is a problem for New York. The so-called deficit is the result of the global cap’s failure to account for positive changes in the program. New York has attained one of the highest percentages of residents with health insurance in the country. Much of that success is the result of efforts to enroll eligible New Yorkers into Medicaid. New York should continue to celebrate this achievement and support efforts to provide eligible New Yorkers with Medicaid coverage. The global cap should be eliminated to ensure access to Medicare and Medicaid services. Alternatively, it should be adjusted to take into account changes in enrollment, changes in minimum wage, appropriate payment to home care workers and the growing aging population’s need for services.

Auto-Assignment into MLTC Plans

The Legal Aid Society proposes that the Department of Health (DOH) automatically enroll consumers into a Managed Long Term Care (MLTC) plan after they have been approved for Medicaid and for MLTC enrollment and after they have been given the opportunity to choose their own plan but have been unable to do so. Currently, those who cannot manage to navigate the many hurdles to timely enroll in an MLTC plan lose their eligibility for MLTC because the Maximus
Conflict-Free assessment approval expires after 75 days, and they must begin the entire process again. This change would align the MLTC program with mainstream Medicaid managed care, in which individuals approved for Medicaid have always been auto-enrolled in a plan after a choice period. This change should reduce the cherry-picking by which plans now discourage enrollment of members who may be perceived as having high needs, since the plan wants to avoid providing high-cost care with the fixed capitation rate. The plans do this by saying that they would authorize only 4 hours/day for someone who clearly needs 12/7. The consumer is then incentivized to shop around for another plan that might approve the number of hours needed. If the consumer is assigned to the plan, the plan must give the necessary services, resulting in spreading high-need members fairly across all plans. Ultimately this should result in lower rates. As in mainstream managed care, auto-assignment would be on a weighted basis and would only occur after the consumer had a chance to select a plan. It would reduce Maximus costs by eliminating the need for duplicate assessments if the conflict free assessment expires -- the CFEEC will be deemed to be in effect – and would not expire – if the auto-assignment is not completed by the 75th day after the CFEEC determination.

Thank you for your attention to these proposals.

Sincerely,

Rebecca Antar Novick
Director
Health Law Unit