NYAHSA | New York Association of Homes & Services for the Aging

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M E M O R A N D U M

TO: All Members

FROM: NYAHSA Public Policy Solutions

DATE: February 25, 2011

SUBJECT: **MRT Package**

ROUTE TO: Administrator/Director

ABSTRACT: NYAHSA provides initial analysis of Medicaid Redesign Team package.

Introduction

Yesterday, following a surprising earlier than scheduled vote, Governor Cuomo accepted the 79 recommendations of the Medicaid Redesign Team (MRT). According to the governor's official announcement:

> *Governor Andrew M. Cuomo today accepted a report from the Medicaid Redesign Team which meets the Governor's Medicaid spending target contained in his 2011-2012 budget by introducing a global cap on State Medicaid expenditures of $15.109 billion. The report included 79 recommendations to redesign and restructure the Medicaid program to be more efficient and get better results for patients.*
>
> *The recommendations submitted today to Governor Cuomo meets the Governor's budget target by introducing a global cap on State Medicaid expenditures of $15.109 billion through a variety of mechanisms, including:*
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> *•Proposals that would reform the Medicaid payment and program structure and generate $1.138 billion in total state savings*
> *•Eliminating the permanent law statutory cost drivers which generate $186 million in state savings (NOTE: This refers to Medicaid trend factors)*
> *•Implementing a two-percent across-the-board rate reduction to generate $345 million in savings*
> *•Prepaying certain Medicaid payments to leverage additional enhanced Federal matching funds made possible under ARRA, which generates a $66 million benefit*
> *•Industry-led cost containment initiatives totaling up to $640 million in savings, representing an unprecedented partnership between the state and its healthcare industry. The Medicaid program will be subject to a contingency reduction if this goal is not met.*

The original schedule to review and vote on the package was slated to occur over three days – yesterday, today and Monday. But unbeknownst to observers, the team was asked to vote on the package at the end of yesterday's session, in advance of the original March 1, 2011 deadline for submission of the full MRT report.

For additional background on the governor's budget proposal and the MRT, please refer to the following NYAHSA documents:

- Medicaid Redesign Raises Concerns
- NYAHSA Priority Recommendations for MRT
- SFY 2011-12 Executive Budget Proposal
- Preliminary Budget Math

The MRT Meeting and Vote

Voting took place at yesterday's meeting after a day-long process of reviewing a brief description of each item by administration staff, with a brief opportunity for questions and comments by the MRT members. There were many concerns raised by MRT members, and in several cases there were questions asked that could not be immediately answered or addressed.

State Budget Director Robert Megna delivered one piece of good news during yesterday's meeting, revising downward previous estimates of Medicaid enrollment and utilization in state fiscal year 2011-12 by $475 million. In addition, he advised that pre-paying certain costs during the current period of enhanced Federal Medical Assistance Percentage will save the Medicaid program an additional $66 million. The resulting $541 million effectively reduces the governor's proposed Medicaid state share spending reduction from $2.85 billion to roughly $2.3 billion.

The package passed on a unanimous vote minus three abstentions: Assembly Health Committee Chairman Richard Gottfried, Senate Health Committee Chairman Kemp Hannon and Medicaid Matters Executive Director Lara Kassel. Issues were raised with the overall process and the need for further deliberations, in addition to previous concerns voiced over specific items in the package. Despite those calls for a delay in the vote, those in favor of voting as quickly as possible prevailed. Some members also expressed concern that the full process was being short-changed by not allowing MRT members to fully explore the proposals and/or offer their own amendments.

With the vote completed, the administration is working through this weekend to finalize legislative amendments to the 2011-12 Executive Budget proposal for those MRT recommendations requiring statutory changes and/or appropriations. Under the 30-day amendment process, the governor has until March 3 to submit his changes. NYAHSA has been working to clarify many elements of the proposals, and will be seeking to review proposed legislative language prior to its submission on March 3.

Global Spending Cap

Although the final figures are unclear, MRT proposal #4651 seems to be aimed at bridging the $640 million gap between the total $1.67 billion in Medicaid savings that the MRT package enumerates (sum of reforms, trend factor elimination and across-the-board cuts) and the governor's revised reduction target of $2.3 billion. The proposal would establish a global Medicaid spending cap ($15.1 billion state share in 2011-12) which would be monitored

quarterly by the Department of Health (DOH) and the Division of the Budget. If spending targets were exceeded, DOH would take have the statutory flexibility to make "corrective actions" in the form of utilization controls and/or rate reductions.

It envisions shifting state Medicaid budget-making and appropriations to a biennial (2-year) time frame and reinforces the permanent elimination of the current trend factor methodology as a way of updating Medicaid rates. It is also the proposal that specifies a two percent across-the-board (ATB) cut for providers in both the 2011-12 and 2012-13 state fiscal years, while allowing each provider sector to substitute new Medicaid savings initiatives for all or a portion of the ATB reductions.

NYAHSA's Preliminary Analysis

NYAHSA is very concerned that nursing homes, home care agencies, adult day health care programs and other home and community services providers are once again being asked to shoulder significant Medicaid cuts. Besides the trend factor eliminations and the 2 percent ATB cuts, other targeted reductions are being proposed for these services that will have direct effects on providers. With long term care providers more dependent on Medicaid revenues than many other Medicaid providers and on the heels of hundreds of millions in Medicaid cuts in recent years, these reductions will have a more severe effect in the short term.

It remains to be seen whether the global spending cap on Medicaid expenditures will result in the need for further mid-year spending reductions. Providers and recipients will be at risk for cuts in payments and services if spending levels exceed the cap or other elements of the MRT package do not generate sufficient savings. It's not at all clear how such reductions would be taken if they are needed, and how various provider sectors would be affected. NYAHSA is extremely concerned with the scope of authority this proposal would bestow on DOH and is seeking clarification on exact reduction amounts that are being proposed. We are actively exploring alternatives to ATB cuts and are examining the potential benefit of more predictable funding that biennial budgeting may facilitate.

Looking farther ahead, the MRT plan seeks to bring virtually all Medicaid recipients into managed care/coordinated care arrangements. This would have major implications for NYAHSA members that receive significant Medicaid funding. Nursing homes, home care agencies, adult day health care programs and other programs will essentially be faced with a choice of either becoming part of a managed care/coordinated care arrangement or being paid by a managed care or coordinated care organization. This movement from predominantly a fee-for-service system to a capitated/risk sharing model will create both significant opportunities and threats. NYAHSA will continue to work with policymakers to maximize the opportunities for our members while working to address the associated threats.

NYAHSA has advocated strongly on the point that provider rates are not the cost driver in Medicaid. It is volume, and we believe that this package fails to adequately and fully address the long term care eligibility issues fundamental to this problem. Having said that, the following MRT proposals attempt to get at some aspects of eligibility:

- MRT # 18 - Eliminate Spousal Refusal (mirrors NYAHSA proposal)
- MRT # 102 - Centralize Responsibility for Medicaid Estate Recoveries (mirrors NYAHSA proposal)
- MRT # 132 - Expand the Definition of Estate (mirrors NYAHSA proposal)

- MRT # 141 - Accelerate State Assumption of Medicaid Program Authorization
- MRT # 1116 - Apply 60 Month Look Back Period to Non-institutional LTC
- MRT # 1462 - LTC Insurance Proposals (mirrors NYAHSA proposal)

Managed Care/Care Coordination

As previously noted, the other major theme impacting on almost every aspect of the proposals is the increasing shift towards models of managed care and care coordination (see NYAHSA Doc. ID # n00005014). Even the nursing home bed hold proposal detailed below contains a managed care incentive. The administration views the expansion of these models as a critical tool in controlling Medicaid spending and making the state's Medicaid outlays more predictable.

The listing of proposals (see below for details) based on coordination of care models is a testament to degree to which the administration is banking on managed care and includes:

- MRT # 70 Expand current statewide Patient-Centered Medical Homes (PCMH)
- MRT # 89 Implement Health Home for High Cost, High Need Enrollees
- MRT # 90 Mandatory Enrollment in MLTC Plans/Health Home Conversion
- MRT # 101 Develop Initiatives to Integrate and Manage Care for Dual Eligibles
- MRT # 217 Create an Office for the Development of Patient-centered Primary Care Initiatives
- MRT # 243 Explore Models to Implement Accountable Care Organizations (ACOs)
- MRT # 1427 Allow consumer direction in MLTC; provide regulatory framework for CDPAP

Details on Relevant Proposals

Following are details on proposals that NYAHSA is highlighting for our members as especially critical areas of either support of concern. To view any of the proposals in its entirety or to see other proposals of interest please refer to the Complete Packet of 79 MRT Proposals. They are arranged in sequence in the Short List of Proposal Titles.

MRT# 5: Reduce and Control Utilization of Certified Home Health Agency (CHHA) Services

As part of a two-stage implementation of measures to control CHHA costs, phase one would implement provider-specific aggregate annual per patient spending limits on 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 are at risk of 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.

The second phase would implement an episodic pricing system (EPS) for CHHAs.

*NYAHSA has concerns that must be addressed **before EPS is implemented**. First, NYAHSA is 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.

MRT #21: Streamline the processing of nursing home rate appeals

This proposal caps the annual impact of processing nursing home rate appeals to no more than $80 million annually for four years. It permanently authorizes DOH to: 1) establish priorities among appeals by taking into consideration a facility's financial condition and other factors "deemed appropriate" (e.g., significant capital projects); 2) negotiate settlements with homes that have multiple pending appeals; and 3) reduce negotiated settlement amounts by any outstanding assessment or other amounts the facility owes to the state. Facilities would be required that appeal settlements be first used to meet any outstanding assessment obligations, that any negotiated settlements are final.

In effect, this would continue the $80 million cap on appeal payments that was in place this year for another four years with an estimated annual state savings of $20 million ($40 million provider impact). While it would help those with appeals that are deemed to be priority appeals, it would further delay the payment of many of the 5,800 outstanding appeals.

MRT # 29: Transportation

DOH would accelerate the procurement of regional transportation management contracts in the Hudson Valley, NYC, and other areas. This proposal was first approved in the 2010-11 budget. Transportation costs will be carved out of certain benefit packages such as managed care and transportation for individuals in the Office for Persons with Developmental Disabilities. Reimbursement for dialysis will be at the same level as adult day health care transportation and opportunities to pay "group ride" rates rather than individual fee-for- service transportation rates will be explored. County transportation fees, including mileage will be frozen at 2011 levels. With the introduction a transportation manager and changes in county rates, these changes will affect Method 2 ADHC programs, which are the programs that utilize local Medicaid/DSS to handle transportation. It will also affect Method 1 ADHC programs when they order transportation for registrants to medical appointments. There is no provision in the proposal to alter current Method 1 ADHC transportation rates.

MRT #31: Eliminate worker recruitment and retention

Beginning April 2002, certain Diagnostic and Treatment Centers (D&TCs) have been paid Worker Recruitment and Retention (WRR) rate add-ons totaling $13 million annually. This proposal would eliminate this add-on, reportedly due to the significant investment in ambulatory care rates through the implementation of APGs. It would also reduce an administrative burden to DOH.

MRT # 34: Establish Utilization Limits for Physical Therapy, Occupational Therapy, and Speech Therapy/Pathology

This proposal would establish utilization limits for physical therapy, occupational therapy, speech therapy and speech-language pathology for practitioners and clinics. These therapies are federal optional Medicaid services, for which New York currently covers without limit. Utilization limits will be set to a maximum of 20 visits in a 12 month period, and enrollees under

age 21 and the developmentally disabled population will not be subject to the limit. These limits are reportedly in line with those imposed by some commercial insurance payers. The estimated state savings is $2.5 million for SFY 2011-12, and $4.9 million for the subsequent three SFYs. NYAHSA is seeking clarification on whether this measure would impact outpatient therapies provided by nursing homes.

MRT #37: **Eliminate Case Mix Adjustment for AIDS Nursing Services in CHHA and LTHHCP Programs**

This proposal will eliminate the case mix adjustment factor for AIDS nursing services provided by CHHAs and long term home health care programs (LTHHCPs). Since 1990, reimbursement rates for home care nursing services provided to patients with AIDS have been increased by a case mix adjustment of 1.2988. According to cost report data, 28 CHHAs and 25 LTHHCPs provided AIDS Nursing Services in 2009. The estimated impact of this proposal would be concentrated in New York City, where providers would see a decrease of $3.7M in 2011-12. Impact in the rest of the state totals $0.3M in 2011-12. DOH indicates there is no evidence that the average costs of nursing services provided to AIDS patients exceed the average costs of nursing services provided to other patients.

NYAHSA has concerns about this proposal, as it would reduce payment for specialized services.

MRT # 61: Home Care Worker Parity - CHHA / LTHHCP / MLTC

As per the MRT, this proposal will significantly help reduce turnover in the home and community based long term care system. This is a provision that requires as a condition of provider enrollment in the Medicaid program that all CHHAs, LTHHCPs, and managed long term care (MLTC) comply with any local living wage law within a geographic area in which they serve Medicaid recipients. This enrollment requirement would apply to all direct care workers.

NYAHSA opposes this proposal because this is an unfunded mandate that raises costs without a commensurate increase in reimbursement.

MRT Proposal #67: Assist Preservation of Essential Safety-Net Hospitals, Nursing Homes, and D&TCs

The proposal provides for operational and restructuring assistance to safety net facilities to prevent closure whenever possible, or facilitate closure if no other option is feasible. Applications would be sent to DOH to request assistance to facilitate an orderly closure, merger, or restructuring. A proposed plan enumerating financial and operational challenges and potential impact of closure on the community would accompany the application. DOH is granted sole authority to initiate contracts and request consultations to determine feasibility of plan and community impact. The DOH could appoint temporary operators to facilitate the merger, downsizing, or closure as appropriate.

NYAHSA sees this as a way to provide management direction for a struggling facility and to potentially rescue a facility that may otherwise close, and additional funding can be provided for a closing facility to make the closure a more orderly process. However, NYAHSA is concerned that: (1) DOH has the ability to facilitate closure of a facility if it is deemed to be more feasible, as opposed to a merger that the facility may have preferred to venture into; and (2) the provider

may get lost in the process – once DOH's assistance is requested, the department essentially takes over and determines the fate of the facility.

MRT Proposal #68: Repatriate Individuals in Out-of-State Placements

Currently approximately 700 New York residents are placed in facilities out of state and Medicaid is providing the reimbursement to out-of-state facilities. The majority of these residents needed services that were not readily available in New York at the time of their placement: i.e. ventilator care, neurobehavioral care for Huntington's or brain injury.

NYAHSA is pleased that under this proposal, reimbursement would be provided to a NY facility and help support the NY economy; patients would be closer to their families; and savings may be able to be realized. However, there may not be facility capacity available to provide the care that is needed.

MRT# 69: Uniform Assessment Tool

This proposal essentially endorses the Uniform Assessment Project currently underway at DOH, however the populations included in the effort have been expanded and would now include assessments for Medicaid-eligible individuals receiving home and community-based services including managed long term care (MLTC) plans, personal care, consumer directed personal assistance program, adult day health care (ADHC), assisted living program (ALP) and DOH HCBS waivers (LTHHCP, TBI and NHTD). According to DOH, the uniform assessment tool (UAT) will standardize individual needs assessment across programs and support the creation of an integrated, statewide information system. The assessment measures an individuals' health, functional, cognitive and other abilities. It results in a list of needs, risks for decline and/or opportunities for improving health status to inform care planning and program determination. The new data source will be used for policy decisions surrounding access, quality and cost that are currently unavailable to state policymakers. The proposal involves initial some increased funding in the next two fiscal years, but ultimately would yield savings.

In general, NYAHSA supports this effort in that it will help to standardize and automate the assessment process, allow for "apples to apples" comparisons of people in different programs, provide more rational basis for resource utilization, and ideally translate to a refined process for determining reimbursement levels based on utilization of resources for programs such as the ALP. At the same time, we are concerned about the implementation process and the impact on service delivery and access, as well as a transition to new reimbursement systems in programs such as the ALP and ADHC. There is also the potential for an unfunded mandate that could result in duplicate assessment tools and a more lengthy assessment process. NYAHSA will work with DOH on these issues.

MRT #70: Expand current statewide Patient-Centered Medical Homes (PCMH)

Medical home is a model of care where each patient has an ongoing relationship with a personal physician, nurse practitioner, pharmacist or clinic. Medical homes organize care around patients, working in teams and coordinating and tracking care over time to assure that patients receive appropriate care when and where it is needed. Care is also managed through use of registries, information technology, health information exchange, and other means to assure patients obtain proper care.

This proposal would involve several initiatives that would result in the expansion of the current Statewide PCMH Program to more payers and over 1 million more members. The initiatives include the following: anti-trust protection, technical assistance for smaller practices, testing of new models of payment, creating an advisory group to the Commissioner to make recommendations for the development of infrastructure, exploring with CMS inclusion of dually eligible members to participate in the medical home program; improving the relationship of fee for service (FFS) Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of on-going continuity relationship with providers/ practices; and providing more reliable care management payments to those providers which are independent of specific visit types. Significant state savings is estimated though improved management of complex populations, greater access to services, and use of prevention strategies. Ultimately, it predicted that this will result in a reduction of hospitalization and nursing home placement of enrollees, as well as overall better health outcomes.

NYAHSA had proposed that the state explore and expand the medical home model, and ensure that our members, who are well-positioned to coordinate care, be involved in the consortia of providers that constitute these models.

MRT # 89: Implement Health Home for High-Cost, High-Need Enrollees

Similar to the medical home model (see MRT # 70), high cost, high need patient management can be addressed through the provision of care coordination (health home) services. NYAHSA had proposed the state pursue this opportunity, given that the health home model benefits from a 90% federal financial participation through the ACA for a two year window of time, exponentially increasing the opportunity for state savings. The health home model can be seen as an evolution of the medical home model, though many of the details are subject to an agreement between DOH and CMS and are yet to be determined. We do know that the model prioritizes certain populations that tend to be drivers of high-cost services. As with medical homes, the model is expected to reduce the use of hospitalization and emergency room services, while improving overall health outcomes of enrollees.

NYAHSA has advocated to ensure that several different types of long term care providers, which have years of experience and expertise in coordinating care for frail elderly and chronically ill people, can be involved in these models.

MRT # 90: Mandatory Enrollment in MLTC Plans/Health Home Conversion

This proposal would transition Medicaid recipients age 21 and older in need of community-based long term care services into MLTC plans. As envisioned in a previous version, this proposal would have effectively eliminated the LTHHCP and resulted in significant disruptions to other elements of the home and community based service infrastructure. NYAHSA strongly advocated for a continued role for the LTHHCP and other proven community models, and we are seeking further clarification on this recommendation.

MRT #101: Develop and Implement Initiatives to Integrate and Manage Care for Dual Eligibles

The State will develop care models and reimbursement mechanisms for people who are dually eligible for Medicare and Medicaid to address people residing in the community and in nursing homes. Possible initiatives to be examined include, but are not limited to New York State

assuming risk for all Medicare services for duals, and developing a gain sharing demonstration that would allow New York to share in the savings from reduced hospitalizations and emergency room use resulting from care management of nursing home residents and people residing in the community.

MRT #109: Require hospitals and nursing homes to provide patient centered palliative care

This proposal requires hospitals and nursing homes to provide access to palliative care and pain management services for people with advanced, life-limiting illnesses and conditions. The provision seeks to improve the quality of care and quality of life for individuals with life-limiting conditions and suggests that it may result in fewer inpatient admissions, fewer ED visits and less aggressive, unwanted and futile care at the end of life. No funding is attached to the mandate and no state savings is assumed, although the NY State Health Foundation has estimated 10-year savings of $12 billion from a similar initiative.

MRT #121: Better utilize county nursing homes

This proposal creates a state authority that county and state nursing homes could opt to join that would make it possible for them to avoid civil service rules and maximize administrative personnel functions. The entity would allow for group purchasing and for centralized personnel functions. This could potentially be a significant benefit to county and state operated homes. No savings figure is specified although the state would presumably offset the costs of the authority through long term savings based on reduced facility expenditures and by maintaining the safety net public nursing homes represent.

MRT # 139: Implement the new waiver for LTHHCP

The waiver was renewed through a CMS approval in Sept. 2010 for 5 years. This proposal, which seeks implementation of the waiver, includes provisions in the program advocated for by NYAHSA such as the change in frequency of the re-assessment and allowing for collaboration between the LTHHCP and other services.

MRT #147: Eliminate or modify unnecessary regulations and improvements for capital access

There are several proposals involved in this particular package. Some of these proposals are being referred to the SAGE Commission and MRT Workgroups. The legislative initiatives under this proposal are:

- Temporary suspension of the Nursing Care Quality Protection Act, Chapter 422 of 2009, which requires hospitals, nursing homes, and D&TCs to disclose, upon request, specified information concerning nursing care staffing levels;
- Authorize modification of NYPORTS adverse event reporting for hospitals and D&TCs to align with national consensus standards adopted by the National Quality Forum under a contract with AHRQ;
- Capital Access: Reinstate Industrial Development Agency (IDA) financing for health care facility capital projects and explore alternatives that include other local financing authority and ownership by publically traded companies; and,

- Death reporting requirement for adult care facilities to apply for suicide or questionable circumstances.

Overall, NYAHSA is pleased with the legislative initiatives as they seek to reduce burdensome reporting requirements. NYAHSA authored the proposal related to the ACF death reporting, as well as a proposal to reinstate the IDA and provide other means for capital financing.

The regulatory initiatives under this proposal are:

- Authorize observation units as an adjunct to hospital emergency departments and create a Medicaid rate for the units;
- Facilitate access to capital financing through obligated groups, including multi-state obligated groups;
- Implement a uniform incident report system for nursing home providers;
- Implement a policy to allow approved nurse aide training program sponsors to provide training at nursing home sites which currently do not sponsor their own training;
- Modify the reporting deadlines of the home care worker registry;
- Allow home health aide training programs to have a single qualified supervisor RN for multiple training programs;
- Eliminate the requirement for a physician to be on the Quality Improvement (QI) Committee of Licensed Home Care Services Agencies (LHCSAs); and
- Review reporting requirements for community based services.

More information is needed on some of the above proposals, however, NYAHSA is pleased with many of these regulatory initiatives as they seek to reduce burdensome regulations and allow greater efficiencies throughout the continuum. We are concerned, however, about the increased use of observation beds in hospitals as that reduces the potential for Medicare coverage for nursing home services, should a Medicare-eligible individual require certain skilled services post-observation. Despite these proposals, NYAHSA is disappointed that more initiatives were not included as we have provided several recommendations for regulatory and legislative reforms that would result in greater efficiencies throughout the system. We will advocate with the MRT and in other forums to advance these proposals as well.

MRT #191: Decrease the incidence and improve treatment of pressure ulcers

This proposal would provide financial incentives to support demonstrations that would bring coalitions of providers from different care settings together to coordinate care and to prevent and effectively treat pressure ulcers. It refers to unspecified Medicaid savings and does not provide a source or amount of funding, while pointing out that cost savings will require an initial investment by nursing homes for additional staff, specialized training and equipment. It allows for grant funding for collaborative initiatives to increase awareness and promote cross-setting coalitions, such as the Gold STAMP program.

NYAHSA supports this proposal, which could improve quality of care, and result in savings through pressure ulcer reduction and subsequent reduction of comorbidities. We have been very active participants in the Gold stamp program and will be working with the state on the design of this initiative.

MRT #196: Supportive Housing Initiative

This proposal is based on our recommendations. It creates a supportive housing interagency work group with a goal of formal proposal submitted to the MRT by July 1, 2011. The goal of the workgroup is create between 5,000 and 10,000 housing opportunities for persons at risk of nursing home placements. The workgroup is to focus on both the elderly population and the behavioral health population. While the proposal is expected to save Medicaid dollars by preventing nursing home placement, the state intends to provide some funding in future budget years.

NYAHSA has long been advocating for a greater emphasis on housing with services as an opportunity to save Medicaid dollars. This work group would enable a forum to address policy questions related to supportive housing in relation to other licensed services in the state, and work through obstacles and barriers to expansion.

MRT # 200: Change in scope of practice for mid-level providers to promote efficiency and lower Medicaid costs

This would expand the scope of practice for RNs, LPNs and home health aides to improve access to services and decrease associated costs in delivering services. Proposals under this heading include:

- Reform the state's supervision and orientation regulations for home health aides and personal care workers. Permit nurses/patients (under their scope of practice/practice exemption) to orient/direct HHAs and PC workers to provide "nursing care" as is currently allowed in the consumer directed personal assistant program;
- Allow nurse practitioners to sign Medical Evaluations for ACF/AL;
- Eliminate restrictions on nursing practices in ACFs;
- Allow LPNs to complete assessments in LTC settings;
- Extension of medication aides into nursing homes;
- Expand the scope of practice of home health aides to include the administration of pre-poured medications to both self-directing and non-self directing individuals.

DOH plans to work with the State Department of Education to ensure that these proposals are implemented in a way that ensures the safety of consumers.

NYAHSA believes that these reforms, if implemented carefully, can result in greater efficiencies and an improved consumer experience, without jeopardizing safety. NYAHSA authored the proposal to enable nurse practitioners to sign ACF/AL medical evaluations, and to eliminate restrictions on nurse practices in ACFs (with the caveat that the risk to Supplemental Security Income must be explored), as well as a medication aide proposal for nursing homes, ACFs and home care.

MRT #889: Redesign NYS Medicaid bed hold policy for nursing homes

This proposal eliminates bed hold reimbursement for all Medicaid recipients over 21, effective January 2012. Nursing homes could regain the ability to receive bed hold payments under the current rules (i.e., 95% of the rate, 14 day cap on hospital leave, etc.) if they enroll 50 percent of their eligible residents into a Medicare managed care program. It assumes state savings of $20 million in SFY 2012-13 with a total impact of -$40 million.

NYAHSA opposes the elimination of the nursing home bed hold from both a consumer and provider perspective, and views it as another potential payment cut to nursing homes.

MRT #1172: Nursing home sprinkler loan pool

This proposal assists nursing homes in obtaining financing (which would be reimbursed through the nursing home Medicaid capital rate) by combining individual debt financings to install sprinkler systems into one pooled financing. This would provide easier and lower cost access to needed capital for nursing homes that are required to meet this regulatory mandate by August 2013. The proposal envisions the state working with the Dorm Authority (or similar entity) to create a program that would provide bonded or leased financing for these projects.

This NYAHSA proposal would benefit homes needing to finance sprinkler system installation, and could yield state savings.

MRT #1427: Allow consumer direction in MLTC; provide regulatory framework for CDPAP

This proposal promulgates regulations for the Consumer Directed Personal Assistance Program (CDPAP). Currently, CDPAP is guided by the personal care services program regulations. This also makes consumer directed services part of MLTC.

MRT #1451: Establish various MRT workgroups

The MRT will establish various workgroups to focus discussion on major reform issues. The workgroups will include: Payment Reform , Basic Benefit review, Program streamlining, Supportive housing, Assisted Living Program redesign, Workforce flexibility, Long Term Care waiver redesign, Managed Long Term Care implementation; these workgroups will continue the work on these issues with a reporting deadline of November 1, 2011.

NYAHSA will be closely monitoring the progress of these workgroups and will seek to play a lead role in the process on behalf of our members.

MRT #1458: Managed Care Population and Benefit Expansion, Access to Services, and Consumer Rights

This is part of a series of omnibus care management initiatives, which eliminates many excluded/exempt populations, expands the benefit package, promotes access to services, and ensures consumer rights. Included in this proposal are expansion of Medicaid managed care non-dual enrollment and modification of the benefit package, and additional services are added to the mainstream benefit.

MRT # 4652: Reform Personal Care Services Program in New York City

This proposal contains three major elements:

1. Split shifts and high end users – examines the 1,500 high end users and to determine more effective utilization and care management;
2. Cap housekeeping hours at 8 hours per week, instead of the current cap of 12 hours; and
3. Increase technology and improve assessment of Personal Care Assistance consumers.

This will be accomplished as consumers are enrolled into MLTC.

Conclusion

This memo provides NYAHSA members with an initial summary of the details of the MRT package. Even more critical for our members, however, is an understanding of how this translates into our advocacy efforts. We will be providing advocacy talking points and other materials in the next few days. Please contact policy staff with any questions at 518-867-8383.