NEW YORK STATE | Department of Health

New York Medicaid Redesign Team II: Meeting 2

Keeping the Medicaid Promise

March 10, 2020

Welcome & Agenda

Agenda

I. Recap & Timeline Review
II. Public Comment Feedback
III. Proposal Submission Feedback
IV. Summary of Submitted Proposals
    i. Long Term Care Advisory Group Report Out
V. Next Steps

Recap & Timeline Review

Medicaid Redesign Team II Membership

Co-Chairs

- Michael Dowling – President and CEO of Northwell
- Dennis Rivera – former President of SEIU Healthcare

Executive Director

- Donna Frescatore – Medicaid Director and Executive Director of the New York State of Health

Members

- Dr. Steven Corwin, President and CEO, New York Presbyterian
- Thomas Quatroche, PhD, President and CEO, Erie County Medical Center
- LaRay Brown, CEO of One Brooklyn Health
- Mario Cilento, President of New York State AFL-CIO
- Christopher Del Vecchio, President and CEO of MVP Health Care
- Pat Wang, President and CEO of Healthfirst
- Emma DeVito, President and CEO of VillageCare
- Wade Norwood, CEO of Common Ground Health
- Steven Bellone, County Executive, Suffolk County
- T.K. Small, Director of Policy at Concepts of Independence
- Donna Colonna, CEO, Services for the UnderServed (S:US)
- Todd Scheuermann, Secretary of Finance, NYS Senate
- Blake Washington, Secretary of Ways and Means, NYS Assembly
- Paul Francis, Deputy Secretary for Health and Human Services, Governor's Office
- Dr. Howard Zucker, Commissioner of Health
- Dr. Ann Sullivan, Commissioner for the Office of Mental Health
- Arlene González-Sánchez, Commissioner of the Office of Addiction Services and Supports
- Dr. Theodore Kastner, Commissioner of the Office for People With Developmental Disabilities
- Robert Megna, Senior Vice Chancellor and COO, SUNY

Timeline Update

✓ February 11th:	MRT II Meeting 1	Albany
✓ February 14th:	Public Comment Day	New York City
✓ February 18th:	Public Comment Day	Rochester
✓ February 21st:	Public Comment Day	Albany
✓ March 2nd:	Public Comment Day	New York City
✓ **March 10th:**	**MRT II Meeting 2**	**New York City**
✓ March 19th:	MRT II Meeting 3	Albany

Introductory Comments by the Chairs

- The Chairs have met with numerous stakeholders directly to hear their perspective on these issues
- There is a recognition that the growth in long term care and CDPAP are the largest contributors to the Medicaid spending deficit. The recommendations of the Long-term Care Advisory Group and other long-term care proposals will address this issue.
- There is also a need to better align the responsibilities of the State and Counties in Medicaid administration
- Certain proposals offer promising long-term efficiencies and should be explored further (e.g., Sepsis proposal from HCA)

Public Comment Feedback

Public Comment – Overview

Provided an additional opportunity to include public feedback into the MRT II process

- Conducted Four Public Comment Days across the State:
  - Forum 1: February 14 - New York City
  - Forum 2: February 18 - Rochester
  - Forum 3: February 21 - Albany
  - Forum 4: March 2 - New York City
- Over 400 attendees
- Over 150 registered speakers
- Cataloged over 150 ideas and feedback from the public

Public Comment: Summarized Feedback

- High Medicaid growth must be addressed
- The disability community in particular expressed concern that actions not impact services on which they rely
- Access to care is a cornerstone of New York's Medicaid program, especially for the most vulnerable populations, and it must be preserved
- Care management plays an important role in healthcare delivery, but improvements can be made

Public Comment: Summarized Feedback Continued…

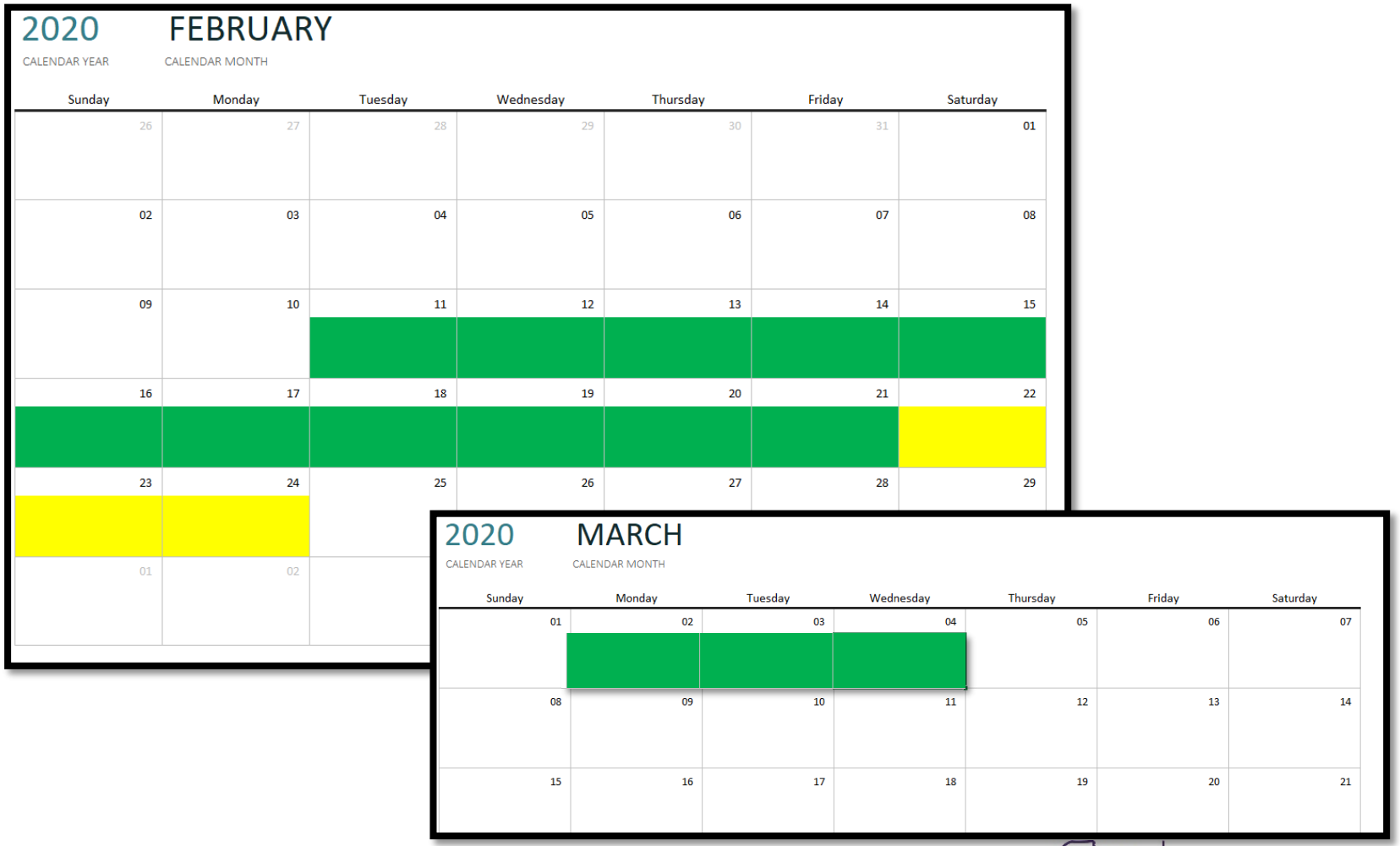
- Considerable progress was made under DSRIP and VBP and it is important to continue that work, especially in the support of community based organizations that address the social determinants of health
- Maximizing the use of telehealth and integrated data exchange may help reduce costs and streamline care delivery
- Considerations to protect safety net providers and enable them to be successful must be part of the delivery system redesign

Proposal Submission Feedback

Public Proposal Submissions – Overview

The State managed an online public submission portal to support the intake and processing of publicly submitted proposals to support Medicaid redesign.

- Portal was opened from Feb. 11th to Feb. 21st
- Extended three additional days to Feb. 24th
- Reopened from March 2nd to March 4th



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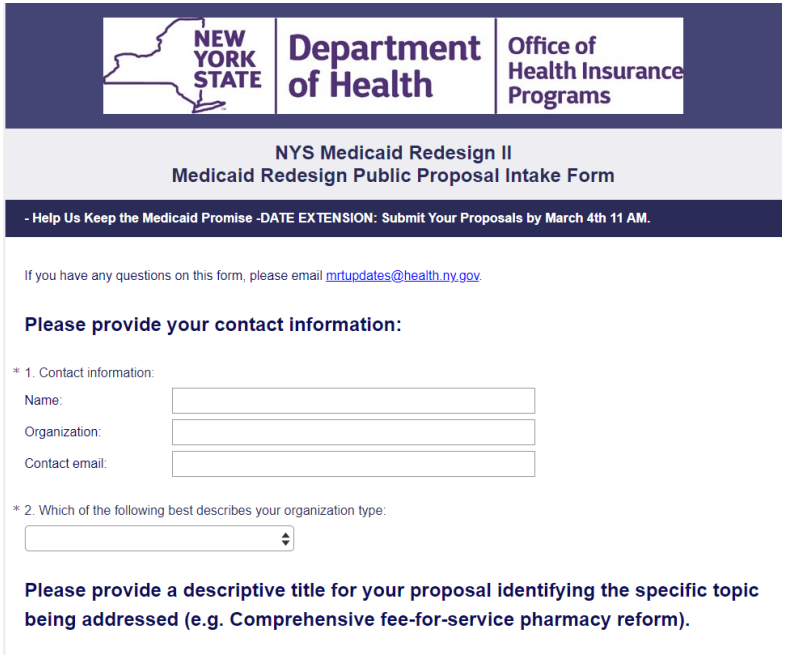
Public Proposal Submissions – Overview

- Over **2,200 individual submissions** were transmitted or recorded
- Submissions were received from:
  - Individuals;
  - Associations;
  - Medicaid consumers;
  - Providers;
  - Managed Care Organizations;
  - Local social services districts;
  - State and local representatives;
  - Community based organizations; and
  - Other stakeholder groups from across the State.



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NYS Medicaid Redesign II
Medicaid Redesign Public Proposal Intake Form

- Help Us Keep the Medicaid Promise -DATE EXTENSION: Submit Your Proposals by March 4th 11 AM.

If you have any questions on this form, please email mrtupdates@health.ny.gov.

Please provide your contact information:

* 1. Contact information:

Name:

Organization:

Contact email:

* 2. Which of the following best describes your organization type:

Please provide a descriptive title for your proposal identifying the specific topic being addressed (e.g. Comprehensive fee-for-service pharmacy reform).

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Public Proposal Submission Process

Submissions were accepted and immediately reviewed by appropriate subject matter teams across the Department of Health (DOH) and state agencies for review and analysis. Based on an established process, each submission was:

1. Logged
2. Assigned to appropriate subject matter professionals (SMP) with DOH for primary review
3. As necessary, shared across multiple offices within DOH and other state agencies for input and analysis
   - Invaluable assistance was offered by DOH's Office of Primary Care and Health System Management, DOH's Office of Quality and Patient Safety, AIDS institute, NY State of Health, Office of the Medicaid Inspector General, Office for People With Developmental Disabilities, Office of Mental Health, Office of Alcohol and Substance Abuse Services, and others

Public Proposal Submission Process Continued…

4. Reviewed and analyzed taking into account the scope and directives of MRT II
5. Consolidated based on commonalities for further review and analysis
6. Formatted into a set of proposals and provided to MRT II Members

FY20 Budget Actions

FY20 Savings Actions That Will Continue in FY 21

Budget Actions in FY 2020 and FY 2021
1% Across-the-Board Rate Reduction
Discontinue Enhanced Safety Net Hospital Payments
Delay eFMAP Reconciliation
Discontinue DSRIP Equity Pools
Discontinue MMC Quality Pool Payments
Discontinue MLTC Quality Pool Payments
Discontinue VBP Stimulus Payments
MMC Rate Range Reduction
MLTC Rate Range Reduction
Supportive Housing Payment Reduction

Overview of Submitted Proposals

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Table of Contents for Submitted Proposal Categories

- Global Cap
- Hospitals
- Care Management
- Managed Care and VBP
- Long Term Care
- Pharmacy
- Transportation
- Program Integrity
- Healthcare-related Revenue
- General Savings
- Workforce
- Health Information Technology (HIT)
- Social Determinants of Health

Medicaid Global Cap

Medicaid Global Cap Proposals

- **Re-Define the Global Cap Growth Metric**
  - Redefine the Global Cap such that the spending limits are solely placed on programs and services that receive Federal financial participation; are required under CMS rules; or are required under the State Plan
  - Adjust Medicaid Global Cap Growth Rate in place of the current Consumer Price Index (CPI) to either utilize a different metric and/or account for enrollment increases
  - Expand the Global Cap to cover all Medicaid spending, including labor costs associated with the minimum wage, and stop the State practice of diverting state Medicaid funding to the General Fund
- **Replace the Global Cap with a global budgeting process** overseen by an independent commission; alternatively, **eliminate the Global Cap altogether**

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Hospitals

Hospitals Proposals

- **Enhance Financial Sustainability of Safety Net Hospitals:**
  - Place less reliance on supplemental payments, including public hospital upper payment limits
  - Modify the voluntary hospital Indigent Care Pool (ICP) so that a higher proportion of the funds are distributed to safety net hospitals
  - Allow the ICP “transition collar” to sunset to increase progressivity of ICP distributions
  - Replace DSH funding now distributed through the public hospital ICP with Intergovernmental Transfer DSH funding

Hospitals Proposals continued…

- **Ensure financial sustainability of safety net hospitals:**
  - Protect safety net hospitals from the impact of State and Federal budget cuts
  - Enter into a capitated risk arrangement with H + H under which H + H would assume responsibility for certain high cost populations in a construct that would achieve savings for the State
  - Achieve savings by reducing various “supplemental payments” that disproportionately benefit non-safety hospitals (e.g., DSRIP Equity Pools, Excess Medical Malpractice payments)

Hospitals Proposals continued…

- **Additional Hospital savings proposals included:**
  - Reduce capital reimbursement rates for hospitals
  - Realize financial plan savings associated with Enhanced Safety Net payments which have not been approved by CMS
  - Eliminate the Hospital Quality and Sole Community Hospital Pools

Care Management

Care Management Proposals – Health Home

- **Implement Health Home reforms that drive efficiencies while preserving core programs**
  - Eliminate Outreach payments
  - Move low acuity members into less intensive case management
  - Increase accountability by penalizing health homes that do not meet quality standards
  - Achieve administrative efficiencies by reducing unnecessary documentation
  - Consolidate and geographically optimize Health Home networks

Care Management Proposals – PCMH

- **Achieve efficiencies in the Patient-Centered Medical Home (PCMH) incentive payment program by tying payments to quality and performance**
  - Maintain Medicaid PCMH incentive payments at current levels to support lower cost, higher value PCMH programs
  - Evaluate incorporation of tiered quality component into the incentive payments to align with other State initiatives (e.g., the Prevention Agenda, Medicaid Value-Based Payment), with a potential focus on chronic conditions.
  - Promote primary care practices reaching PCMH designation to further increase quality and reduce cost.

Care Management Proposals – Prevention and Chronic Disease Management

- **Improve prevention and management of Chronic Diseases**
  - Promote prevention and management of Diabetes
  - Promote smoking cessation services
  - Promote Promising Practices for asthma care in children via home visits with attention to identification and mitigation of asthma triggers.
  - Target care coordination/phases of care (i.e. pediatric to adult) for members with sickle cell disease
  - Identify efficiencies with the elimination of new HIV infections through adequate screening and prescription of PrEP by primary care providers.
  - Optimize Pharmacy Services by deploying pharmacist expertise in roles such as Collaborative Drug Therapy Management (CDTM), Prescribing & Counseling, and point-of-care testing

Managed Care and Value Based Payment (VBP)

Managed Care – Reimbursement Proposals

- Restore the Managed Care Quality and Value Based Payment (VBP) Payments in the Managed Care Quality Incentive (QI) Programs and Equity Pools and VBP Stimulus funding

- Withhold a portion of administrative payments to Plans for submission of incomplete Encounter Data

- Alternatively, proposals were submitted supporting the continuation of the elimination of the Managed Care Quality Incentive and VBP Stimulus pools

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Managed Care – Policy Proposals

- **Enact statutory reforms intended to reduce inappropriate payment denials**
  - Limit certain administrative payment denials
  - Establish "Pay and Pursue" construct for medical necessity payment denials
  - Establish an Administrative Simplification Workgroup to Standardize the Claims Process
  - Limit "down coding" outside of CMS/AMA guidelines
  - Establish new criteria for certain Plan actions:
    - Reduce the period plans may take to respond to a Prior Authorization or other claim appeal (administrative or clinical) to 30 days
    - Require plans to make determinations on inpatient rehabilitation services within one day to improve emergency department capacity.
    - Require quarterly reporting on denials and appeals to increase transparency

- **Require Plans to contract with Behavioral Health providers willing to accept the Medicaid FFS rate**

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Managed Care – VBP Proposals

- **Support VBP through alignment of Managed Care Organizations (MCOs) and provider incentives**
  - Adjust rates to incentivize adoption of VBP arrangements
  - Explore options to transition payments for maternity and newborn services to a maternity bundle VBP model
  - Require a minimum set of data sharing/exchange standards between MCOs and providers
- **Create a Member Incentive Workgroup** and knowledge sharing library to support best practices
- **Implement VBP arrangements for Personal Care**
- **Implement "Global Budget" VBP Demonstrations**

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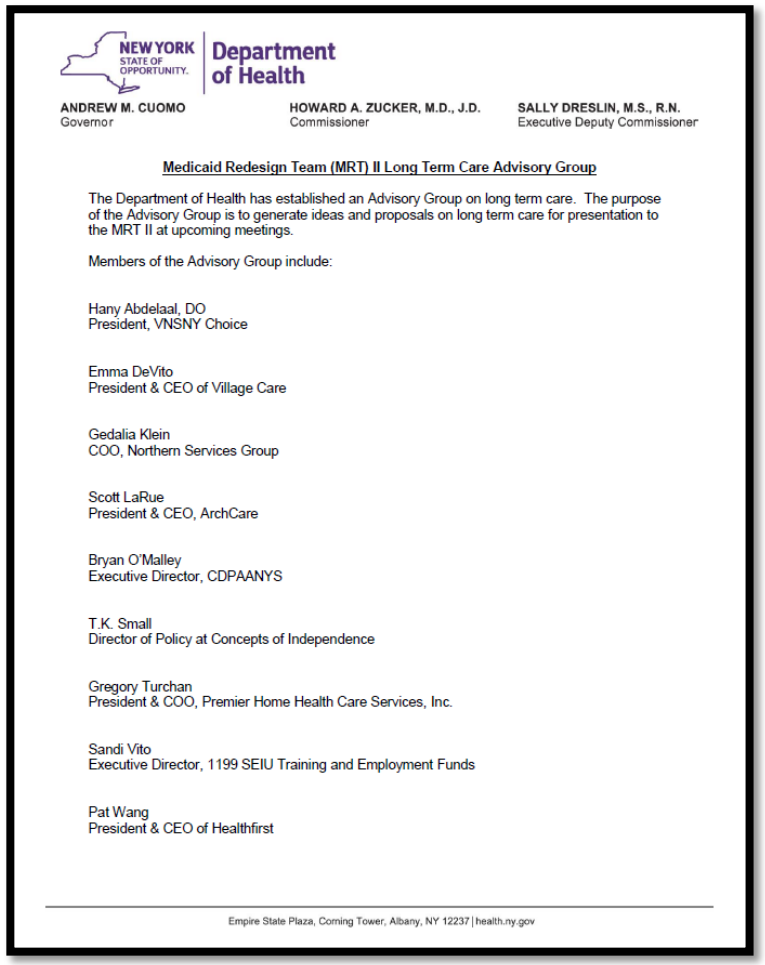
Long Term Care

Long Term Care Proposals

- Two groups of Long Term Care Proposals are being advanced to the MRT:
  - The first group are proposals that were unanimously supported by the Long Term Care Advisory Group
  - The second group are additional proposals that were advanced through the public process

Long Term Care Advisory Group



NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO, Governor | HOWARD A. ZUCKER, M.D., J.D., Commissioner | SALLY DRESLIN, M.S., R.N., Executive Deputy Commissioner

Medicaid Redesign Team (MRT) II Long Term Care Advisory Group

The Department of Health has established an Advisory Group on long term care. The purpose of the Advisory Group is to generate ideas and proposals on long term care for presentation to the MRT II at upcoming meetings.

Members of the Advisory Group include:

Hany Abdelaal, DO
President, VNSNY Choice

Emma DeVito
President & CEO of Village Care

Gedalia Klein
COO, Northern Services Group

Scott LaRue
President & CEO, ArchCare

Bryan O'Malley
Executive Director, CDPAANYS

T.K. Small
Director of Policy at Concepts of Independence

Gregory Turchan
President & COO, Premier Home Health Care Services, Inc.

Sandi Vito
Executive Director, 1199 SEIU Training and Employment Funds

Pat Wang
President & CEO of Healthfirst

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

- On February 18th, membership in the Long Term Care Advisory Group was announced and is composed of key leaders across the long-term care industry with diverse perspectives, including three MRT Members
- The Long Term Care Advisory Group convened three times:
  - February 19th in Albany
  - February 26th in New York City
  - March 6th in New York City
- Throughout the discussion the Advisory Group was mindful to protect access to services for people with disabilities
- Following robust and collaborative discussions, the Long Term Care Advisory Group is advancing approximately 30 proposals (across 12 topic areas) to the full MRT for consideration

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Long Term Care Proposals – Advanced by the Advisory Group

- **Restructure Managed Long-Term Care (MLTC) Plans**
  - Implement a moratorium on new partial capitation MLTC plans and geographic expansions for existing partial capitation MLTC plans with appropriate exceptions for member access.
  - During the duration of the moratorium, develop a process for consolidation of existing partial capitation MLTC plans, while preserving member access and choice.
  - Impose reasonable limitations on the number of certificates of authority granted for Medicaid Advantage, Medicaid Advantage Plus, and PACE plans to avoid market fragmentation and encourage development of plans with experience in providing integrated plan options.

Long Term Care Proposals – Advanced by the Advisory Group

- **Reform Managed Long-Term Care (MLTC) Plans**
  - Implement the use of uniform tasking tool to help inform the number of hours of services a member needs, which would be based on information obtained from the Community Health Assessment.
  - Increase eligibility criteria for enrollment in a partial capitation MLTC plans so that individuals require community based long term care services for a continuous period of more than 120 days to individuals *and* limited or greater assistance with more than two activities of daily living (ADLs).
  - Eliminate requirement in model contract for MLTC plans to make monthly care management calls, and promote alternatives for care management.

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Long Term Care Proposals – Advanced by the Advisory Group

- **Reform Fair Hearing Process**
  - Building on prior year budget actions, reform the fair hearing appeals process by providing further education to Hearing Officers on MLTC, including but not limited to, additional training and education on the plan determination process, the tasking tool and the clinical evidence afforded by the member's plan of care.
  - Modify the appeals process to ensure that a fair hearing request must include proof of exhaustion of a plan's internal appeals process (or deemed exhaustion) prior to hearing a case, consistent with recent changes to federal regulations, or else to dismiss the fair hearing for lack of jurisdiction.
  - Impose procedural and scheduling changes to make the fair hearing process more efficient.

Long Term Care Proposals – Advanced by the Advisory Group

- **Increase Enrollment in Integrated Plans for Dual Eligibles**
  - Implement a comprehensive suite of strategies for integrated care to Medicaid's 770,000+ Dual Members (Members in Medicare and Medicaid), including:
    - Enroll mainstream MCO members who become Dual Members in integrated products;
    - Educate members about the value of integrated plans;
    - Modify auto-assignment processes to integrated plans

Long Term Care Proposals – Advanced by the Advisory Group

- **Reform Consumer Directed Personal Assistance Program (CDPAP)**
  - Permit personal assistants to transport consumers to routine medical visits when safe and appropriate
  - Verify that individuals in CDPAP are capable of self-directing establish clear standards for consumers and designated representatives
  - Implement other CDPAP conflict of interest rules

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Long Term Care Proposals – Advanced by the Advisory Group

- **Standardize Personal Care Services Authorization**
  - Use a Conflict-Free Evaluation and Enrollment Center-type process to centralize and standardize the FFS and managed care plan processes in determining eligibility for CDPAP and personal care services.
  - Promote timely and expanded access to this independent panel by permitting use of telemedicine to facilitate the physician order process.
  - Reduce the frequency of Community Health Assessment from every six months to annually.

- **Implement Reforms to Wage Parity for Unrepresented Home Care Workers**
  - Pool wage parity dollars into a fund for unrepresented home care workers who do not have coverage through their employer or governmental insurance

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Long Term Care Proposals – Advanced by the Advisory Group

- **Promote Assisted Living Programs (ALPs)**
  - Continue to increase bed capacity in ALPs as a high quality and less costly alternative to nursing home care.
  - Explore programs with the federal government, including in lieu of services (ILS), to increase flexibility for MLTC plans to use ALPs as an alternative for members who need high hours of home care services.
  - As capacity expands, incentive nursing homes to discharge eligible residents into ALPs.

- **Promote Long-Term Care Quality Programs**
  - Promote a long-term care quality program for MLTC plans that uses established metrics based on outcomes, aligns with efforts to promote enrollment in integrated plans for duals, and aligns with current value-based payment strategy.

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Long Term Care Proposals – Advanced by the Advisory Group

- **Promote Telehealth and Telemedicine**
  - Promote and encourage MLTC plans to use telehealth as a consideration in completion of the CHA and tasking tool, such that new technological advances and telehealth modalities to substitute for approved personal care hours when appropriate.
  - Permit certain required assessments to be conducted via synchronous telehealth modalities, rather than in-person in each instance.

- **Implement Electronic Visit Verification (EVV)**
  - Permit adoption of an EVV model that allows both consumers and providers with a choice of verification methods, rather than a single statewide model, by federal deadlines.

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Long Term Care Proposals – Advanced by the Advisory Group

- **Offer non-Medicaid Long-Term Care Programs to Encourage Delayed Medicaid Enrollment**
  - Develop a state consumer website, hosted through the NY State of Health Marketplace, that serves as a trusted source for non-Medicaid individuals to purchase pre-negotiated packages of personal care hours on a private pay basis.
  - Increase awareness of services offered through the State's Expanded in Home Services for the Elderly Program (EISEP) as a means to defer Medicaid enrollment.

Long Term Care Proposals – Advanced by the Advisory Group

- **Create an Advisory Group on the Aging Population**
  - Create a State-commissioned advisory group composed of key stakeholders and consumers in the long-term care sector that will analyze and address how to ready the State for the aging population.
  - Topics to be addressed by this advisory group would extend beyond Medicaid and include:
    - Housing development that would enable citizens to age in place;
    - Long-term care capacity across service modalities;
    - Tax policy and estate planning; and
    - Reforms on the private long-term care insurance market.

Additional Long Term Care Proposals Submitted

- **Make reforms to Medicaid Eligibility**
  - Institute a Medicaid eligibility lookback period of 60 months for Medicaid home and community based long-term care services, including personal care and CDPAS, to align with the lookback period for nursing home care.
  - Eliminate spousal refusal for spouses living together in the community when the applicant is not an “institutionalized spouse” under spousal impoverishment budgeting rules, and refusal by parents living with their child.

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Additional Long Term Care Proposals Submitted

- **Implement other CDPAP reforms to improve oversight and accountability**
  - Substantially reduce the number of FIs, limit FIs to not-for-profits and prohibit FI marketing
  - Restrict or eliminate reimbursement of family members as personal assistants
  - Prohibit FIs from assisting in completion of Medicaid applications
  - Eliminate MLTC plan requirements and statutory requirements to notify consumers of CDPAS entitlement
  - Fully replace partial capitation MLTC plans
  - Eliminate wage parity for CDPAS
  - Reconsider reimbursement methodology for FIs based on a medical-loss ratio formula
  - Alternatively, rescind Request for Offers (RFO) process for FIs in favor of alternative reforms

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Additional Long Term Care Proposals Submitted

- **Implement other eligibility reform in Mainstream Managed Care and Fee-For-Service**
  - Extend the increased MLTC eligibility criteria for CDPAP and PCS to Mainstream Medicaid Managed Care plans and fee-for-service by requiring individuals to need limited or greater assistance with more than two ADLs in order to qualify to receive either Level I or Level II PCS or CDPAS.
  - Require authorization by an Independent Assessor of hours in excess of a determined threshold to ensure the member can remain safely in the community.
  - Mandate that the review of Fair Hearing Officers be limited to whether plan process was followed and require that Fair Hearing Officers defer to the clinical determination of the plan's care management professionals or interdisciplinary care team

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Additional Long Term Care Proposals Submitted

- **Implement nursing home and ALP reforms to promote more efficient settings**
  - Mandate ALPs as part of the managed care benefit package for both MLTC and Mainstream managed care to give plans and consumers another option for serving persons who were nursing home eligible and/or in need of high hours of home/personal care.
  - Reduce nursing home rates for eligible ALP residents to encourage nursing home discharges to ALPs.
  - Restore the full long term nursing home benefit in partial capitation MLTC plans.
  - Allow MLTC plans to market and sell their plans to the private pay market, with a price to be determined by the plan and with Department of Financial Services approval.

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Pharmacy

Pharmacy Proposals

- **Full Carve Out of the Pharmacy Benefit from Managed Care to Fee-for-Service (FFS)** to achieve full transparency, administrative simplification and standardization and lower net pharmacy costs
- **Implement a Statewide Formulary/Preferred Drug Program** to leverages the States purchasing power and standardize the Medicaid formulary across FFS and Managed Care
- **Enhance Purchasing Power to Reduce Drug Costs**
  - Enable further savings from the Medicaid Drug Cap by pursuing deeper volume-based discounts or alternative payment arrangements for super high cost drugs (e.g., new gene therapies) and require manufacturers to disclose pricing information to level the playing field in price negotiations
- **Limit Coverage of Over the Counter (OTC) Drugs** to no longer reimburse for certain lower cost OTCs.
- **Eliminate Prescriber Prevails** to reduce the use of higher cost and sometimes lower value medications.

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Transportation

Transportation Proposals

- **Increase the overall efficiency, quality and access for non-emergency medicaid transportation by:**
  - Transitioning to a Medicaid Transportation Broker
  - Carving transportation out of the MLTC Benefit (excluding PACE)
  - Maximizing Public Transit in New York City and other urban areas
  - Reducing Taxi/Livery Rates and promoting other modes of transportation
  - Implementing an ambulance diversion - Triage, Treat and Transport (ET3) - support program to reduce avoidable hospitalizations
  - Exploring a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities

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Program Integrity

Program Integrity Proposals

- **Ensure use of Third Party Health Insurance (TPHI) where available**
  - Identify TPHI for MCO members at the point of enrollment or prior authorization to ensure Medicaid remains the payer of last resort
  - Prohibit denials of TPHI claims due to lack of prior authorization
  - Establish a Medicaid Prompt Payment Standard requiring carriers to respond to a request for payment within 60 days of receiving the request, with an uncontestable obligation to pay after 120 days

Program Integrity Proposals Continued…

- **Modernize Program Integrity Statutes and Regulations**
  - Expand ability to impose monetary penalties on Plans for actions contributing to waste, fraud and abuse
  - Require Home Health Aides, PCAs, and CDPAP personal assistants to obtain a unique identifier to be used on Medicaid claims
  - Strengthen self-disclosure requirements related to overpayments
  - Enforce requirement for providers to bill Medicare first for dual eligibles

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Program Integrity Proposals Continued…

- **Support Improvements to County Administration**
  - Improve fraud referrals between NY State of Health and local districts
  - Provide greater oversight over Pooled Trusts
  - Provide reimbursement to counties for eligibility verification contracts
  - Maximize use of Veteran Affairs Benefits
  - Accelerate State takeover of all Medicaid administration

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Program Integrity Proposals Continued…

- **Partner with Counties to Implement Existing Program Integrity Efforts**
  - Estate for Medicaid Recoveries
  - Identify Medicaid populations who may be eligible for the Medicare Savings Program (MSP) but are not currently enrolled
  - Enhance the Asset Verification System to include local banks

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Healthcare-related Revenue

Healthcare-related Revenue Proposals

- **Raise healthcare -related revenue to help reach the $2.5 billion target**
  - Utilize the existing “for-profit” insurance tax structure and increase the tax from 1.75% to 3.00% of premiums; use additional assessment funding to finance State spending for Medicaid
  - Implement insurance plan profit caps and/or more stringent medical loss ratio (MLR) requirements to generate increased revenue to the State
  - Implement a State-level Individual mandate in place of the federal ACA mandate that was repealed in 2019 and use additional revenue to support insurance premium tax credits and to finance State spending on Medicaid
- **Alternatively, proposals were received opposing any increase in health care taxes**

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

General Savings Action Proposals

General Savings Proposals

- Increase the 1% across-the-board FY 20 Budget action if necessary to achieve the $2.5 billion MRT II target

Healthcare Workforce

Healthcare Workforce Proposals – Scope of Practice

- **Modernize scope of practice and other workforce related statutes, regulations and administrative barriers**
  - Authorize emergency medical technicians to provide services in non-emergency situations
  - 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
  - Address licensure rules and scope of practice limitations for certain Behavioral Health licensed providers
  - Allow hospice in Assisted Living Programs
  - Make permanent provisions to the Nurse Practitioner Modernization Act which sunsets in 2021 including physician collaborative agreement requirement
  - Adopt the Health Services Executive (HSE) License standard in NY for nursing home, assisted living and home and community based service agencies

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Healthcare Workforce Proposals – Training and Support

- **Advance workforce training and support initiatives to address workforce shortages**
  - Evaluate, promote and improve training and support programs for direct care workforce, Certified Nurse Assistants, Home Health Aides, Personal Care Aides, Health Home Care Managers.
  - Explore potential opportunities for loan forgiveness programs
- **Enhance healthcare workforce flexibility** by offering greater reciprocity to out of state but nationally credentialed professionals
- **Develop a universal worker training program** for direct care workers and establish Pilot Regional Training Centers

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Health Information Technology (HIT)

Health Information Technology Proposals

- **Expand the utilization of telehealth services**
  - Explore a state-wide, hosted Telehealth platform to reduce interoperability barriers
  - Expand telehealth models, especially to address behavioral health, oral health, maternity care and high-need populations
  - Explore increases to telehealth reimbursement to encourage payor and provider participation
  - Enhance broadband for telehealth to ensure connectivity in rural areas and among all provider types, including specialists

PROPOSALS SHOWN ARE NEITHER ENDORSED NOR OPPOSED BY THE EXECUTIVE

Health Information Technology Proposals Continued…

- **Modernize Medicaid data technology and expand access to data**
  - Integrate claims and clinical data
  - Modify protocols and approval process that govern data exchange
  - Expand access to SHIN-NY / QEs
  - Facilitate patient data-sharing consent process to promote data exchange
  - Conduct comprehensive review of NYS Health IT Infrastructure to drive efficiencies

Social Determinants of Health

Social Determinants of Health (SDOH) Proposals

- **Create regional Social Determinant of Health Networks (SDHN).**
  - Create a single point of contracting for SDH services
  - Establish a regional referral network with multiple CBOs and health systems
  - Utilize a state-wide IT platform to coordinate a regional referral network
  - Assess Medicaid members for the key State-selected SDH social risk factors (using a State-selected assessment tool) and make appropriate referrals based on need
- **Standardize SDH screening** to identify unmet resource needs and establish an SDH quality measure
- **Expand access to medical respite programs** to address those without stable housing needing medical care which does not meet inpatient hospital level of care need
- **Authorize medically tailored meals as a Medicaid benefit**
- **Permit Level 1 VBP contracts for SDOH to count as "Other Medical" costs on the Plan Cost Report**

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Next Steps

MRT Member Feedback

- Member feedback is being incorporated into the process in several ways:
  - Facilitated discussion
  - Submission of comments in writing to the MRT
  - Solicitation of member feedback
- In addition, MRT members will be asked to rate key proposals which will help inform the final package of proposals to be voted on by the MRT.