HCA 2020 State Medicaid Budget Proposals

The Governor has commissioned a stakeholder Medicaid Redesign Team (MRT) to recommend $2.5 billion in reforms, revenues and savings for the 2020-21 state budget.

On behalf of home care throughout New York State, HCA is eager to work with the Legislature, Governor and MRT on proposals to meet state health and budget goals in positive ways. Our proposals reduce Medicaid cost ***by millions*** and improve health through new policies to optimize entitlement to Medicare home health and hospice coverage over Medicaid, enable new efficiencies in managed care and home care, and cost-effectively address high cost-high risk conditions.

HCA urges the MRT, Legislature and Executive to adopt our proposals for progressive policy change and savings, and avoid budget ravages to these sectors already beset with severe funding gaps and health worker shortages.

Proposal I - Optimize entitlement to Medicare coverage through home care, hospice and MLTC, and further tap existing private coverage options.

Actions to Implement

• Apply best practice guidelines for plans and providers to employ for optimizing Medicare-covered home health and hospice. Amend LTC eligibility guidelines for dually-eligible Medicare-Medicaid recipients to more cost-effectively enroll and maintain Medicare-covered patients in Medicare home care/hospice as appropriate. • Reactivate expired laws providing for referral to hospice. • Maximize new potential for extended home health coverage provisions under the federal *Jimmo settlement*. • Secure expanded, new Medicare service and eligibility coverage through Medicare section 222 flexibility waivers. • Promote/incentivize use of long-existing but overlooked home care riders that are required in law to be made available by private, general health insurance that cover 365 annual home care visits, offsetting Medicaid and Medicaid spend-down and further opening alternative financing.

Proposal II - Create efficiencies and strengthen cost control capabilities in MLTC, home care and CDPAP.

Actions to Implement

Amend state laws and procedures to: • Allow MLTCs and home care providers better capability to control utilization and costs; • Implement operational and procedural efficiencies, including ability to preempt avoidable visits and to eliminate costly operational and regulatory redundancies; • Prevent organizational practices tied to higher costs; • Other.

Proposal III - Leverage savings from home care intervention in high-cost/high-risk/complex care.

Actions to Implement

Score state budget savings from home care interventions in public health, prevention, and better health outcomes (especially avoided hospital, emergency room, and institutional care use) through home care interventions such as in areas of: • Sepsis (sepsis is #1 NYS avoidable hospitalization cost for overall Medicaid); • Asthma ($19.5 million projected Medicaid home care savings); • Housing/case management support; • Mental health; • Telehealth; • Specialty pediatric care programs; • Other.

See reverse side for additional details

HCA proposals for State Budget Efficiencies and Savings – details for page 1 proposals

I - Optimize entitled use of Medicare coverage through home care, hospice and MLTC, and tap private coverage

Several hundred million potential

Actions to Implement

A. Enumerate and employ best practices for optimization; vet with stakeholder advisors, refine, finalize and employ through plan/provider adoption and use; also promulgate to referral sources.

B. Flex LTC eligibility criteria for dually-eligible Medicare-Medicaid recipients to more cost-effectively enroll and maintain Medicare-covered patients in Medicare home care/hospice/MLTC as appropriate. Flex the 120-day mandatory managed care enrollment threshold where it promotes Medicare optimization through home health, and efficient coordination with MLTC/Medicaid as secondary payor.

C. Leverage opportunity for new, expanded Medicare coverage under federal *Jimmo Settlement*. *Jimmo* prohibits the practice of federal agents limiting Medicare coverage of home health agency service based on duration of service or recipient improvement. *Jimmo* clarifies that Medicare can cover skilled care when needed for maintenance, stability, and produces opportunity for further Medicaid offset.

D. Expanded Hospice Use: Systematize patient referral to hospice, optimizing Medicare and private (vs Medicaid) coverage and patient quality of care/life. Update and reenact expired 1991-92 Medicaid cost-containment laws (sections of Chapters 165 of 1991 and 41 of 1992 budget bills) that required hospice referral upon eligibility, physician approval and patient consent.

E. Medicare Waivers: Secure federal section 222 Medicare waivers to provide NY home care flexibility to expand Medicare home care service coverage (in lieu of Medicaid) which 222s have permitted in other states.

II. Savings from Improved Controls and Efficiencies

Several hundred million potential

Actions to Implement

A. Address State barriers to MLTC and provider cost controls in MLTC, and promote plan/provider efficiencies. Examples:

- Ease the current restriction on MLTC and network provider ability to adjust care plans of patients enrolling into an MLTC from a consolidating or withdrawing MLTC. Present rule is too rigid; prohibits care plan change for 120 days even if needs are decreased.
- Permit nurse use of telehealth/telephonic visits in lieu of in-person in-home visits when appropriate for tasks like aide orientation to care plan or for scheduled aide supervision visits. Supervision visits are now mandated as frequently as bi-weekly. Technology provides new options for efficiency of nurse/aide scheduling, task and cost.
- Streamlining - Implement regulatory "LEAN" for MLTC-CHHA-LHCSA joint care to streamline myriad state requirements, clarify roles, and reduce duplication and costs. Allow tracking of annual aide in-service requirements via state aide registry.

B. CDPAP Initiative Examples:

- Create efficiency and nurse visit savings by restoring once/year assessment option for persons with stable disability conditions, vs current every 6 months. Patients prefer too.
- Remove or ease the current mandate requiring continued offering (at continuous intervals) of the program to persons determined ineligible/inappropriate.
- Revisit CDPAP operation under MLTC to ensure operation aligns to the program's core intent of self-directed care by individuals with disabilities, and is the appropriate option when requested as service for non-self-directed individuals.

C. Private Coverage: Promote/incentivize use of longstanding general health insurance riders that privately cover 365 home care visit/year. Will promote much-needed alternative methods of coverage helping to offset Medicaid, Medicaid spend-down and transfers. alternatives.

III. Leverage Savings from Home Care Intervention

Over one hundred million potential

Actions to Implement

A. Home Care Sepsis Savings: Score savings from home care sepsis screening and intervention currently led statewide by HCA and home care agencies. Further savings can be leveraged by incentivizing MCO/MLTC VBP contracts to include this sepsis screening. Savings are via prevention and avoided hospital, ER and LTC.

E.g.: Sepsis is NY #1 in preventable hospitalization for overall Medicaid cases. In Medicare, NYS FFS hospital cost for sepsis cases from home care setting totaled ≈ $200M in 2016. **If only 50% hospital prevented, saves $100M in FFS alone.**

B. Home Care Asthma Savings: Promote savings from asthma ER/hospital prevention and mitigation; implement through home care asthma management program proposed by HCA. **$19.5 million projected savings using MRT metrics.**

C. Telehealth: Promote home care telehealth initiatives and high-cost /high-risk patient savings and improvement (e.g., CHF, COPD, Diabetes, Mental Health) with savings in both hospital and LTC prevention.

D. Mental Health – Home Health Collaboratives: Enact S.3872/A.6566 of 2020 to provide regulatory waivers for home care-mental health provider collaboratives authorized under new 2018 law; program under OMH, intended to improve care and save Medicaid; needs this bill's flexibility.

E. Additional Specialized Home Care Programs: Leverage and score savings from additional home care programs of specialized primary care, public health, long term care, and housing/community based organization service and innovation.