County Recommendations to the MRT II for Medicaid Cost Containment

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Honorable Members of the Medicaid Redesign Team II:

On behalf of New York County Governments, which administer and fund nearly $8 billion of the Medicaid program in the State of New York, we offer the following cost saving recommendations for your consideration.

Sincerely,

John F. Marren, NYSAC President

1. New York City & NYS Comptroller Recommendations
   a. Reconciling State Health Exchange and LDSS clients to identify recipients residing out of state while still using their New York benefits;
   b. Identify duplicate cases in LDSS Medicaid client population;
   c. End Capitation Payments to the Deceased: identify previously unreported cases where capitation payments were made to plans after the reported date of death and recover;
   d. Identifying Medicare and mainstream care managed care overlap;
   e. Identify State Health Exchange and third-party insurance overlap;
   f. Identify cases of excess wages for household members who are not applying but whose income is required to be included;
   g. Identifying duplicate coverage across the state;
   h. Include additional edits in the State Health Exchange and WMS systems to ensure fee-for-service payments cannot be made to a client in a Managed Long-Term Care plan; and
   i. Work with the DOH contractor Health Management Systems to amend data-sharing agreements with third-party insurers to require more frequent insurance updates, such as weekly updates across all insurance providers to allow for more timely removals from Medicaid.

2. Modify Look-Back Rules in Long Term Care

In recognition of our aging population and the dramatic rise in long term care costs, the state should consider harmonizing income and asset look-back rules across all long-term care programs.
3. Review Spousal Refusal

The state should once again have a dialogue about the impact of “spousal refusal” cases, as this population has found a way to “buy” health care coverage at the Medicaid rate, something that no one else can do. Only New York and Florida allow this practice to occur. If spousal refusal cannot be eliminated the state should consider Community Spouse Income or Resource Allowance.

NYS adopted amongst the highest allowances permissible under Federal law for both categories. This is not consistent with how other states implemented their Medicaid programs. A reduction in the resource allowance would not be an undue hardship for community spouses and would result in considerable Medicaid savings. A third option would be to allow counties to enter into a spousal refusal demonstration program where counties could retain one-third of any recoveries.

4. Re-Institute Expanded Definition of Estate for Medicaid Recoveries

Re-institute the expansion of “estate” for Medicaid recoveries. The Governor expanded the definition, which would have brought in Medicaid cost savings through recipient joint bank accounts and other means, which currently pass outside the “estate” and are not recovered by Medicaid.

5. Re-Evaluate Assets in the Eligibility Process

There are too many exemptions to assets that allow applicants of significant means to become eligible for Medicaid. This should include lower asset thresholds when determining eligibility; require applicants to provide marital status to see if third party insurance is available; and re-evaluate countable income including child support, alimony and unemployment.

6. Make Long-Term Care Insurance More Affordable

We should be working to incentivize more individuals to acquire long term care insurance and at a much earlier age. The state should consider redirecting savings from the Governor’s proposal to cap the income threshold for the long-term care tax credit to individuals on the lower end of the income scale to improve the affordability of long-term care insurance. Serious consideration should be given to the NYS Long Term Care Compact, a program initiated by the NYS Bar Association Elder Law Section.

7. Lower Prescription Drug Costs, Especially Voluntary Reimportation Programs

Counties support the expanded use of generic medications in the Medicaid program, maximizing rebates, and proposals to incentivize voluntary reimportation of prescription drugs when medically appropriate. An efficiency in this area would be for any provider to take the “spenddown” on client’s cases, this would stop the unnecessary communication with the local districts and deliver health care in a more-timely fashion with the audit trail in place. In terms of reimportation, some counties have utilized reimportation (CanRx) prescription drug plans on a voluntary basis with their employees and are saving millions of dollars annually as a result.
8. Expand the Use of Telemedicine Opportunities by Utilizing Emergency Medicine Triage

While the State has made big strides in reducing unnecessary emergency room use, New York still falls in the bottom quartile in this regard. Counties support expanding the use of telemedicine in the Medicaid population to further reduce unnecessary emergency room use. This can be achieved by educating Medicaid recipients about the availability of this technology to help with their care management, and the state should consider mandating that managed care plans implement a robust telemedicine plan.

New York State should amend the coverage of telehealth services to include Emergency Medicine Triage. Medicaid managed care plans and county governments should be encouraged through fiscal incentives to implement Emergency Medicine Triage systems for Medicaid recipients. Similarly, New York State should encourage the use of Emergency Medicine Triage for fee-for-service Medicaid recipients.

Emergency Medicine Triage is defined as telehealth communications through a program that includes emergency medicine providers, 911 dispatch, certified emergency medical technicians, and patients for the purpose of triaging a patient’s level of severity and appropriate next steps of care when an acute medical problem arises. This can include assessment, diagnosis, e-prescribing medication, and referral for diagnostic testing or treatment, often without transporting the patient to the hospital emergency room.

Rensselaer County has implemented such a program and is seeing significant ER diversions on top of the DSRIP efforts to do the same. The Rensselaer program, done in partnership with CDPHP and United Concierge Medicine, has successfully diverted 97 percent of its calls so far from an emergency room visit.

Taken statewide, the developers of this plan think it could save between $150 million and $200 million.

9. Review Medicaid Non-Emergency Transportation Models

Since the State took over control of Medicaid transportation services the system has generated efficiencies and reduced costs in some key areas, but there are pockets across the state where costs have increased dramatically, with some counties reporting increases approaching 1000 percent. The state should look to reconfigure transportation plans in the areas experiencing higher costs under the state-controlled model by incentivizing mixed rides, mass transit solutions and even considering waiving freedom of choice, if it has not already been done. A review of all county mass transit routes should be undertaken and find a way to use these routes for the Medicaid population instead of the individual taxi services.

10. Review of CDPAP Rates Among the Different State Agencies (OPWDD) and how this Program has Changed our Landscape of Homecare

The State should review MLTC rates and actual expenditures to see if clients should be in fee-for-service. Expand the number of edits in the state’s billing and eligibility system to ensure multiple providers cannot receive reimbursement for the same service. In this discussion, having an active role in the high user cases and see where we can all partner because many times these same clients are being served in our county “homeless” programs. We should be looking at outcomes aiming for stable health and housing.
11. Enhance County Medicaid Audit Authority

County audit authority under Medicaid has been substantially diminished, and only a few counties are actively conducting audits. The Office of Medicaid Inspector General has achieved significant recoveries, but audits for counties have become so narrow in focus that they can achieve very little in savings. Any review on the recipient side has been halted in recent years as the state has directed the focus to other areas. Local DSS have not been asked for, nor received any potential fraud referrals from the State Exchange to investigate, to knock on client doors and verify information. Counties look to work with the state to rebuild our authority to pursue Medicaid audits on a larger scale, informed by what we are seeing in our communities. The HMS Estate and Casualty Medicaid Recovery Project needs to be reviewed and actively partnered within the local districts. We also recommend that counties be able to retain 20 percent of all Medicaid recoveries. Currently, only New York City is granted this recovery authority.

12. Reassess Third Party Health Insurance Reviews to Limit Duplicate Reimbursements

The reimbursement of third-party health insurance premiums needs to be reassessed. The original ideas and current practices have drifted apart, and we now see cases where we are paying for family coverage where the original covered person lives apart from the family.

13. Eliminate Medical Per Diem for Foster Children in Managed Care

The state requires that all foster care children, even those in residential placements, to be in Medicaid managed care which was then supposed to eliminate medical per diem. The system now places all foster care children into managed care and still provides a medical per diem. This should be revisited.

14. Maximize Veteran’s Health Care Coverage for Those that are Eligible

The state should expand its efforts to ensure other federal programs’ coverage of health costs is maximized, especially among our veterans. The federal government provides extensive health care benefits to veterans and we need to ensure they are fully accessing these health benefits in the first instance. Targeting state and county veteran’s resources and boosting education and enrollment in veteran’s programs should be maximized.

15. Complete the State Takeover of Local Medicaid Administrative Functions

Counties continue to support the full takeover of the administration of the Medicaid program. Local districts have years of experience and stand ready to assist to complete this effort.

16. Eliminate the Spend Down Program and the Need to Issue Refunds/Credits

Non-Modified Adjusted Gross Income rules allow individuals with income over the State standards to become Medicaid eligible if they agree to meeting a monthly spend down. Without agreeing to the spend down, they would not be eligible for Medicaid. Annually, county Medicaid staff have to determine if a credit or a refund needs to be issued to individuals who pay in more than the amount of services they utilize during a given year. (NOTE: Private Insurance companies do not reimburse clients who underutilize services).
17. Consider a Sliding Fee Scale or Monthly Fee for Medicaid Services, in Targeted Circumstances, Similar to the way Child Health Plus works.

18. Charge a Premium for Individuals Eligible for Medicaid Buy-in Working People with Disabilities (MBI-WPD)

This was part of the original State plan, but the premium has been waived since the inception of the program.

19. Eliminate Allowance to use Debit Cards on Supplemental Needs Trusts (SNTs)

SNT’s allow individuals with excess resources and/or income to qualify for Medicaid. Debit cards allow income to be sheltered, but it is still readily available to the client.

20. Provide Greater Oversight on the use of Pooled Trust and Supplemental Needs Trust Funds

Too often these trusts are being used to circumvent the Medicaid income and resource eligibility standards, but basically being used as personal checking accounts for the families of beneficiaries rather than for qualified, “quality of life” purchases for the sole or primary benefit of the disabled individual.

21. Rescind the State Directive not to Pursue Self-Employed Income Attestation

For self-employed individuals, we overwhelmingly found that income reported on tax returns did not match their actual earned income making them ineligible.

22. End the practice of the New York State Health Exchange Allowing Medicaid MAGI (under 65, non-disabled) Applicants to Simply Attest to their Income

23. Amend Civil Practice Law and Rules (CPLR)

Amend the CPLR to provide that personal injury actions cannot move forward until the plaintiff’s attorney has filed proof that HMS/LDSS/DOH has been notified of pending action. Counties lose out on the opportunity to recover some of the settlement costs.

24. Require Fraud and Tamper-Resistant Sign-In and Sign-Out for Providers who are in the Consumer Directed Personal Care Assistance Program

Additional authority in this area should prevent abuse within the system, as counties have found under further examination that there are cases where Medicaid was billed for services never provided.
25. Reject Promissory Notes to Family Members as an Approved Emergency Medicaid Planning Device

The use of promissory notes as a planning device to qualify for long term care services when a person with resources and income over the maximums allowed has been found to be unsupported by law. This kind of promissory note planning shortly before applying for long term coverage is a “purposeful attempt to thwart the Medicaid Statute’s eligibility requirements.” Landy v. Velez, 958 F. Supp. 2d 545, 557 (D.N.J. 2013).

26. Expand Medicaid Estate Recovery under Social Services Law 369 to Include Community Medicaid

Currently, just eligible for long term care community-based services and skilled nursing facility care.

27. Speak with Medicaid Examiners across the State for input into the AVS system

Local banks are not included in the search options.

28. Reassess Managed Long-Term Care Practices

a. Evaluate the Conflict Free Evaluation Enrollment Center (CFEEC) as counties have seen clients with no score or a score of 3 being admitted into a MLTCP.

b. Turn edits on in the MLTCP so Fee-For-Service bills cannot be generated.

c. Review of all MLTCP cases and determine if more cost effective in Fee-For-Service instead of the MLTCP.

29. Invest $20 Million in Funding to Address Growing Wait Lists Identified by Area Agency on Aging

We estimate this investment could result in Medicaid savings to the state of $60 million. This is similar to a proposal advanced and funded by the State last year.

The Area Agencies on Aging have reported an additional 9,200 older New Yorkers are eligible and awaiting community-based services in the following categories: personal care levels I & II, home delivered meals, case management, nutrition counseling, transportation, legal assistance, personal emergency response systems, home modifications and minor home repairs.

After reviewing more than 2,000 individual case files of those older adults who were awaiting services but were not receiving them from 2017-2019, 10 percent went directly to a skilled nursing facility and 6 percent went to community Medicaid/MLTC. Due to the incomes of this population along with their daily functional limitations, most, if not all, would spend down to Medicaid almost immediately, costing the state hundreds of millions of dollars.

The continued state investment in addressing these unmet needs has a net positive savings in the state Medicaid Program, while assuring a policy that doesn’t require individuals to impoverish themselves in order to get the care they need.