NYAHSA | New York Association of Homes & Services for the Aging
50 Years 1961 • 2011

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February 17, 2011

On behalf of the membership of the New York Association of Homes and Services for the Aging (NYAHSA), I urge you to consider the attached analysis and recommendations regarding the list of Medicaid Redesign Team (MRT) proposals that you and other members of the MRT will vote on this week. NYAHSA represents more than 500 not-for-profit and public providers of long term care (LTC), senior living facilities and services throughout the state, including nursing homes, adult day health care, home care, managed long term care, assisted living, retirement communities and housing.

Before offering our input, however, please accept our sincere gratitude to you for your service on the MRT. We all agree that New York's Medicaid program is in serious need of reform, and difficult choices need to be made. There is no doubt that you have a challenging task before you, and you have our appreciation for being a part of this important process.

While we all agree that Medicaid is unsustainable in its current form, there is wide divergence on what interventions are needed. In the past, the State has most often resorted to provider rate cuts and taxes presented under the guise of Medicaid "reforms." In fact, LTC providers have already incurred more than $1.5 billion in cuts over only the past three years. These measures haven't addressed the underlying systemic realities that are leading to increased volume and utilization (e.g., eligibility, covered services); in fact, they have only made things worse by jeopardizing the financial viability of many LTC providers. In other words, the problem is not the amount providers are reimbursed, and therefore more cuts are not the solution.

Since most providers have not received inflationary rate adjustments for three years now, the notion that provider rate growth is escalating the cost of Medicaid is implausible. The real cost driver in Medicaid is in the volume of recipients and utilization. In LTC, Medicaid has become the predominant payer, effectively "crowding out" private financing sources. For too long, the state has chosen to ignore this fundamental problem with the system, and we are concerned that the current list of measures fails to confront this issue in any meaningful way. I recommend that the MRT go back to the administration and ask that this issue be addressed.

Based upon the administration's stated goal of looking beyond the short-sighted budget-cutting strategies of the past and, instead, seeking out meaningful and sound public policy reforms, we offer the attached analysis and recommendations for your use in evaluating the MRT proposals.

Please contact me at (518) 867-8383, ext. 128 or dheim@nyahsa.org if you have any questions or require any further information on the attached analysis. NYAHSA remains committed to working with the MRT and state policymakers on constructive solutions to the Medicaid challenges we collectively face.

Sincerely,

Daniel J. Heim
Interim President/CEO

Enclosure

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MEDICAID REDESIGN TEAM

NYAHSA ANALYSIS AND RECOMMENDATIONS

The Medicaid Redesign Team (MRT) was provided with a list of 49 reform proposals to review by February 18, using an evaluation tool, in anticipation of a March 1 vote on a final series of proposals. What follows is NYAHSA's evaluation of, and recommendations on, selected proposals on the list of 49 affecting long term care (LTC) services. This document also identifies other proposals we submitted or support that the MRT should consider for endorsement. By way of reference, we have identified each such proposal using the "Proposal #" identified in the documents that MRT members received.

There is a clear vision in this packet of measures to move the system toward more coordinated care in one form or another. What is lacking, however, is recognition that for providers to re-tool for this new vision, they must be able to invest in new programs and systems, including health information technology. Providers already barely surviving from Medicaid check to check are in no position to make the investments necessary to make the state's vision a reality. The state has to recognize that in order to fulfill its vision it has to be willing to make strategic investments in the system.

NYAHSA hopes that as MRT members score the various proposals, they are attuned to the effects that various changes (which would have interactive effects) would have on quality and access to services. In an overall framework necessitating the equivalent of a 10 percent funding cut, we are most concerned that several of the proposed measures could compromise access to quality services.

LTC Medicaid Providers

Proposal #1 would increase the cash receipts assessment taxes on nursing homes, adult day health care programs and home care agencies. Over the past few years, LTC providers have sustained repeated cuts to their Medicaid rates. Increasing the gross receipts tax on these providers is, in essence, a further cut to providers already struggling to stay afloat. ***Suggested score: Cost First Year: 3; Cost Year Two: 3; Quality: -1; Efficiency: -1; Overall Impact: -1***.

Proposal #4 would eliminate the 2011 trend factor of 1.7 percent for nursing homes, adult day health care programs, home care agencies and other providers. Providers' trend factor adjustments have been eliminated for the past three consecutive years on top of other cuts and new mandates. These trend factor cuts get factored into future year's rates, to varying degrees, in different Medicaid programs, creating compounding effects as time goes on. The rate never catches up to the current day rates, ignoring increases in labor and other costs and further threatening already vulnerable providers. ***Suggested score: Cost First Year: 3; Cost Year Two: 3; Quality: -1; Efficiency: -1; Overall Impact: -1.***

Home Care

Proposal #2 would eliminate Level I personal care services and implement provider-specific aggregate patient spending limits at the 2006 spending level; ***proposal #7*** would eliminate the personal care benefit for people who are not nursing home eligible. NYAHSA opposes both proposals as written because individuals who receive these services rely on them to live safely and independently in the community, which prevents or delays more expensive facility-based care. Effective personal care decreases the amount of time people spend in higher-cost settings. In addition, to deny a large group of people necessary personal care services would arguably violate the U.S Supreme Court's Olmstead decision. ***Suggested score: Cost First Yr 3; Cost Out Yrs 3; Quality -1; Efficiency -1; Overall -1.***

To control costs, NYAHSA proposes instead to cap the Personal Care Services Program at 75 percent of the nursing home rate. Individuals who exceed this cap would be enrolled automatically into a long term home health care program (LTHHCP) or managed long term care (MLTC) plan, which includes single-cap MLTC, PACE and MAP.

Proposal #5 would implement provider-specific aggregate annual per patient spending limits on certified home health agency (CHHA) services that are at 2006 spending levels. NYAHSA has concerns with this proposal. We are worried that imposing spending limits will change provider behavior, causing some agencies to "cherry pick" low-cost patients. Under this proposal, CHHAs risk losing large sums of money for serving high-cost, chronic patients because there is no outlier payment add-on. Consideration must be made to certain rural areas where only one CHHA operates. ***Suggested score: Cost First Yr 3; Cost Out Yrs 3; Quality 0; Efficiency 1; Overall 0.***

Proposal #79 would implement an episodic pricing system (EPS) for CHHAs. NYAHSA has concerns that must be addressed **before it is implemented**. First, we are very concerned over the outlier payment for high-cost cases that exceed the episodic payment. The outlier threshold is set at the 80th percentile for each case-mix group within each episode, however, the EPS model only reimburses for 50 percent of the outlier costs. As mentioned under ***proposal #5***, we are worried that the EPS will change provider behavior and CHHAs will be at risk of losing large sums of money for serving high-cost, chronic patients. ***Suggested score: Cost First Yr 0; Cost Out Yrs 0; Quality -1; Efficiency 0; Overall 0.***

For both ***proposal #5*** and ***proposal #79***, we are concerned that the grouper employed to determine case- mix does not calculate all aspects of patient need, including chronic illness and psycho-social factors. These proposals do not include funding for provider quality and performance. Finally, we believe that assessment reform must come first, followed by dramatic payment reform. We also insist that any reimbursement change be implemented *only* after it has been adequately tested and the results and implications analyzed.

Proposal #61 would require that all CHHAs, LTHHCPs and MLTC plans comply with any local living wage law within the geographic area in which they serve Medicaid recipients. NYAHSA opposes this proposal because home care providers simply cannot afford to pay every home health aide and personal care aide the local living wage. If this proposal were implemented, the cost of care for Medicaid recipients would dramatically increase and providers would be faced with a largely unfunded mandate. Many home care providers already offer health care benefits and competitive wages to their workers. Although agencies may retain a larger percentage of the work force, NYAHSA believes that the quality of care Medicaid recipients receive is not dependent on any local living wage law, and suggests the market and individual agencies drive local wages for home care workers. ***Suggested score: Cost First Yr 0; Cost Out Yrs 0; Quality -1; Efficiency -1; Overall -1.***

Managed Care

NYAHSA has concerns with a variety of proposals that seek to enroll all Medicaid beneficiaries into managed care:

- ***#91:*** Carve In for Behavioral Health Services into Managed Care **(*Suggested score: Cost-Year 1 = -1, Cost-Years 2-3 = -1, Quality= -1, Efficiency = -1, Overall Impact= -1*);**
- ***#96:*** Expand Managed Care Enrollment **(*Suggested score: Cost-Year 1 = 1, Cost-Years 2-3 = 2, Quality= -1, Efficiency = -1, Overall Impact= -1*);**
- ***#97:***Assign Medicaid Enrollees to Primary Care Providers **(*Suggested score: Cost-Year 1 = 1, Cost-Years 2-3 = 1, Quality= 1, Efficiency = 1, Overall Impact= 1*); *and***
- ***#101:*** Develop and Implement Initiatives to Integrate and Manage Care for Dual Eligibles **(*Suggested score: Cost-Year 1 = Information not available, federal waiver required unlikely to see savings in the next couple of years, Cost-Years 2-3 = Information not available, Quality=?, Efficiency =? , Overall Impact= negative*).**

The above listed proposals all raise the same serious concern about enrolling broad groups of Medicaid recipients into plans operated by managed care organizations (MCOs). Historically, there have been exemptions and exclusions for good reasons – these populations have specialized needs that don't fare well under typical MCO model, and specialized services have developed over the years to help these individuals remain in the community at a reduced cost to the state. These proposals would undermine programs such as the LTHHCP, which has a successful track record of *more than 30 years* of coordinating the care of people who would otherwise be institutionalized. MCOs are not the only option for managing the care of frail elderly and disabled people in the state. New York has many programs that have decades of expertise and experience in chronic care management and that serve people right in their own communities.

Personal care utilization has been cited as a problem; however, there are several programs that can manage the needs of people in personal care. This mass enrollment of various populations systematically ignores the value of time-tested programs and an infrastructure that already exists in the state. Not only would these plans undermine our existing programs, but the clinical expertise of existing providers would be undermined even if they continued to operate under this new model. It also begs the question of how new initiatives fare in an MCO world. For example, the health home model shows promise for the coordination of care of certain populations while holding the potential for bringing in significant federal dollars. It is unclear, though, how someone would be enrolled in both an MCO and a health home.

These proposals erode fundamental consumer choice. For example, many people with chronic conditions have developed relationships with their service providers that may not be an option in an MCO. In addition, MCOs don't have experience with the specialized needs of people with mental illness, substance abuse or HIV/AIDS, nor psychotropic medications and the complex pharmaceutical issues of these populations. If services are simply denied to reduce cost, it could have a dramatic impact on a person's well-being, which could result in devastating health outcomes as well as increased costs over time.

Lastly, it will take significant time for MCOs to establish themselves in this area and develop contracts, delaying the actual cost-savings to well beyond the 2011-12 state fiscal year. At the same time, transitioning large numbers of people from existing programs into MCOs is likely to result in significant service disruption. If these populations are historically difficult to manage, then a comprehensive approach to the problems of abuse/utilization needs to be taken. An alternative is to rely on existing expertise in this area for the management of people with these complex needs. Some payment reforms in existing programs to align incentives could result in additional savings.

Proposal # 90 would require Medicaid recipients of community-based LTC services to be enrolled into MLTC plans and proposes that MLTC plans be qualified as health homes under the federal Affordable Care Act.

MLTC has proved very effective in some parts of the state, but not in others. This initiative would effectively eliminate existing programs such as the LTHHCP over time. LTHHCPs have a successful track record of coordinating the care of people who would otherwise be institutionalized and are operating at full capacity in the New York City area, where this initiative would apparently begin. This could erode consumer choice by forcing participants of other programs into MLTC plans. This effort could in, fact, increase institutionalization, as these plans may not have managed large numbers of such high users of service in the past. The result could be increased costs to MTLC plans and a possible increase in nursing home placements and hospitalizations.

There are several programs in the state that manage the care of participants well, and MLTC/ MCO models are not the only care management options. These options should be able to co-exist in the state. The state should further examine these high-utilization areas to determine appropriate use of these services and develop targeted approaches. Again, payment reforms can be made to those existing programs to better align incentives.

We support the proposal to designate MLTC plans as health homes, and encourage the state to examine other facilities and programs that could qualify for the designation and associated enhanced federal share. ***Suggested score: Cost-Year 1 = 2 Question the savings because it requires a federal waiver, Cost-Years 2-3 = 3 Question the savings, Quality= 0, Efficiency = 1, Overall Impact= -1.***

Proposal #6 would reduce Medicaid Managed Care and FHP profit from 3 percent to 1 percent. If provider-based MLTC plans are included in this proposal, they should be exempted. Compared with mainstream MCOs, MLTC programs are smaller entities that specialize in populations more susceptible to costly end-of-life care. As not-for profits, these plans do not extract operating capital in profits but reinvest toward growth. As a model identified by various analysts (e.g., Lewin Group) as helping to hold down Medicaid cost growth, the state should facilitate and encourage enrollment growth. This proposal would inhibit expansion, thereby increasing the possibility that individuals would be served in higher-cost settings. Strategies to encourage enrollment, such as temporarily lifting the moratorium on partial-cap MLTC plan expansion and streamlining MLTC enrollment would do more to save costs.

Nursing Homes

Proposal #16 would implement a pricing reimbursement methodology for nursing homes and reduce overall funding by $100 million. By cutting an additional $100 million from nursing home funding while implementing a new reimbursement methodology, the state would exacerbate the huge redistribution of funding that the new methodology would already drive. Based on state estimates, the proposal guarantees that 326 homes will face an average reduction of nearly $1 million per year after year three while all cost differences other than hourly compensation and patient acuity (such as staffing levels and facility configuration) would be ignored. Various strategies discussed by the state's Nursing Home Reimbursement Workgroup to more adequately reflect facility differences in the reimbursement system are also ignored. This level of redistribution is unsustainable for many homes, even if they were faced with no other cuts. ***Suggested score: Cost First Yr 2; Cost Out Yrs 2; Quality -1; Efficiency -1; Overall -1.***

Independent Senior Housing

Proposal #196: This proposal would establish a supportive housing initiative. Senior housing is the least restrictive, most affordable and most flexible congregate living arrangement in the senior living and services array. It offers an ideal platform for efficiently and effectively delivering home care, other health services and social and environmental supports. These services enable seniors to remain independent for as long as possible. Ensuring access to capital financing for senior housing development and renovations and providing access to supportive services prevents avoidable and costly admissions to facilities. NYAHSA also submitted an MRT proposal to the state that would encourage the development of independent housing and service models by clarifying that adult care facility (ACF) and assisted living (AL) regulations should not apply to these models.

Medicaid Eligibility and Private Financing Sources

Medicaid has become the state's *de facto* LTC insurance program rather than a safety net for the indigent. As a result, Medicaid pays for 76 percent of nursing home days and even higher percentages of several home- and community-based programs. While Medicaid serves an essential role in funding LTC for low-income individuals, even consumers with financial means have become dependent on the program for their LTC needs. Over-reliance on Medicaid has desensitized the public to the risk of needing LTC, reinforced an entitlement mentality toward the program, created confusion about who pays LTC bills and adversely affected the marketability of private LTC insurance.

Among the list of 49 proposals, NYAHSA recommended and strongly supports ***proposal #18***, which would eliminate the use of "spousal refusal" and the opportunity for legally responsible relatives to refuse to financially support a relative seeking Medicaid coverage. Similarly, we support ***proposal #111,*** which would create more plan options for the Partnership for LTC, an innovative program that combines a commercial LTC insurance policy with Medicaid catastrophic reinsurance.

Among the 225 "additional proposals" tab in the evaluation tool, NYAHSA strongly supports the following recommendations:

- ***Proposal #102***: Centralize responsibility for Medicaid estate recoveries ($39 million state savings estimated for 2011-12);
- ***Proposal #107***: Provide income tax incentives to non-legally responsible relatives of a Medicaid recipient to contribute toward the cost of their care (this should apply across settings);
- ***Proposal #114***: Create a marketing campaign for the Partnership for LTC insurance program;
- ***Proposal #132***: Expand the definition of an "estate" for Medicaid recovery purposes
- ***Proposal #203***: Promote enrollment in the federal Community Living Assistance Services and Supports (CLASS) Act, a new broad-based LTC insurance plan; and
- ***Proposal #218***: State takes over collection of Medicaid recipient cost-sharing amounts.

NYAHSA also submitted other specific proposals – which were not included in the lists MRT members received – to maximize other LTC financing sources, thereby taking pressure off Medicaid. We would be pleased to share the templates we developed for each of these proposals with interested MRT members:

- Maximization of Medicare coverage and funding;
- Maximization of veterans' benefits funding; and
- Encouraging the use of reverse mortgages to pay for LTC costs.

Mandate and Liability Relief

New York is a highly regulated state when it comes to LTC and other health care services. Federal and state authorities provide inconsistent, duplicative and conflicting regulatory oversight. Regulations often are developed incrementally, with little regard to costs or broader systemic implications. The complex web of regulations and enforcement has limited provider collaboration and development of innovative service models built around consumer needs. Along with regulations, provider liability – and the associated litigation and insurance costs – diverts precious resources away from actual service delivery and threatens quality. In an environment in which provider payments are being reduced, efforts are needed to reduce the costs of mandates and reform liability.

Among the 225 "additional proposals" tab in the evaluation tool, NYAHSA strongly supports the following:

- ***Proposal # 40***: Allow LPNs to do assessments in LTC settings;
- ***Proposal #123***: Streamline the assisted living program (ALP) admission process;
- ***Proposal #130***: Allow nurse practitioners to sign medical evaluations for ACF/AL admissions;
- ***Proposal #138***: Eliminate restrictions on nursing practice in ACFs;
- ***Proposal #147***: Collaborate to eliminate/modify unnecessary regulations;
- ***Proposal #149***: Eliminate the need for a CHHA in the ALP;
- ***Proposal #151***: Extend the use of medication aides into nursing homes (our proposal included assisted living and home care settings as well);
- ***Proposal #152***: Eliminate private right of action for nursing homes; and
- ***Proposal #236***: Reorganize ACF/AL survey process to focus on poorly performing facilities and "look-alikes."

NYAHSA also submitted other specific proposals – which were not included in the lists MRT members received – to reform regulations and address liability. We would be pleased to share the templates we developed for each of these proposals with interested MRT members:

- Allow for less restrictive regulations on continuing care retirement communities, which are private-pay care arrangements;
- Streamline admissions into ALPs and LTHHCPs;
- Allow binding arbitration provisions to be included in admission agreements; and
- Eliminate the presumption that nursing home surveys can be used as evidence in private actions.

Optional Services

The list of 49 proposals includes several measures to put tighter controls on pharmacy services and proposes changes in dental benefits but seemingly falls short of looking at the total array of optional services offered under New York's Medicaid program. We recommend that the MRT examine other recommendations made on optional services contained in the "additional proposals" tab in the MRT Member Feedback Tool. At a time of serious financial constraints, every effort should be made to examine the scope of services offered without seriously impacting the quality of life of the state's Medicaid recipients.

Other Proposals NYAHSA Supports

NYAHSA supports several other proposals contained in the listing of 49 proposals, including the following:

- ***Proposal # 10***: Eliminate direct marketing of Medicaid recipients and facilitated enrollment activities by Medicaid managed care plans;
- ***Proposal # 11***: Bundle pharmacy into MMC;
- ***Proposal # 32***: Prior authorization for exempt drug classes;
- ***Proposal # 35***: Prescription limitation to 5/month;
- ***Proposal # 43***: Eliminate Part D drug wrap in Medicaid;
- ***Proposal # 57***: Limit opioids to a four prescription fill limit every thirty days;
- ***Proposal # 67***: Assist preservation of essential safety-net hospitals, nursing homes and D&TCs;
- ***Proposal # 69***: Uniform assessment tool for LTC;
- ***Proposal # 70***: Expand current statewide Patient-Centered Medical Homes;
- ***Proposal # 89***: Implement health home for high-cost, high-need enrollees;
- ***Proposal # 95***: Include personal care benefit in managed care financing; and
- ***Proposal # 243***: Accountable care organizations.

We also support the following ideas contained in the list of 225 "additional proposals":

- ***Proposal # 62***: IDA financing;
- ***Proposal # 77***: Provide additional financial assistance to financially unstable NHs;
- ***Proposal # 106***: Guidelines for Medicaid reform; and
- ***Proposal # 122***: Seek federal recognition under ACA's balancing incentive payments program.