DRAFT MESSAGE POINTS ON THE MRT 1115 WAIVER AMENDMENT SUMMARY

- ***Support the overall aim of the waiver.*** The federal government should share a portion of the savings it is deriving from the Medicaid redesign initiatives being implemented by New York. Strategic investments of these shared savings should be made in the state's health care and housing infrastructure to ensure access to needed services and supports and facilitate provider level care coordination.

- ***Primary care expansion.*** This proposal should be modified to provide start-up funding to assist nursing homes and other long term care providers to develop Medicare Advantage special needs plans (SNPs). SNPs emphasize the use of physician extenders to provide greater medical oversight to Medicare beneficiaries, most of which are dually eligible for Medicaid in long term care (LTC) settings. Formation of SNPs would further state and federal plans to better coordinate care for duals.

- ***Health home development.*** Health homes offer the potential to better coordinate a range of needed services and supports across care settings for high-cost, high-need Medicaid recipients. However, the state has yet to propose a health home model focused on the chronically ill population needing greater than 120 days of long term services and supports. The state should work with the industry and federal government to develop LTC health homes to meet this need, and make development funding available to these health homes for capital and operating support for the costs of health information technology, care managers and governance.

- ***New care models.*** New partnerships and models of care should be explored and tested to bring about various approaches to managing care across settings. To that end, the concept of investing in "hospital/nursing home partnerships that better manage transitions in care," seems well advised given the shared federal-state goals of reducing avoidable hospitalizations and emergency room visits and improving the patient care experience. However, it is unclear how this concept differs from the "managed long term care preparation program" in the summary, which also refers to avoiding unnecessary hospitalizations.

  Investing in "telehealth initiatives" is also vitally important in that it would improve access to services particularly in rural areas, encourage health monitoring and timely interventions, allow services to be provided in the least restrictive setting and make more effective use of the clinical workforce. Monitoring and other assistive technologies should be integrated with senior services and supports, such as housing and home care, to enhance care coordination and forestall the need for more intensive services.

- ***Expand the vital access provider program and safety net provider program.*** While we would support added investments in the Vital Access Provider Program and the Safety Net Provider Program, the qualifying criteria and expected outcomes of these programs are unclear, and there may be other types of providers that should be eligible for funding. The stated preference for participation in health homes may be problematic, particularly if a health home model for LTC recipients is not developed and supported.

- ***New models of care for the uninsured.*** The uncompensated care burden to public hospitals remains, but there is no recognition of public nursing homes that may be providing uncompensated care. This initiative should be broadened to ensure that these facilities can maintain their safety net role.

- ***Medicaid supportive housing expansion.*** Further investments are needed in affordable, safe, accessible, and supportive housing to ensure the success of Medicaid redesign and adherence to the tenets of the Olmstead decision. However, the proposed program would limit funding to only those housing projects that target health home eligible Medicaid members. With no LTC health home model in place, this could preclude making the vitally important investments in independent senior housing that the MRT action plan references. Without a greater supply of affordable senior housing with supportive services, managed care plans will have greater difficulty serving enrollees in the community, and more low-income seniors who are at risk of needing health care services will needlessly be placed in more expensive and restrictive care settings funded by Medicaid.

- ***Managed long term care preparation program.*** With Medicaid accounting for 75 percent or more of total patient days in nursing homes, mandatory enrollment of the LTC population in managed long term care (MLTC) plans will lead to a sea change in the nursing home care delivery and business models. Among the more significant implications is the potential change to the state's longstanding policy on Medicaid reimbursement of approved capital costs. The proposed pre-payment of capital costs and other strategic investments have significant potential to deal with several concerns that nursing homes have regarding the transition to mandatory MLTC enrollment. However, this concept needs to be more fully developed and the linkage between this initiative and the future role of nursing homes needs to be fully explored and understood.

  Corresponding investments should also be made in other programs that have proven experience in managing the complex health care needs of dual eligible recipients, including Long Term Home Health Care Programs, Certified Home Health Agencies, Adult Day Health Care Programs and Assisted Living Programs. Assisting these programs in preparing for mandatory MLTC enrollment will help to preserve access to services, ensure continuity of care and retain care management expertise. These programs should remain as care management options and be adapted to achieve broader system goals rather than being abandoned. The federal government should also be asked to provide definitive clarity on the role of 1915(c) waiver programs in the context of mandatory managed care enrollment.

- ***Capital stabilization and transition.*** The proposal would make funding available for hospital debt retirement, rightsizing and creation of additional

services. However, no comparable funding has been set aside for LTC providers. HEAL NY phases that targeted similar activities in LTC settings were significantly oversubscribed, providing strong evidence of need for further investments. LTC facilities in New York are older, on average, than facilities in many other states. The impending uncertainty around Medicaid capital cost reimbursement under managed care and the lack of capital funding for health information technology for both facility-based and community-based LTC providers underscores the need to extend these funding sources to providers other than hospitals.

- ***Workforce training.*** A highly skilled workforce will be needed to support increased demand for services, better coordination of these services and less reliance on institutional settings. Strategic investments in the workforce are essential in the areas of training in telehealth and patient care technologies, health information and care coordination. Programs aimed at recruiting and retaining physicians and physician extenders to serve in underserved areas should incorporate the need to promote the development of geriatrics and greater use of medical personnel in LTC settings. Creation of the Health Workforce Data Repository would help to ensure uniformity and consistency of data collection and create more real-time information on the existing workforce and the future supply of workers. A wide range of organizations – including providers – should be eligible to provide workforce training under this initiative.

- ***MRT and waiver evaluation program.*** Implementation of the MRT action plan and the 1115 waiver should be closely monitored and systematically evaluated. In addition to the proposed quality measures, there should be a focus on monitoring continuity of care, the financial and operational status of managed care plans and providers, access to needed LTC and other services, the respective roles of key stakeholders (e.g., the state, local governments, enrollment brokers, plans) and transitions in enrollment status (i.e., fee-for-service vs. managed care) and service setting (i.e., home vs. institution).

- ***Financial concerns.*** The Medicaid global spending cap is the centerpiece of the shared savings proposition underlying the proposed 1115 waiver. According to the MRT action plan, the Affordable Care Act will add hundreds of thousands of new beneficiaries to the New York Medicaid program. The critical question is how the costs associated with these new recipients will be accommodated under the global spending cap, which is adjusted to reflect unit cost growth in medical services but not increases in enrollment. The waiver summary also indicates that all federal reinvestment funds will be matched by state and local dollars not currently used for federal claiming. With the local share already effectively capped, this adds to the concern about how added state spending will be supported in light of the global cap.

- ***Amendment vs. new waiver.*** The summary does not explain the rationale for amending the state's existing 1115 Partnership Plan waiver vs. initiating a new 1115 waiver for Medicaid redesign. This raises several important questions, including what bearing it may have on pending HEAL NY projects, OMIG audit targets, overall budget neutrality and the process for obtaining public input on the waiver. The state should provide further information to stakeholders on the basis for this approach.

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