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**TO: Memo Distribution List**

LeadingAge New York

**FROM: Hinman Straub P.C.**

**RE: Medicaid Redesign Team II Final Recommendations**

**DATE: March 20, 2020**

**NATURE OF THIS INFORMATION:** This is general information you might find helpful or informative.

**DATE FOR RESPONSE OR IMPLEMENTATION:** None – this is for your information.

**HINMAN STRAUB CONTACT PEOPLE:** Sean Doolan, Caron Crummey, Wendy Saunders, Matthew Leonardo, David Previte, Deborah Kozemko, Stephanie Piel, Jonathan Gillerman, and Michael Paulsen

**THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:**

**Category:** #7 Legislature (NYS)

**Suggested Key Word(s):**

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The Medicaid Redesign Team (MRT) held the third and final meeting on March 19, 2020, advancing recommendations to the Executive and Legislature for the Fiscal Year (FY) 2021 budget in order to achieve \$2.5 billion in Medicaid savings. The recommendations, which include actions impacting managed care plans, hospitals, nursing homes, care management, and pharmacy, total \$2.5 billion in FY21 and more than \$3 billion in FY22. The MRT recommendations include increasing the current 1% across-the-board (ATB) reduction to 1.875% for FY21 (\$219m) and FY22 (\$50m). How that cut impacts plans whose rates have been reduced to the lowest end of the actuarially sound rate range remains to be determined.

The MRT was presented with the full package of recommendations prepared by the Department of Health, and voted on recommending the full package in a single vote. MRT members expressed full support for the package of recommendations and recommended approval, with a few members abstaining (3 members), but no member voted against the recommendations. The Budget Director, Robert Mujica, noted that the State will use a portion of increased FMAP dollars coming from the federal Government to soften the immediate impact of the recommendations that are being advanced; however, the need to stabilize the Medicaid program will continue beyond the current crisis and the recommendations made here will inform the continued efforts to stabilize Medicaid. Mr. Mujica also indicated that the Governor is seeking the authority to implement these initiatives at his discretion, given the COVID-19 pandemic.

In addition to the specific proposals, the MRT also recommended the following long-term actions:

- Negotiate a redefinition of the Medicaid Global Cap as part of the FY21 budget to become effective for FY22, to increase the amount of total spending under the Global Cap through modifications in the base on which spending growth is calculated and/or a different allowable growth metric;
- Further evaluate the management of the Medicaid program, including the respective roles of the State and counties, information technology infrastructure, data analytic capacity, and other functions, to most effectively manage the program;
- Utilize future work groups focused on particular aspects of the Medicaid program; and
- Continue to analyze “promising” proposals submitted to the panel, like sepsis screening in community-based settings.

The following specific recommendations will be considered as part of the FY21 budget process. It is important to highlight that the materials presented by the MRT do not contain the specific mechanisms to implement all of the proposals contained herein. It is anticipated that the mechanisms will be contained in the Article VII language of the final negotiated FY21 budget.

### **Managed Care**

- **Managed Care Quality Incentive Pool:** Restore 50% of the quality pools and restructure to more closely align with performance. This restoration would be funded withholding a percentage of premium from Medicaid managed-care plans until they submit complete encounter data. The expectation is that most Medicaid managed-care plans will earn back the amount of this “encounter data withhold” in the following fiscal year.
- **Reduce Inappropriate Payment Denials:** Recommends a package of statutory reforms that are primarily focused on reducing inappropriate payment denials for inpatient hospital care based on medical necessity and certain administrative deficiencies. This provision applies

to both commercial insurance and Medicaid Managed Care. Other elements of the proposal would streamline administrative processes between Medicaid managed-care organizations and hospitals.

- Standard Prior Authorization Data Set: Require DOH to develop a standard prior authorization data set that includes the minimum information necessary for MCOs to accept and make a determination on the prior authorization request.
- Bronx Integrated Delivery System: Authorize DOH to design and implement a five-year demonstration program, subject to CMS approval, to be led by an academic medical center, and is aimed at accelerating (a) regional population health improvement initiatives, and (b) the adoption of value-based payment models.
- VBP: Implement more refined behavioral health/substance use disorder VBP arrangements to include incentives to provide robust models of integrated care in community and ambulatory settings, intensive outpatient care, and partial hospitalization, as well as advance opportunities for bundled arrangements or shared savings arrangements based on quality outcomes that reduce avoidable readmissions and other costly avoidable complications.
- Electronic Notification: Authorize MCOs to distribute notice of benefit package changes and benefit determinations to enrollees electronically (Enrollees would retain the right to opt out and continue to receive mailed notices).
- Modernize Regulations: Enact reforms to create efficiencies, reduce or eliminate unnecessary costs to the program, and enhance the State's program integrity efforts, relating to establishment and oversight of managed care plan fraud and abuse prevention activities, requirements related to Medicaid as the payer of last resort, financial security for specified provider types, and provider compliance programs.
- Third Party Health Insurance (TPHI): Prohibit denials by third-party health insurance (TPHI) carriers of claims solely due to a lack of prior authorization, to require timely payment of dollars owed to Medicaid by TPHI carriers and to require more frequent reporting of coverage. These actions will ensure that commercial insurers pay primary to Medicaid whenever possible, consistent with federal and state requirements.

## Hospitals

- Indigent Care Pool (ICP) Revisions: Reduces by \$75m (state share) the voluntary hospital ICP by reducing distributions to hospitals that have less than the statewide average in government pay revenue; eliminates the "transition collar" (\$12.5m); and eliminates the ICP pool for public hospitals (\$70m).
- H+H: Convert Upper Payment Limit (UPL) payments into reimbursement rates to protect against a reduction in federal Medicaid disproportionate share hospital (DSH) payments; and authorize H+H and to enter into a full-risk capitation payment with respect to the highest cost Medicaid patients – including the homeless and the most seriously mentally ill.
- Additional Savings:
  - Eliminate certain hospital supplemental payment program funding pools
  - Reduce hospital inpatient capital rate add-on and capital reconciliation payments

**Excess Medical Malpractice**

- Reduce State funding for excess medical malpractice insurance coverage by requiring that the beneficiary of the insurance policy contribute 50% of the cost of coverage.

**Nursing Homes**

- Capital Reimbursement: Reduce nursing home capital reimbursement by 5%.
- Return on Equity: Eliminate funding associated with return on equity payments to for-profit nursing homes.

**Home Care**

- LHCSA RFP: Issue an RFP to limit the number of LHCSAs authorized to participate in Medicaid. The evaluation criteria would establish a baseline value for wage and wage-related costs paid to home health aides and personal care workers employed or contracted by the LHCSAs, such that LHCSAs would be selected based on their ability to deliver administrative efficiencies in their operations, among other criteria, including quality.
- Wage Parity: Implement additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides. Provisions in this proposal include a written certification of compliance, imposition of criminal penalties and sanctions for false certifications of compliance, an annual assessment of wage parity compliance, and required notice to employees of wage parity requirements.
- Workforce Recruitment and Retention Funding: Reduce funding by \$45 million.
- Private Pay Personal Care Services: Create a private pay personal care services option, supported through the NY State of Health Marketplace, that would serve as a trusted source for individuals to purchase pre-negotiated and pre-priced packages of personal care services from LHCSAs.

**Long-Term Care**

- HCBS Lookback: Institute 60-month look-back period for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services.
- Community Spouse Resource Amount: Modify the minimum community spouse resource amount to the federal minimum level.
- Eliminate Spousal Refusal: Eliminate ability of spouses living together in the community and parents living with their child to refuse to make their income and resources available during the determination of an applicant's eligibility for Medicaid.
- Integrated Care for Duals: Promote integrated plans and facilitate pathways for enrolling duals into existing integrated products.
- Community First Choice Option (CFCO): Delay the implementation date of CFCO services from January 1, 2020 to April 1, 2022.
- Community Health Assessments: Migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).

**MLTC**

- Quality Incentive Pools: Restore 50% of the quality pools and restructure to more closely align with performance. This restoration would be funded withholding a percentage of

premium from MLTC plans until they submit complete encounter data. The expectation is that most MLTCs will earn back the amount of this “encounter data withhold” in the following fiscal year.

- **Fair Hearings:** Change various procedures and rules of evidence related to the managed care plan appeal and fair hearing processes regarding “actions” taken by managed care plans that reduce or limit services rendered to enrollees. The proposals are designed to address concerns that the current fair hearing processes and procedural rules inhibit the ability of managed care plans and LDSS to manage appropriately the care authorized for its enrollees, especially as applied to hours for PCS.
- **Enrollment Growth:** Establish a target growth rate for individual partial capitation MLTC plans. The State would withhold a percentage of the premium from MLTC premiums, which plans could recoup provided that actual enrollment growth did not exceed the target. MLTC plans would need to manage their business in order to not exceed the enrollment target, or they would forfeit some of the withheld premium amount.

### **Personal Care Services (“PCS”) and CDPAP**

- **Eligibility for Personal Care and CDPAP:** In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs). This policy will be applicable in FFS, mainstream managed care, and MLTC.
- **PCS and CDPAP Administrative Reforms:**
  - Use an independent clinician panel, similar to the State’s Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols;
  - Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community;
  - Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status;
  - Implement a uniform tasking tool for use by plans and LDSS to help determine service utilization, including the hours of PCS and CDPAS required each day; and
  - Employ the provider “choice” model to proceed with the implementation and electronic visit verification (EVV) system.
- **CDPAP Reforms:**
  - Proceed with the Request for Offer (RFO) process to streamline the number of fiscal intermediaries (FIs);
  - Require that consumers work with a single FI;
  - Eliminate conflicts of interests associated with FI services and plan or LHCSA services in the same legal entity and without appropriate safeguards;
  - Implement restrictions on FI advertising;
  - Eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually;
  - Permit personal assistants to transport consumers during approved care hours when deemed safe and appropriate; and

- Develop standards to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.

### **Pharmacy**

- Pharmacy Benefit Carve Out: Move the pharmacy benefit back to FFS and create a single formulary for consistency in the pharmacy benefit across the Medicaid program. The carve out will be subject to planning during FY21 and implemented for FY22.
- Eliminate Prescriber Prevails: Eliminate prescriber prevails for both FFS and Managed Care.
- Coverage of OTC Drugs: Reduce coverage of certain OTC products and increase copayments, with exceptions for the most vulnerable populations based on a clinical review by OHIP.
- Reduce Drug Cap Growth: Provide authority for the state to negotiate: (1) rebates across FFS and MMC for any drug or drug class where it has been determined to be in the best financial interest of the state; (2) rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and (3) value-based agreements with manufacturers.
- Optimize Pharmacist Services: Expand the Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications.

### **Care Management**

- Health Home Efficiencies: Eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home; move lower acuity members into less intensive care management arrangements.
- Patient-Centered Medical Home (PCMH) Expansion: Continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments.
- Management of Chronic Disease: The MRT recommends targeted interventions utilizing evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease:
  - Children's Behavioral Health Services: Exempts children's health homes from across the board cuts and restores specialized transition rates for Children and Family Treatment and Support Services (CFTSS).
  - Managed Care Process Optimization for Behavioral Health: Includes revisions to the HARP 1115 standard terms and conditions to move behavioral health HCBS under rehabilitation services, which will eliminate some of the technical barriers to accessing BH HCBS.
  - Invest in Medically Fragile Children: Invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase FFS PDN rates over a three-year period to benchmark to the current Medicaid Managed

Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services; and allow MCOs to capture private duty nursing hours on their MCCOR.

- Preventive Dentistry: Proposes to increase the application of fluoride varnish by primary care providers, including RNs, which will decrease early childhood decay and associated restorative costs, and expand Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.
- Addressing Barriers to Opioid Care: Includes bundled payments that support opiate treatment through the adjustment of APG payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.
- Promote Maternal Health: improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals; ensure all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.
- Emergency Room Avoidance: Reduce unnecessary ED utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.

### **Transportation**

- Transportation Broker: Transition to a Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer
- Transportation Carve Out: Carve out transportation from MLTC benefit (excluding PACE).
- Maximize Public Transit: Encourage use of public transportation as alternative to livery when appropriate.
- Taxi/Livery Rates: Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.
- Ambulance Diversion: Provide support for an ambulance diversion program to reduce avoidable hospitalizations.
- Certified Public Expenditure Program: Explore a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities.

**Healthcare Workforce**

- **Modernize Scope of Practice:**
  - authorize emergency medical technicians to provide services in non- emergency situation;
  - authorize cardiovascular technologists (CVTs) to administer contrast materials under the direct supervision of a physician;
  - codify the practice of nurse anesthesia;
  - authorize the use of Medication Technicians in Nursing Homes; and
  - address licensure rules and scope of practice limitations for certain behavioral health licensed providers.
- **Workforce Training:** Improve training and support programs for direct care workforce, Certified Nurse Assistants, Home Health Aides, Personal Care Aides, and Health Home Care Managers; enhance workforce flexibility by offering greater reciprocity to out-of-state but nationally credentialed professionals.

**Health Information Technology (HIT)**

- **Expand Telehealth:** Expand telehealth reimbursement and service models, specifically to address behavioral health, oral health, maternity care and other high-need populations. The proposal contemplates a state-wide, hosted telehealth platform to help mitigate interoperability barriers, as well as to enhance broadband to ensure telehealth connectivity in rural areas.
- **Medicaid Data Technology:** Leverage the State's investments in the SHIN-NY and the All Payer Database (APD) to integrate claims and clinical data and strengthen program integrity efforts.

**Social Determinants of Health (SDH)**

The MRT recommends targeted investments in SDH that are proven to have a high return on investment, such as medically tailored meals. The proposal contemplates creating regional SDH networks and the single point of contracting for SDH services; establishing a regional referral network with multiple community based organizations and health systems; utilizing a state-wide IT platform to coordinate a regional referral network; and assessing Medicaid members for the key State-selected SDH social risk factors (using a State-selected assessment tool) and making appropriate referrals based on needs.



**MRT II**  
**Executive Summary of Proposals**  
**March 19, 2020**

**Introduction**

Governor Andrew M Cuomo formed the Medicaid Redesign Team II (MRT II) on February 4<sup>th</sup>, 2020 with the objective of restoring financial sustainability to the Medicaid program while connecting other programmatic initiatives that would advance the core healthcare strategies he has pursued since taking office in 2011. The MRT II process and the \$2.5 billion MRT II target were established before the outbreak of the COVID-19 public health emergency which has created significant disruption to the health care system and the broader economy.

The request of MRT II members is to approve recommendations that are consistent with Governor Cuomo's original charge to the group and to send those recommendations to the Governor for further consideration. MRT II recommendations will be advanced in the Budget through Appropriation and Article VII language that provides the Executive with full discretion with regard to the effective dates of these proposals in light of the healthcare and economic disruption caused by COVID-19. In addition, it is recommended that a portion of the enhanced FMAP funding, to the extent practicable, will be used to mitigate the implications of COVID-19 on impacted healthcare providers.

The MRT II proposals described in this Executive Summary reflect recommendations and proposals submitted by the stakeholders, including a number of proposals advanced by MRT II members. The proposals represent a balanced approach that put in place programmatic reforms that advance the core healthcare strategies, while restoring fiscal sustainability to the Medicaid program. The major proposals and FY21 savings are described below.

In addition to the proposals described below, three other recommendations will be included in the final MRT II recommendations:

- First, while the MRT II has identified programmatic areas needing reform, a further review should evaluate the way in which the State manages the \$75 billion Medicaid program, to ensure that the State has the necessary infrastructure and appropriate organizational structure to most effectively manage the program. This structural review would include the respective roles of the State and counties, information technology infrastructure, data analytic capacity, and other functions.
- Second, the experience of the MRT II with the Long Term Care Advisory group indicates the value of workgroups that focus on particular aspects of the Medicaid program. Among the areas that would benefit from workgroups include Integration and Alignment of Incentives and managed care, addressing the needs of individuals with disabilities, and continued reform opportunities in behavioral health and developmental disabilities. A number of MRT II members have expertise in these areas and could be asked to serve as

the Chair of one or more of future workgroups. This list of workgroups is not intended to be exhaustive.

- Third, many proposals submitted to the MRT II that were promising but not ready to be adopted or implemented without further analysis. While the proposals below highlight specific issues that the State should explore, these references are not intended to be exhaustive. An example of a potentially promising idea that was not ready for adoption as a recommendation by the MRT was a proposal to include sepsis screening in community-based settings. There are many others that should be further examined with the goal of determining whether they can be made actionable.

### **Redefining the State Medicaid Global Cap**

The MRT II has recommended that the Executive negotiate a redefinition of the Medicaid Global Cap as part of the FY21 budget in a manner that takes into account developments since the State Medicaid Global Cap was first enacted in 2011. The current “Global Cap” growth metric is the 10-year rolling average of the medical CPI. This redefinition would increase the amount of total spending under the Global Cap through modifications in the base on which spending growth is calculated and/or a different allowable growth metric. Changes to the “Global Cap” would become effective beginning in the FY22 Budget and would not have an impact on the FY21 Budget.

### **Hospitals – FY21: (\$399M), FY22: (\$459M)**

- Increase the progressivity of Indigent Care Pool distributions – FY21: (\$157M), FY22: (\$157M)
- Strengthen NYC Health + Hospitals – FY21: (\$186M), FY22: (\$193M)
- Realize additional savings without impacting core hospital operations – FY21 (\$56M), FY22: (\$109M)

These proposals directly affect hospitals. In addition, one of the key Managed Care proposals – “Enact statutory reforms intended to reduce inappropriate payment denials” – are expected to significantly benefit the economic conditions of hospitals by reducing inappropriate payment denials. The hospital proposals as a group are designed to generate a portion of the MRT II \$2.5 billion target in a way that, to the extent possible, protects New York State’s financially distressed hospitals.

Although Medicaid spending on hospitals has grown more slowly than other parts of the Medicaid budget, hospitals still account for approximately 24 percent of total Medicaid spending, including fee for service and Medicaid managed care.

Increase the Progressivity of Indigent Care Pool Distributions (ICP): This Proposal has three components: first, it reduces the size of the voluntary hospital ICP by \$75 million (State share),

by reducing distributions to hospitals that have less than the statewide average in government pay revenue (i.e., Medicaid plus Medicare). Second, the ICP proposal eliminates what is known as the “Transition Collar”, which generates an additional \$12.5 million in savings by ending supplemental payments that are disproportionately distributed to wealthier hospitals. Third, the proposal generates \$70 million in savings by eliminating the ICP pool for Public hospitals.

Strengthen H + H: This proposal contemplates two related initiatives that have been advanced by H + H. The first initiative would convert the value of Upper Payment Limit (UPL) payments received by H + H (and perhaps by other public hospitals) into reimbursement rates, which would help protect against a reduction in federal Medicaid disproportionate share hospital (DSH) payments. The second initiative would involve H + H entering into a full-risk capitation payment with respect to the highest cost Medicaid patients – including the homeless and the most seriously mentally ill. Both H + H and the State would benefit financially from this arrangement by more effectively and efficiently managing the medical care for these vulnerable populations.

Realize additional savings without impacting core hospital operations: This proposal recommends that the State realize additional savings from hospitals by reducing programs that will not materially impact core operations. As noted above, the negative impact of these hospital savings actions will be at least partially offset by other initiatives, including the managed care reforms to reduce inappropriate payment denials. Specifically, this proposal includes eliminating certain hospital supplemental payment program funding pools, reducing hospital inpatient capital rate add-on and capital reconciliation payments, and reducing State funding for excess medical malpractice insurance coverage by requiring that the beneficiary of the insurance policy contribute 50 percent of the cost of coverage.

#### **Care Management – FY21: (\$43M), FY22: (\$70M)**

- Implement Health Home Improvement, Efficiency, Consolidation and Standardization – FY21: (\$33M), FY22: (\$37M)
- Promote Further Adoption of Patient-Centered Medical Homes (PCMH)– FY21: (\$6M), FY22: (\$18M)
- Promote Effective and Comprehensive Prevention and Management of Chronic Disease– FY21: (\$5M), FY22: (\$14M)
  - *Comprehensive Prevention and Management of Chronic Disease – FY21 (\$17M), FY22: (\$37M)*
  - *Children’s Preventive Care and Care Transitions – FY21: (\$0), FY22: (\$0)*
  - *Children's Behavioral Health Services – FY21: \$2M, FY22: \$2M*
  - *Managed Care Process Optimization for Higher Risk Behavioral Health Patients – FY21: (\$0), FY22 (\$1M)*
  - *Invest in Medically Fragile Children – FY21: \$13M, FY22: \$26M*
  - *Preventive Dentistry – FY21: (\$2M), FY22: (\$4M)*
  - *Emergency Room Avoidance and Cost Reductions – FY21: (\$0), FY22: (\$2M)*

- *Addressing Barriers to Opioid Care – FY21: \$0; FY22: \$2M*
- Promote Maternal Health to Reduce Maternal Mortality – FY21: \$1M, FY22: (\$1M)

These proposals are designed to continue the State’s strategy of care coordination and increased access to advanced primary care, in addition to care management related initiatives to improve prevention and management of chronic diseases.

Implement Health Home Improvement, Efficiency, Consolidation and Standardization: As described in the first meeting of the MRT II, Health Homes have produced improved health outcomes for certain high-cost Medicaid patients, including those with serious mental illness and multiple chronic conditions. At the same time, after nearly nine years of experience, opportunities to achieve efficiencies while preserving the most important aspects of the program have been identified. These efficiencies include eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home. Finally, placing the most seriously mentally ill clients in care management arrangements with appropriate caseload sizes – overseen by the Office of Mental Health – while moving lower acuity members into less intensive care management arrangements will both improve program quality and achieve efficiencies.

Promote Further Adoption of Patient-Centered Medical Homes: This proposal reflects the greater maturity of the PCMH program by continuing this valuable approach to proactive primary care while achieving modest efficiencies. The proposal continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments to align with other State initiatives such as the Prevention Agenda.

Promote Effective and Comprehensive Prevention and Management of Chronic Disease: This proposal recommends a number of initiatives to keep people healthy and avoid utilization of high-cost downstream services by improving the management of chronic diseases, improving prenatal and postpartum care, promoting preventive dentistry, supports early childhood health and behavioral health screening and referrals. It also helps ensure early access to preventive behavioral health services and access to cost-effective home and community-based care for medically fragile children and adults with serious mental illness and establishes bundled payments to support opioid treatment. The proposal includes a focus on sickle cell disease, improved prevention and management of diabetes, asthma, osteoarthritis, chronic kidney disease, HIV/AIDS, continuing smoking cessation efforts and deploying pharmacist expertise in a variety of roles including collaborative drug therapy management and point-of-care testing.

Specific initiatives packaged under this proposal are highlighted below:

*Medicaid investments are noted by plus sign (+):*

Comprehensive Prevention and Management of Chronic Disease: Through focused and targeted interventions, this proposal advances the use of evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Specifically, the

proposal will: (1) promote the use of evidence-based, self-care education, and prevention strategies; (2) implement an awareness campaign to educate Medicaid Managed Care (MMC) Plans, providers, and Medicaid members on the various resources and programs that are available; (3) educate the provider community relative to adherence to established evidence-based practice guidelines; (4) optimize services that are already covered by Medicaid, including expanding who can provide services; (5) optimize pharmacist services and leverage the frequency of patient visits to the pharmacy by expanding Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications; (6) focus on chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes (HHs); initially, focus treatment and care management resources on adults with diabetes and hypertension, and children with asthma

Children's Preventive Care and Care Transitions (+): This proposal promotes behavioral health integration in pediatrics by continuing ongoing pilot work focused on pregnancy and early childhood (e.g., preschool screening and universal, light-touch home visits) and leverages participation in CMMI's Integrated Care for Kids (InCK) model of integration of medical and behavioral health care, using resources already available in the community. In addition, this proposal improves care transitions for children with chronic medical and behavioral conditions, with a special focus on children with sickle cell disease (SCD) moving from pediatric to adult care settings.

Children's Behavioral Health Services (+): This proposal exempts children's health homes from across the board cuts and restores specialized transition rates for Children and Family Treatment and Support Services (CFTSS). In addition, the proposal supports continued success of reprogramming work advanced by MRT I subcommittee on Children's Health and Behavioral Health Services.

Managed Care Process Optimization for Higher Risk Behavioral Health Patients (HARP/BH HCBS): This proposal aims to simplify and remove technical barriers through additional workflow reforms to HARP members accessing to care for Behavioral Health Home and Community Bases Services (HCBS). The complexities of the current BH HCBS workflow have resulted in very low uptake in service utilization. The proposal requests revisions to the HARP 1115 standard terms and conditions to move behavioral health HCBS under rehabilitation services, which will eliminate some of the technical barriers to accessing BH HCBS, thereby improving care options available to individuals with serious mental illness.

Invest in Medically Fragile Children (+): This proposal invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase FFS PDN rates over a three year period to benchmark to the current Medicaid Managed Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services; and allow MCOs to

capture private duty nursing hours on their Medicaid Managed Care Operating Report (MCCOR).

Preventive Dentistry: This proposal promotes evidence-based preventative dentistry using fluoride varnish and silver diamine fluoride. Specifically, the proposal increases the application of fluoride varnish by primary care providers, including RNs, which will decrease early childhood decay and associated restorative costs. In addition, the proposal expands Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.

Emergency Room Avoidance and Cost Reductions: this proposal reduces unnecessary ED utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.

Addressing Barriers to Opioid Care (+): This proposal implements a series of Opioid related interventions to address certain barriers to care for Medicaid members, including but not limited to, better bundled payments that support opiate treatment through the adjustment of APG payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.

Promote Maternal Health to Reduce Maternal Mortality (+): This proposal focuses on optimizing the health of individuals of reproductive age, including discussions on comprehensive family planning and patient centered primary and preventive care. The proposal aims to improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals. The proposal also includes ensuring all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.

#### **Managed Care – FY21: (\$41M), FY22: (\$8M)**

- Promote Encounter Data Accountability and Partially Restore Mainstream Managed Care (MMC) Quality Incentive Pools– FY21: (\$47M), FY22: (\$26M)
- Enact statutory reforms intended to reduce inappropriate payment denials – FY21: \$9M, FY22: \$37M
- Standardized Medicaid Managed Care Prior Authorization Data Set – FY21: \$0, FY22: (\$1M)

- Explore new efforts to facilitate Value Base Payment (VBP) arrangements – FY21: \$0, FY22: (\$9M)
- Explore integrated delivery system and global budget demonstrations for the Bronx and rural areas – FY21: \$0, FY22: (\$5M)
- Authorize Electronic Notifications – FY21: (\$2M), FY22: (\$5M)

These proposals are designed to generate savings while advancing long-standing programmatic goals of the MRT, VBP and delivery system redesign.

Promote Encounter Data Accountability and Partially Restore Mainstream Managed Care (MMC) Quality Incentive Pools: The FY20 Budget actions eliminated funding for managed-care quality pools, which would generate \$120 million in savings in FY21 if continued. This proposal would restore 50 percent of the quality pools, while restructuring them in a way that is more closely aligned with performance. This restoration would be funded – and generate additional savings – by withholding a small percentage of premium from Medicaid managed-care plans until they submit complete encounter data, which is crucial for ratemaking, quality measurement and other policy decisions. The expectation is that most Medicaid managed-care plans will earn back the amount of this “encounter data withhold” in the following fiscal year.

Enact statutory reforms intended to reduce inappropriate payment denials: This proposal recommends a package of statutory reforms that are primarily focused on reducing inappropriate payment denials for inpatient hospital care based on medical necessity and certain administrative deficiencies. Other elements of the proposal would streamline administrative processes between Medicaid managed-care organizations and hospitals. The proposal is estimated to increase Medicaid costs by \$9 million in FY21 and \$37 million in FY22, because it would reduce the amount of payment denials that Medicaid managed-care organizations would be able to sustain against hospitals. The proposal would create administrative efficiencies for both hospitals and Medicaid managed-care organizations.

Standardized Medicaid Managed Care Prior Authorization Data Set: The proposal calls for the Department of Health to take administrative action to reduce the number of service request denials and appeals that are filed solely due to lack of basic information necessary to process the request. This would be accomplished by creating standard prior authorization data set that includes the minimum information necessary for Medicaid managed care organization to accept and make a determination on the prior authorization request. Use of a standard data set, such as diagnosis, provider identifiers, procedure codes and enrollee clinical information, would significantly lower the number of Medicaid managed care organization denials due to lack of information, and would ultimately reduce the number of plan appeals triggered by these denials.

Explore new efforts to facilitate VBP arrangements: This proposal includes a variety of initiatives to advance the State’s long-standing commitment to Value-Based Payment reimbursement arrangements. Specifically, this proposal explores opportunities to implement more refined behavioral health/substance use disorder VBP arrangements to include incentives to provide robust models of integrated care in community and ambulatory settings, intensive outpatient care, and partial hospitalization, as well as advance opportunities for bundled

arrangements or shared savings arrangements based on quality outcomes that reduce avoidable readmissions and other costly avoidable complications.

Explore integrated delivery system and global budget demonstrations for the Bronx and rural areas: Montefiore Medical Center submitted a proposal to pursue an all payer/multi-payer global budget approach to provide more flexibility in removing barriers to the transformation of inpatient capacity to outpatient services in the Bronx. The Bronx is well-suited for a demonstration project of this type, because it is an area in which providers have low reimbursement rates associated with high volume of Government pay, which makes it difficult to finance needed transformation efforts. The proposal calls for the Commissioner of Health to have the authority to design and implement a five-year demonstration program, subject to the approval of the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Financial Services, to be led by an academic medical center, and is aimed at accelerating (a) regional population health improvement initiatives, and (b) the adoption of value-based payment models, in line with the Department's Medicaid Value-Based Payment Roadmap. This proposal is similar to the North Country Innovation Pilot that major providers in the North Country have been pursuing in coordination with of the Department of Health.

Authorize Electronic Notifications: This proposal recommends statutory changes to authorize Medicaid managed care organizations to distribute notice of benefit package changes and benefit determinations to enrollees electronically versus the current requirements for paper mailing. Enrollees would retain the right to opt out of receiving these notices electronically and continue to receive paper mailed notices. This change would align State and federal requirements for these processes, improve customer satisfaction, and generate operating efficiencies.

#### **Long-Term Care—FY21: (\$715M), FY22 (\$1,147M)**

- Promote Encounter Data Accountability and Partially Restore Managed Long Term Care (MLTC) Quality Incentive Pools– FY21: (\$67M), FY22: (\$55M)
- Institute a Home and Community Based Eligibility Lookback Period of 60 Months (to be consistent with look-back for nursing homes) FY21: (\$20M), FY22: (\$24M)
- Eliminate Spousal and Legally Responsible Relative Refusal FY21: (\$2M), FY22: (\$2M)
- Change Eligibility Criteria for Personal Care Services (PCS) and Consumer Directed Personal Assistance Program (CDPAP) and Eligibility Criteria for Enrollment in MLTC Partial Plans – FY21: (\$154M), FY22: (\$360M)
- Make Administrative Reforms to PCS and CDPAP Program – FY21: (\$82M), FY22: (\$263M)
- Implement Comprehensive CDPAP Programmatic Reforms and Efficiencies – FY21: (\$33M), FY22: (\$41M)
- Provide Integrated Care to Dual Eligible Members – FY21: (\$5M), FY22: (\$42M)
- Reform the Fair Hearing Process – FY21: (\$0), FY22: (\$1M)
- Delay Implementation of the Expansion of Community First Choice Option (CFCO) Services– FY21: (\$47M), FY22: (\$47M)



- Cap Statewide Managed Long Term Care (MLTC) Enrollment Growth at a Target Percentage – FY21: (\$215M), FY22: (\$215M)
- Enhance Wage Parity Enforcement – FY21: \$0, FY22: \$0
- Issue a Request for Offers for License Home Care Services Agencies (LHCSA) – FY21: \$0, FY22: \$0
- Reduce Workforce Retraining and Retention Funding– FY21: (\$45M), FY22: (\$45M)
- Require all Uniform Assessment System Community Health Assessments (CHA) and reassessments to be conducted by an Independent Assessor (IA) – FY21: (\$8M), FY22: (\$16M)
- Implement Changes to the Community Spouse Resource Amount – FY21: (\$6M), FY22: (\$7M)
- Offer Non-Medicaid Long-Term Care Programs to Encourage Delayed Enrollment in Medicaid including a private pay option for consumers to purchase on NYSoH – FY21: (\$0), FY22: (\$0)
- Reduce Nursing Home Capital Funding– FY21: (\$30M), FY22: (\$30M)

Spending on long-term care—more specifically, personal care and consumer directed personal care services (CDPAS)—is growing at an unsustainable rate and is the single largest cause of the State’s Medicaid structural deficit. Therefore, reforming the way in which Medicaid reimburses for personal care is the area with the largest number of proposals being advanced to the MRT II.

In recent years, enrollment in MLTC plans has increased by 13 percent annually, with annual spending growth totaling approximately \$1.3 billion. In calendar year 2018, CDPAP accounted for approximately 50 percent of year over year spending growth in MLTC plans and 68 percent of year-over-year personal care utilization growth.

Initiatives in prior years that were intended to control MLTC spending within the growth rates established by the Medicaid “Global Cap” have failed to adequately address the problem. Accordingly, a comprehensive series of reforms and actions to redesign the delivery of Medicaid services are being advanced, many of which were unanimously endorsed by the Long-Term Care Advisory Group formed by the Department of Health as part of the larger MRT II process.<sup>1</sup>

Promote Encounter Data Accountability and Partially Restore of Managed Long Term Care (MLTC) Quality Incentive Pools: The FY20 Budget actions eliminated funding for MLTC quality pools, which would generate \$69 million in savings in FY21 if continued. This proposal would restore 50 percent of the quality pools, while restructuring them in a way that is more closely aligned with performance. This restoration would be funded – and generate additional savings – by withholding a small percentage of premium from Medicaid MLTC plans until they submit complete encounter data, which is crucial for ratemaking, quality measurement and other

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<sup>1</sup> All proposals other than those indicated with an asterisk (\*) were unanimously supported by the Long Term Care Advisory Group.

policy decisions. The expectation is that most MLTC plans will earn back the amount of this “encounter data withhold” in the following fiscal year.

Institute a Home and Community Based Eligibility Lookback Period of 60 Months: utilize the same 60-month look-back period for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services and supports as currently applies to those seeking Medicaid eligibility for nursing home care.

Eliminate spousal and legally responsible relative refusal: Make statutory changes to eliminate the ability of spouses living together in the community, and parents living with their child, to refuse to make their income and resources available during the determination of an applicant’s eligibility for Medicaid.

Change Eligibility Criteria for Personal Care Services and Consumer Directed Personal Assistance Program and Eligibility Criteria for Enrollment in MLTC Partial Plans: This proposal has two components that would raise the entry point for eligibility to receive CDPAS and PCS. The first component would change the current eligibility criteria for individuals to receive PCS and CDPAS as a Medicaid benefit, regardless of whether such services are received through fee-for-service, Mainstream Managed Care plans, or MLTC plans.\* In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence).

Make Administrative Reforms to PCS and CDPAS Programs: A package of five reforms that make common-sense changes to the way that PCS and CDPAS benefits are administered by plans and local departments of social services (LDSS) will generate significant State Medicaid savings. These reforms will improve administrative efficiencies, simplify and streamline processes, institute better compliance controls, and promote access to services: (1) use an independent clinician panel, similar to the State’s Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols. (2) Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community.\* (3) Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status. (4) Implement a uniform tasking tool for use by plans and LDSS to help determine service utilization, including the hours of PCS and CDPAS required each day. (5) Employ the provider “choice” model to proceed with the implementation and electronic visit verification (EVV) system, as required by the Federal 21st Century Cures Act.

Implement Comprehensive CDPAP Programmatic Reforms and Efficiencies: As part of the Long-Term Care Advisory Group, a myriad of potential ways to reform CDPAP were discussed and many were unanimously supported. This proposal consists of several components that would work to reform CDPAP, while preserving the program’s benefits to self-directing consumers and eliminating growth drivers not tied directly to service utilization. These reforms include: (1)

proceed with the Request for Offer (RFO) process to streamline the number of fiscal intermediaries (FIs) that deliver high quality services;\* (2) require that consumers work with a single FI; (3) eliminate conflicts of interests associated with FI services and plan or licensed home care services agency services in the same legal entity and without appropriate safeguards; (4) implement restrictions on FI advertising;\* (5) eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually;\* (6) permit personal assistants to transport consumers during approved care hours when deemed safe and appropriate; (7) develop standards and protocols to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.

Provide Integrated Care to Dual Eligible Members: There are currently more than 770,000 dual eligible Medicaid beneficiaries (i.e., those eligible for both Medicare and Medicaid) in New York State, but only 3 percent of those members are enrolled in integrated Medicaid managed care products. This proposal incorporates a series of actions to promote integrated plans and achieve efficiencies by facilitating the pathways for enrolling duals into existing Medicaid integrated care products.

Reform the Fair Hearing Process: This proposal seeks to change various procedures and rules of evidence related to the managed care plan appeal and fair hearing processes regarding “actions” taken by managed care plans that reduce or limit services rendered to enrollees. The proposals are designed to address concerns that the current fair hearing processes and procedural rules inhibit the ability of managed care plans and LDSS to manage appropriately the care authorized for its enrollees, especially as applied to hours for PCS.

Delay Implementation of the Expansion of Community First Choice Option (CFCO) Services: This proposal would delay the implementation date of CFCO services from January 1, 2020 to April 1, 2022. Many of these services are already being furnished to Medicaid beneficiaries as part of other waivers.\*

Cap Statewide MLTC Enrollment Growth at a Target Percentage: Under this proposal, the State would establish a target growth rate for individual partial capitation MLTC plans. The State would withhold a percentage of the premium from MLTC premiums, which plans could recoup provided that actual enrollment growth did not exceed the target. MLTC plans would need to manage their business in order to not exceed the enrollment target, or they would forfeit some of the withheld premium amount.\*

Enhance Wage Parity Enforcement: Under this proposal, the State would amend the current Home Care Wage Parity Law to implement additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides. Provisions in this proposal include a written certification of compliance, imposition of criminal penalties and sanctions for false certifications of compliance, an annual assessment of wage parity law compliance, and required notice to employees of wage parity requirements.\*

Issue a Request for Proposal for LHCSA's: Under this proposal, the State would issue a request for proposals to limit the number of licensed home care services agencies (LHCSAs) authorized to participate in the State's Medicaid program. The evaluation criteria for LHCSAs would establish a baseline value for wage and wage-related costs paid to home health aides and personal care workers employed or contracted by the LHCSAs, such that LHCSAs would be selected based on their ability to deliver administrative efficiencies in their operations, among other criteria, including quality.\*

Reduce Workforce Retraining and Retention Payments: This proposal would reduce Workforce Recruitment and Retention funding for health care workers, which was authorized in 2002 to support providers' ability to recruit and retain qualified direct care staff. New York City's Independent Budget Office released a report that found substantial growth in home care employment opportunities, which suggests that these incentives are no longer necessary in the amounts previously authorized.\*

Require all UAS Community Health Assessments (CHA) and reassessments to be conducted by an Independent Assessor (IA): This proposal would migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).\*

Implement Changes to the Community Spouse Resource Amount: This proposal would modify the minimum community spouse resource amount, which is used to determine the Medicaid eligibility of an applicant under spousal impoverishment budgeting, such that New York would utilize the federal minimum level.\*

Offer Non-Medicaid Long-Term Care Programs to Encourage Delayed Enrollment in Medicaid including a private pay option for consumers to purchase on NYSoH: This proposal would create a private pay personal care services option, supported through the NY State of Health Marketplace, that would serve as a trusted source for individuals to purchase pre-negotiated and pre-priced packages of personal care services from LHCSAs. The "marketplace model" for this personal care services marketplace has been established in other states.

Reduce Nursing Home Capital Funding: This proposal would reduce funding associated with nursing home capital reimbursement by 5 percent and eliminate funding associated with residual equity payments to for-profit nursing homes. Nursing home capital reimbursement totals approximately \$320 million annually (State share). The proposed reduction is consistent with the proposal to reduce hospital capital reimbursement.

#### **Pharmacy – FY21: (\$71M), FY22: (\$214M)**

- Carve Out the Pharmacy Benefit from Medicaid Managed Care to Fee-for-Service (FFS) – FY21: \$11M, FY22: (\$125M)
- Reduce Medicaid Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs – FY21: (\$46M), FY22: (\$43M)
- Limit Coverage of Over the Counter (OTC) Drugs – FY21: (\$14M), FY22: (\$19M)

- Eliminate Prescriber Prevails – FY21: (\$22M), FY22: (\$27M)

Carve Out of the Pharmacy Benefit from Medicaid Managed Care to Fee-for-Service (FFS):

New York has enacted several policy changes to address rising costs of prescription drugs and to improve transparency, including the implementation of the Medicaid Drug Cap and elimination of the Pharmacy Benefit Manager (PBM) spread pricing in Medicaid managed care. Despite these efforts, Medicaid spending on pharmacy continues to grow faster than the rate of inflation. The Department of Health, after considerable analysis is recommending carving the pharmacy benefit out of managed care back to FFS.

This proposal will move the pharmacy benefit for 4.3 million members back to fee-for-service, where the State will have complete visibility into the underlying cost of prescription drugs and greater control to manage overall prescription drug spending. In addition to providing full transparency, there will be a single formulary to ensure consistency in the pharmacy benefit across the Medicaid program, which in turn will simplify the benefit for members and prescribers, remove any conflicts of interest with intermediaries in the pharmaceutical supply chain, improve the ability to negotiate rebates with drug manufacturers and streamline utilization review protocols.

Reduce Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs: Over the last several years, New York State has implemented a number of initiatives aimed at reducing the cost of prescription drugs. Supplemental rebates (i.e. volume-based discounts) for antiretrovirals, including those that are used for PrEP have been negotiated, and the implementation of the Medicaid Drug Cap in FY18 is saving the state more than \$85M each year.

This proposal provides the State with additional legal authority to leverage its purchasing power for prescription drugs. This authority includes (1) the flexibility to negotiate rebates across FFS and Medicaid Managed Care for any drug or drug class where it has been determined to be in the best financial interest of the state; (2) the ability to negotiate rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and (3) the authority to negotiate value-based agreements with manufacturers.

Limit Coverage of Over the Counter (OTC) Drugs: Many other states have chosen to exclude coverage or to provide a limited OTC benefit in Medicaid. Reducing coverage of certain OTC products and increasing copayments (with exceptions for the most vulnerable populations) would be based on a careful clinical review by Office of Health Insurance Programs (OHIP) medical staff to ensure continued access to clinically critical products and continued coverage of clinically comparable, less expensive OTC products that are in Preferred Drug Program (PDP) drug classes.

Eliminate Prescriber Prevails: Prescriber Prevails applies to the Medicaid fee-for-service pharmacy program and to selected drug classes for managed care plans. Eliminating prescriber prevails would reduce inappropriate prescribing, remove barriers that limit the State's ability to manage pharmacy programs, and minimize the inappropriate influence of pharmaceutical manufacturers in the prior authorization process.

### **Transportation – FY21: (\$94M), FY22: (\$244M)**

- Increase the Efficiency, Quality and Access for Non-Emergency Medicaid Transportation – FY21: (\$94M), FY22: (\$244M)

The Medicaid Transportation proposal consolidates over 200 MRT II submissions to increase efficiencies, quality, and access in the Non-Emergency Medical Transportation (NEMT) program. The key elements of this proposal are as follows:

- Transition to a Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer.
- Carve transportation out of the MLTC Benefit (excluding PACE) to create efficiencies and consistency in purchasing, arranging and managing transportation services across the Medicaid program.
- Maximize Public Transit in New York City and other urban areas to encourage the use of public transportation as an alternative to livery when appropriate for the consumer.
- Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.
- Implement an ambulance diversion – Triage, Treat and Transport (ET3) – support program to reduce avoidable hospitalizations
- Explore a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities

### **Program Integrity—FY21: (\$60M), FY22 (\$74M)**

- Modernize Regulations Related to Program Integrity – FY21: (\$60M), FY22: (\$67M)
- Modernize Third Party Health Insurance– FY21: (\$0), FY22: (\$6M)

Modernize Regulations Related to Program Integrity: This proposal would enact a comprehensive set of legal and regulatory reforms to create efficiencies, reduce or eliminate unnecessary costs to the program, and enhance the State’s program integrity efforts. These laws and regulations relate to establishment and oversight of managed care plan fraud and abuse prevention activities, requirements related to Medicaid as the payer of last resort, financial security for specified provider types, and provider compliance programs.

Modernize Medicaid Third Party Health Insurance: This proposal would amend provisions of the New York State Insurance and Social Services Laws, and associated regulations, to prohibit denials by third-party health insurance (TPHI) carriers of claims solely due to a lack of prior authorization, to require timely payment of dollars owed to Medicaid by TPHI carriers and to require more frequent reporting of coverage. These actions will ensure that commercial insurers pay primary to Medicaid whenever possible, consistent with federal and state requirements.

## FY 20 Budget Actions and General Savings Proposals

- Increase the Across the Board Reduction from 1 percent to 1.875 percent – FY21: (\$219M), FY22: (\$50M). This proposal would increase the 1 percent across the board reduction that was implemented under the FY20 budget to 1.875 percent in the next two fiscal years.

In addition, the State implemented a Medicaid Savings Plan in FY20 to address the Medicaid structural deficit. These actions, detailed in the chart below total \$599 million in FY20 and, would fully annualize to \$851 million in FY21. These savings are included within the \$2.5 billion MRT II target. Implications of the proposed restoration to the quality pools described on page 3 and page 9 are reflected in the chart below.

Current Year Spending Reductions (State share – \$ millions)	FY 20	FY21 Pre MRT	FY21 Post MRT
	(\$599)	(\$851)	(\$757)
Elimination of Mainstream Managed Care Quality Pool Payments (MMC)	(\$60)	(\$119)	(\$60)
Elimination of Managed Long Term Care Quality Pool Payments (MLTC)	(\$35)	(\$69)	(\$35)
Discontinue the Enhanced Safety Net Program	(\$126)	(\$66)	(\$66)
eFMAP Reconciliation Timing	(\$112)	\$0	\$0
Discontinue DSRIP Equity Pool (Retro to 10/1/19)	(\$95)	(\$190)	(\$190)
ATB Rate Reduction (1.0% Annually; Effective 1/1/20)	(\$62)	(\$248)	(\$248)
Managed Care Rate Range Reduction	(\$29)	(\$117)	(\$117)
Discontinue VBP Stimulus	(\$43)	(\$43)	(\$43)
Additional Hospital Actions	(\$1)	\$63	\$63
Discontinue New Supportive Housing Resources Associated with Federal Waiver	(\$3)	(\$18)	(\$18)
Discontinue New Social Determinants of Health Investments		(\$44)	(\$44)

It is important to note that a number of the actions in the FY 20 Medicaid Savings Plan represent Financial Plan savings but do not reduce payments to providers or programs. In particular, the elimination of Enhanced Safety Net payments reflects an inability to receive approval CMS approval for such payments. All payments for existing supportive housing commitments are maintained and Financial Plan savings are associated with the inability to obtain a Federal waiver related to supportive housing. Similarly, although the FY 19 budget contemplated \$44 million for Social Determinants of Health in FY21, no commitments or spending ever occurred.

## Healthcare Workforce Proposals

- Modernize scope of practice and other workforce related statutes, regulations and administrative barriers
- Advance workforce training and support initiatives to address workforce shortages

There are critical workforce shortages in healthcare professions across New York State. The shortages contribute to higher costs and impede access to care. A number of proposals were received to address this problem.

Modernize scope of practice and other workforce related statutes, regulations and administrative barriers: Outdated statutes and regulations are barriers to a flexible and functional healthcare workforce. The reforms include proposals to: authorize emergency medical technicians to provide services in non-emergency situation, authorize cardiovascular technologists (CVTs) to administer contrast materials under the direct supervision of a physician, codify the practice of nurse anesthesia, authorize the use of Medication Technicians in Nursing Homes, and address licensure rules and scope of practice limitations for certain behavioral health licensed providers. There are no scored savings associated with the proposals however, these measures would increase efficiencies and improve access to care within the healthcare system.

Advance workforce training and support initiatives to address workforce shortages: this proposal addresses the workforce shortages by improving training and support programs for direct care workforce, Certified Nurse Assistants, Home Health Aides, Personal Care Aides, and Health Home Care Managers. The proposal also would enhance workforce flexibility by offering greater reciprocity to out-of-state but nationally credentialed professionals.

### **Health Information Technology (HIT) – FY21: (\$8M), FY22: (\$13M)**

- Expand Telehealth Services
- Modernize Medicaid information technology and expand access to data

New York has made substantial investments in health information technology under Governor Cuomo's leadership, particularly for the development of the health information exchange known as the Statewide Health Information Network of New York (SHIN-NY). In addition, New York has been a leader in enabling the use of telehealth services. The Health Information Technology (HIT) proposals advanced to the MRT build on these investments and existing policy platforms.

Expand Utilization of Telehealth services: The ongoing COVID-19 crisis highlights the need for robust telehealth services. This proposal would expand telehealth reimbursement and service models, specifically to address behavioral health, oral health, maternity care and other high-need populations. The proposal contemplates a state-wide, hosted telehealth platform to help mitigate interoperability barriers, as well as to enhance broadband to ensure telehealth connectivity in rural areas.

Modernize Medicaid data technology and expand access to data: This proposal would leverage the State's significant investments in the SHIN-NY and the All Payer Database (APD) to



integrate claims and clinical data and strengthen program integrity efforts. Adoption of this proposal would also streamline the patient data-sharing consent process to promote data exchange among providers.

**Social Determinants of Health (SDH)– FY21: \$4M, FY22: \$17M**

- Advance Social Determinants of Health (SDH) to Improve Care and Reduce Medicaid Costs

The final package of proposals being advanced to the MRT includes targeted investments in Social Determinants of Health that are proven to have a high return on investment. These investments are strategically focused on creating the infrastructure and critical mass necessary for SDH programs to be successful. The proposal contemplates creating regional SDH networks and the single point of contracting for SDH services; establishing a regional referral network with multiple community based organizations and health systems; utilizing a state-wide IT platform to coordinate a regional referral network; and assessing Medicaid members for the key State-selected SDH social risk factors (using a State-selected assessment tool) and making appropriate referrals based on needs.

The proposal would implement SDH interventions in two phases – Phase I would focus on scaling SDH interventions that have demonstrated the highest return on investment, such as medically tailored meals, statewide in an effort to reduce overall Medicaid spending and improve quality of care. Phase II would pilot new interventions in FY22 to demonstrate the return on investment to Medicaid before scaling to statewide implementation.