NYS Strategic Health Equity Reform Payment Arrangements - Comments

May 18, 2022

NYLAG submits comments on the draft NYS Strategic Health Equity Reform Payment Arrangements proposal, focusing on two of the goals expressed – rebalancing long term care services to maximize community-based opportunities and reducing racial disparities in health care, with an emphasis on long term care. NYLAG concurs with the comments of Medicaid Matters NY and The Legal Aid Society and does not repeat those here. NYLAG supports the funding for Medical Respite programs and for low-income housing opportunities that would enable individuals in institutions to live in the community. NYLAG also recognizes the need to shore up safety net providers. We echo the comments of The Legal Aid Society to stress that better oversight and accountability of Managed Long Term Care plans is a necessary first step in preventing unnecessary institutionalization. We focus these comments on the need for more funding to *prevent* permanent placement in nursing homes, and to improve data to track racial disparities in long term care services and to better monitor rebalancing efforts.

I. In Addition to Expanding New Housing Opportunities, Goal 2 Should Also Invest in Preventing a Short-Term Nursing Home Stay from Becoming Permanent

While we support expansion of affordable housing opportunities and creation of alternatives for institutionalized populations in Goal 2, the proposal should also include initiatives to prevent institutionalization in the first place, and to ensure that those who DO have housing can return home, with the goal of minimizing the number of short-term stays that become permanent institutional placements. According to the AARP LTSS Scorecard, New York ranks 43rd in the percentage of short-stay residents who were successfully discharged to the community.[1] The carve-out of long-term nursing home care from the MLTC benefit package, implemented at the height of the pandemic in 2020, has resulted in 20,000 MLTC members being disenrolled from their plans, making it far less likely that they will be able to access Medicaid home care services need to return home. On an ongoing basis, once an MLTC member is in a nursing home for 3 months, they may be disenrolled from the MLTC plan. Once disenrolled, the consumer must start over in applying for services, adding new barriers to returning home. It is ironic that the proposal would target those who have been in an institution for 90 days, for enhanced engagement to explore housing alternatives – when some of these very individuals are people who are disenrolled under the long-term nursing home stay basis for disenrollment. This can occur even for those who have housing that they could return to if community-based long term care services were reinstated or increased.

The master plan for assuring the availability of sufficient long-term services and supports and accessible health care capacity to enable aging in place must include elements to prevent permanent placement. Some of these could be made part of the proposed Enhanced Supportive Housing Initiative services.

[1] *Long-Term Services and Supports State Scorecard New York*, AARP, The Commonwealth Fund, last accessed May 14, 2021, https://www.longtermscorecard.org/databystate/state?state=NY

We recommend the following elements to prevent permanent placement.

A. The Waiver Should Test Payment Mechanisms to Incentivize Timely Provision of HCBS to Avoid Permanent Nursing Home Placement or Enable Return to the Community after a Short-Term Stay

This waiver is an opportunity to test alternate payment mechanisms in the MLTC program to improve the State's rebalancing efforts, which are necessary not only to comply with Olmstead but also to protect vulnerable individuals from the higher risk of contracting COVID in institutions. The state is well informed from MMCOR and other data that several MLTC plans that closed – such as Independence Care Systems (ICS) and Guildnet – tended to authorize higher hours of home care services, and consequently had fewer members in nursing homes than many other plans. See Appendix A. These plans closed in large part because the capitation rate structure, notwithstanding some risk adjustment, did not make it sustainable to provide the necessary amount of home care services for those consumers with extremely high needs, which for ICS were disproportionately people with severe physical disabilities such as quadriplegia, ALS, Parkinson's disease, and similar diagnoses. This waiver is an opportunity to test risk containment methods such as a community-based rate cell or a stop loss mechanism that would mitigate the plan's risk for authorizing high-cost services for those whose needs meet certain benchmark criteria that could be identified through a stakeholder workgroup. Appendix A shows how few members receive more than 480 hours/month of home care – even in ICS and other plans that tend to authorize higher hours. If even ICS authorized more than 480 hours/month for fewer than 6% of its members, then it is clear these members are outliers to the general MLTC population, and a rate cell or other alternate funding mechanism would not break the bank – but would surely help NYS's efforts to keep people out of nursing homes.

Private Duty Nursing – Improved Tracking and Rate Adjustments. Many individuals at risk of institutionalization need Private Duty Nursing (PDN) because of skilled needs, which is even more costly to the plan than personal care or CDPAP. The recently enacted Medically Fragile PDN rates will not improve access to this service for consumers who must be in MLTC or mainstream plans as this program is only for those in FFS. Carving out PDN services from the benefit package or creating a stop loss mechanism for members determined to need PDN services above a benchmark number of hours per week, could be established. Such mechanisms could ensure that the rate paid for PDN in MLTC or MMC plans is the same as the enhanced rate just approved in the State budget for FFS. The State would have ways of tracking use of these mechanisms to ensure they are not mis-used. The waiver could track should track the effectiveness in the above payment mechanisms for reducing institutionalization – both enabling consumers to return home from nursing homes and preventing their placement in the first place.

We note that the MMCOR Reports do not adequately track the extent to which plans authorize Private Duty Nursing. This service is reported as part of "Home Health Care" services, which is broadly defined to include "therapeutic and preventive nursing services, private duty nursing, home health aide services and rehabilitation therapies [and]… pharmaceutical costs for IV therapies."[2] Home Health aide and Private duty nursing services

[2] DOH MMCOR instructions on file with NYLAG. The definition has remained the same since at least 2010, comparing 2021 instructions.

are comparable to PCS and CDPAP in that they are authorized for regular shifts under a plan of care that can be up to 168 hours/week. In contrast, therapeutic and preventive nursing services and rehabilitation therapies are measured by the visit. This overbroad category should be redefined to track private duty nursing services separately by the hour, as is done for CDPAP and PCS.

MLTC Quality Incentives for Enrolling New Members who have been in Nursing Homes and for preventing current members from being disenrolled for a Long Term Nursing Home Stay (LTNHS). The current MLTC Quality Incentives are largely based on data in the Community Health Assessments, which means plans are rewarded for the functional *needs* of their members but not for how the plans meet those needs.[3] Plans should have a quality incentive to meet a benchmark for the number of members who return home from a short-term nursing home placement with HCBS, and for the number of new members who enroll in the plan from an institutional setting. They should be incentivized NOT to have members disenrolled for LTNHS.

MLTC Quality Incentives should penalize High Reversal Rates on Appeal. Additionally, plans whose denials of services or increased services are reversed at a rate above a benchmark, whether in a fair hearing or External Appeal, should face an adverse consequence. Similarly, plans that delay processing a request for a new or increased service beyond the regulatory time limit should be penalized. The waiver should experiment with adjustments to the capitation formulas that would counter the disincentive that MLTC plans have to authorizing high-cost home care for those who need it.

Data must also be developed, included in the plans' MMCOR reports, and made publicly available to track the factors that limit access to HCBS and lead to preventable institutionalization. For example, the processing times for a request to an MLTC plan for increased home care services is not reported anywhere. The rate of plan approvals, denials, and terminations for HCBS services, and appeals and grievance data, are also key measures for identifying barriers to access. MMCOR data now reported for numbers of members in a nursing home by length of stay should also include number of disenrollments for long-term nursing home stay (LTNHS). This could be included in the same table in which the plan reports the reason for discharge after a nursing home stay, in which the sole options are "death" or "Other." "Other" should be broken down to track the number who return to the community, the number who are disenrolled, and the number who are hospitalized.

Now, there is NO public reporting of plan reversal rates, or delays in processing requests for home care services, or increases in those services. The existing state reports to CMS for the 1115 waiver only report the numbers of internal MLTC Plan appeals, with no data on MLTC fair hearings or External Appeals before the NYS Dept. of Financial Services.[4] The lack of fair hearing data is particularly noticeable because there is some

[3] NYS DOH MRT Demonstration Section 1115 Quarterly Report and Annual Report, Demonstration Year 21; Federal Fiscal Quarter: 4 (7/01/2019 - 9/30/2019), Section VII, available at https://www.health.ny.gov/health_care/medicaid/redesign/reports/docs/2019_pp_annual_rpt.pdf, at p. 45.

[4] The annual 1115 waiver reports are available at https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm, click on dropdown for MRT 1115 Demonstration Annual Reports.

aggregated fair hearing data reported for mainstream plans, but not for MLTC plans. The 1115 Waiver requires that the report identifying the top 5 reasons for the hearings. The 2019 report fails to do that for the mainstream hearing stats, and as said above, there is NO reporting of MLTC hearing stats. p.43. [5] Plans have every incentive to delay approving an increase because of capitation, even if they know that the consumer will win a hearing or external appeal. That win can be months down the road and in the meantime the plan saves money. Plans must be accountable through quality incentives or sanctions for these delays.

B. DOH Should Incentivize Nursing Homes, Hospitals, and MCO's to File the Necessary Paperwork for Patients and Residents to Maintain their Income Needed to Pay Rent to Maintain their Homes, and Fund Community-based Organizations to Assist

Inevitably some of the "… total of 19,094 individuals living in a SNF [who] identified that they wanted to transition to the community in 2021" lost their homes because their income went to the nursing home, or because their SSI stopped, because the facility did not assist them with filing the paperwork with the local Medicaid program or Social Security Administration needed to maintain their income to pay rent. Both Medicaid and the SSI programs require an individual to proactively request that these agencies allow their income to continue so that they can pay their rent during a hospital or nursing home stay that is longer than a month. Otherwise, these agencies presume that the placement is permanent, and the nursing home automatically takes the individual's entire income to pay toward the cost of care, or the SSI check stops. NYLAG has helped hundreds of individuals whose income stopped, putting them at risk of eviction, because the nursing home or hospital failed to file simple paperwork described in an article at http://www.wnylc.com/health/entry/117/. A form for reporting a temporary placement for an SSI recipient can be downloaded as part of this fact sheet. http://www.wnylc.com/health/download/594/. These steps to prevent institutionalization should be mandated and incentives created to reward nursing homes, hospitals, and MCO's for taking these steps. Community-based organizations should be funded to help consumers navigate these complicated rules in order to retain their homes.

2. Data Collection Must be Improved and Publicly Reported to Track Racial Disparities in Long Term Care Services – State should Establish a Cross-Agency Task Force with Stakeholder Involvement To Develop a Long-Term Services and Supports Data Transparency Dashboard

While the proposal discusses a goal of improving data infrastructure and standardization of health data, there is no mention of improving the collection and public reporting of data to better track rebalancing efforts to provide long term care services in the community compared to institutions, and especially tracking racial disparities in long term care services. Funding from this waiver should be used as an opportunity for NYS to invest in

[5] The omission of Fair hearing data is significant. In 2016, Medicaid Matters NY issued a report on a study of all fair hearing decisions concerning reductions of hours of personal care and CDPAP services by MLTC plans over a 7-month period. See Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans, June-December 2015, available at https://tinyurl.com/MMNY-MLTC-FH-Report. The report identified striking differences between plans in terms of the number of fair hearings and their outcomes, and makes specific policy recommendations for better oversight and monitoring of plan activities. See Nina Bernstein, *Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients,* New York Times, July 20, 2016, available at https://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html?_r=0.

improving collection, analysis and public availability of data that is necessary to monitor success in reaching two of the main goals of the waiver – addressing racial disparities in health and long term care and rebalancing long term care to promote community-based alternatives to institutionalization. COVID-19 illuminated the ways these two goals intersect, with the disproportionate rate of COVID deaths in nursing homes that have a relatively high share of Black or Hispanic residents. As of Oct. 11, 2020, 73% of New York nursing homes with a relatively high share of Black residents reported one or more COVID-19 deaths, compared with 54% of nursing homes with a lower share of Black residents, and compared with 59% of all NYS nursing homes.[6] A similar gap was observed nationally and in some other states. Id. A 10% gap was evident comparing New York nursing homes with a relatively high share of Hispanic residents with facilities with a low share. Id. The state's proposal fails to mention these racial and ethnic patterns when it discusses the well-known fact that the highest death rates due to COVID were in nursing homes. Pp. 35-36.

Comprehensive and intersectional data collection and reporting is essential to advance equity in all health care, including long-term care. Without data, New York cannot identify disparities in access to and use of services that enable consumers to avoid institutionalization, determine how intersectional factors give rise to racial disparities, or develop strategies and policies to address those disparities. New York should follow the lead of California and other states and use funding from this waiver to conduct a comprehensive Gap Analysis to identify who is receiving services and where, and to create a public Long-Term Services and Supports Data Transparency Dashboard. In order to do this, a cross-agency task force should be assembled, with stakeholder representation, to establish standards for uniform data collection and reporting to be used across agencies, plans, and local districts. Like many states, New York's home and community based services (HCBS) are administered by myriad programs run by different state agencies, with some administered by MLTC and managed care plans and others by local districts, waiver programs and other State agencies such as OPWDD or NYSOFA. This waiver is an opportunity to develop a data infrastructure that can be used across all of these programs. Data elements should support both identifying disparities in access to and use of specific HCBS and institutional long-term care programs and more broadly measuring how well individual HCBS programs and MLTC plans are advancing the state's goal of providing services in the least restrictive setting. Numerous recommendations for how the state can improve collection and transparent use of data to improve equity in HCBS can be found in a December 2021 report of the California Health Foundation.[7]

Minnesota is one state that has created an interactive LTSS Dashboard that tracks some race and ethnicity data in the various HCBS programs. See link at

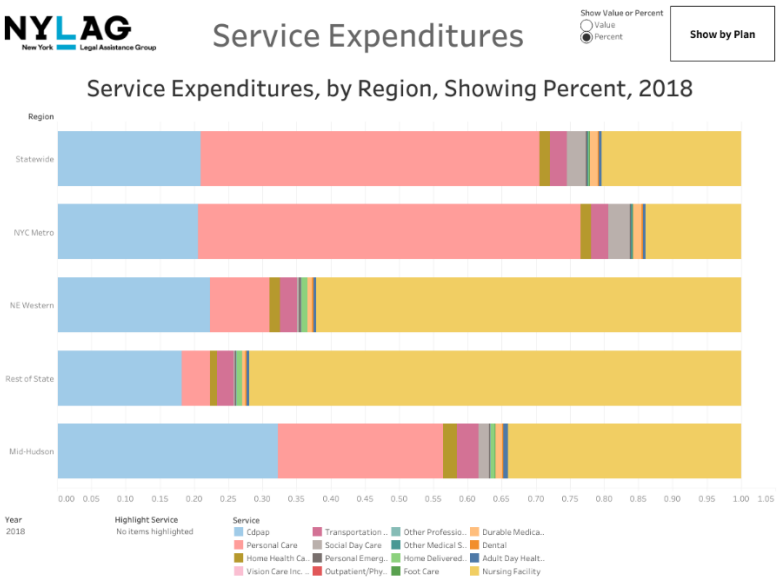
[6] Chidambaram, Neuman, et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, Kaiser Family Foundation, Oct. 27, 2020, available at https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/, last accessed May 14, 2022; see also Rebecca J. Gorges, *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US,* JAMA Network Open. 2021;4(2):e2037431. doi:10.1001/jamanetworkopen.2020.37431, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776102, last accessed May 14, 2022;

[7] Amber Christ and Tiffany Huyenh-Cho, *Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal,* California Health Foundation, Dec. 2021, available at https://www.chcf.org/wp-content/uploads/2021/11/UsingDataGoodHCBSMediCal.pdf, accessed May 14, 2021.

https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/public-planning-performance-reporting/performance-reports/demographic-dashboard/. On a statewide basis and for each county, the user may see the race, ethnicity, age, and language data for each of the various HCBS programs and the relative number receiving LTSS in an institution compared to in the community. The racial makeup of a particular HCBS program can be compared to the racial makeup of the overall population for the region. The dashboard is by no means perfect for complete. For example, there is no race and ethnicity data of the nursing home population, either statewide or by county. There is no tracking of rate of admissions to or discharges from nursing homes, by race and length of stay, or associating which HCBS program an individual was enrolled in either before or after a nursing home placement. As imperfect as Minnesota's dashboard is, it is still a model for New York to start, and funding from this waiver should be allocated toward its development. Many other data elements that should be tracked are described below.

This waiver is an opportunity to reconfigure MMCOR reports and make the data regularly available on the State's Open Data web site at https://data.ny.gov. The extensive data on members functional status and needs, now available stratified by plan, is only meaningful if it is accompanied by data about what services the plans are providing and to what extent. This data is contained in the MMCOR reports which are now only available by a Freedom of Information request, and then not in a format that enables comparison between plans, as we did in Appendix A. Moreover, as stated below, the MMCOR data should be expanded to stratify the data by race and ethnicity.

The little rebalancing data now reported in the 1115 reports is statewide aggregated data, which masks significant differences between regions and between plans. This data should be publicly reported regionally, and by plan for each region in which it operates. Plans already provide much of this data in MMCOR reports for each region in which they operate, and below we suggest ways that the MMCOR reports can be improved to track rebalancing indicators. The regional disparities in MLTC services are striking, as shown in the following table.



SOURCE: MMCOR Data 2018, on file with NYLAG.

We acknowledge that since 2015, when MLTC enrollment became mandatory for all dual eligibles in nursing homes, a plan may have members in nursing homes who had never sought to return home with home care; these members entered nursing homes on a fee for service basis and then were auto-assigned to an MLTC plan once Medicaid was approved. For this reason, a high percentage of members in nursing homes in the 2018 data above is not necessarily the plan's fault. From the 2019 DOH 1115 Report to CMS, however, it appears that only 2,392 members who were in nursing homes were auto-enrolled into an MLTC plan after they were permanently placed. This means that the MLTC plan did not place them into the nursing home, and did not necessarily deny home care services to them. However, this *is less than 20 percent* of 18,255 MLTC members who were reported to be in nursing homes at the end of Sept. 2019. Id. This leaves a big question over why the other 15,000 members were still in nursing homes. More reporting is needed to identify how many of those members who were permanently placed faced a barrier by the plan to returning home, such as a denial of increased or reinstatement of home care services needed to return home. Also, DOH can correlate the placement numbers with the results of MDS 3.0 Section Q questions to identify every resident's interest in talking to someone about the possibility of returning to the community. Investment in systems to regularly track this data should be a high priority for funds from this waiver. Since auto-assignment of nursing home residents to MLTC plans stopped in 2020, the plans will have a higher degree of responsibility for those members who are in nursing homes, and data is crucial to measure that performance.

A. Rebalancing Data Should be Expanded and Stratified by Race, Ethnicity and Age as well as by Plan

Data on "rebalancing efforts" that is now reported to CMS in NYS's annual 1115 Reports is inadequate in many ways, with notable absence of any breakdown by race, ethnicity, age, and no breakdown by plan. See n. 3. Given that the long-term care population is entirely composed of people of disabilities, breakdown by age distinguishing those under or over age 65 would shine a light on the younger disabled population verses the older population. The following table combines the MLTC Rebalancing data from the last three annual DOH 1115 reports for 2017, 2018, and 2019. See n. 3. Though the report is described as an annual report, it appears to report data only for one quarter of each year.[8]

Table 1. Rebalancing Efforts – excerpt from DOH 1115 Reports to CMS 2017-2019

Rebalancing Efforts	7/17-9/17	7/18-9/18	7/19-9/19
New Enrollees to the Plan from a nursing home transitioning to the community	527	955	279
Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	2,954	2,418	2,350
New Enrollees permanently placed in a nursing home who remain in a nursing home[9]	3,168	2,062	2,392

[8] This is 6.8% of all 267,301 enrollees in all types of MLTC plans in Sept. 2019, including MLTC, PACE, MAP, and FIDA. See per DOH enrollment statistics. See DOH Monthly Managed Care Enrollment Report, Sept. 2019, https://health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2019/docs/en09_19.xls.

[9] The wording of this item – only tracking "new" enrollees permanently placed in a nursing home who remain in a home – was apparently framed before the nursing home carve-out was implemented. There should no longer be any new enrollees permanently placed in a nursing home who remain in a nursing home. This data point should be

Rebalancing Efforts	7/17-9/17	7/18-9/18	7/19-9/19
Current plan enrollees who were in nursing homes as permanent placements at the end of the third quarter	15,216	16,732	18,255

Source: DOH 1115 Reports to CMS 2017-2019, see n. 5.

This waiver is an opportunity to strengthen data to track rebalancing efforts generally and by race and ethnicity. Each of the elements in the table above should be broken down by race, ethnicity, and age (to distinguish under 65 vs. 65+).

Whether in the 1115 Report or in the state's other MLTC Reports, all data should be publicly available by plan, for public accountability of each MLTC plan's rebalancing track record. Consumers have the right to know what the plan's track record is on rebalancing.

Additional data that should be tracked and publicly reported regularly would illuminate the racial disparities in long term care access. Examples include:

- The DOH proposal cites the States Minimum Data Set (MDS) as indicating that "…a total of 19,094 individuals living in a SNF identified that they wanted to transition to the community in 2021." This figure should be routinely publicly reported, stratified by race, ethnicity, and age (< 65 or age 65+), and by geographic region in the state.
- Data regarding the MLTC members disenrolled from their MLTC plans because of a long-term nursing home stay, which number more than 20,000 since August 2020 – should be posted regularly, stratified by race, ethnicity, and age (< 65 or age 65+), and listed by plan and by geographic region in the state.
- The number of nursing home residents who are enrolled in MLTC or MMC plans, with their current status with respect to how many have requested services from the plan to return home, with the data stratified by race, ethnicity, and age (< 65 or age 65+), and listed by plan and by geographic region in the state
- The number of nursing home residents who sought but were denied enrollment in an MLTC plan during the time period, again, stratified by race, ethnicity and age, and geographic region in the state
- The 1115 Report gives the number of "new enrollees permanently placed in a nursing home who remain in a nursing home " but it should also report the number of all MLTC enrollees, and not just "new" enrollees.

B. Task Force Should Establish a Set of Core Uniform Access and Utilization measures for all HCBS and long-term care programs, including MLTC and Mainstream Plans, Stratified by Race and Other Demographics

changed to capture the number of MLTC members who were disenrolled because of long-term nursing home placement.

Data must also be developed and made publicly available to track the factors that limit access to HCBS and lead to preventable institutionalization As said above, the processing time for a request to an MLTC plan for increased home care services, along with the rate of plan approvals, denials, and terminations for HCBS services, and appeals and grievance data, should all be stratified by race and ethnicity -- both for identifying disparities and barriers to access.

The State does make public extensive data about the functional and cognitive level of MLTC enrollees, drawn from the Community Health Assessments. This is posted on the Open Data website and published in annual reports to the legislature and consumer guides for MLTC. However, these sources say nothing about how each plan responded to those needs – what types and amounts of services did the plan provide. The data available from the CHA assessments should be stratified by race and other demographics, and then correlated with data on actual service authorization. Plans report the number of hours of home care authorized for members in MMCOR Reports in seven different ranges of hours, from lowest (< 79 hours/month) to highest (>700 hours/month). At this time, this data is not reported stratified by race or ethnicity, but it should be. For example, the Open Data site shows the percentage of MLTC enrollees who have dementia, but not how many of those with dementia identify as Black, and how many enrollees who have dementia are receiving HCBS compared to in nursing homes, again, stratified by race. Without intersecting data including both disability (in this example, dementia) and race, the state cannot determine whether MLTC plans are equitably serving Black people with dementia. This is potentially crucial information because older Black people are statistically twice as likely to have Alzheimer's as a disability compared to other racial groups.[10] This data should then be correlated with the MMCOR data to compare the number of Black people with dementia authorized for the highest amount of hours verse the number of whites.

All data must be public reported by plan and by region. Since the State has delegated to MLTC plans the authorization of community-based long term care services, tracking the patterns in these authorizations including racial disparities must be reported by plan, not on an aggregate basis. This is essential for transparency and accountability.

Thank you for the opportunity to comment on this proposal.

Sincerely,

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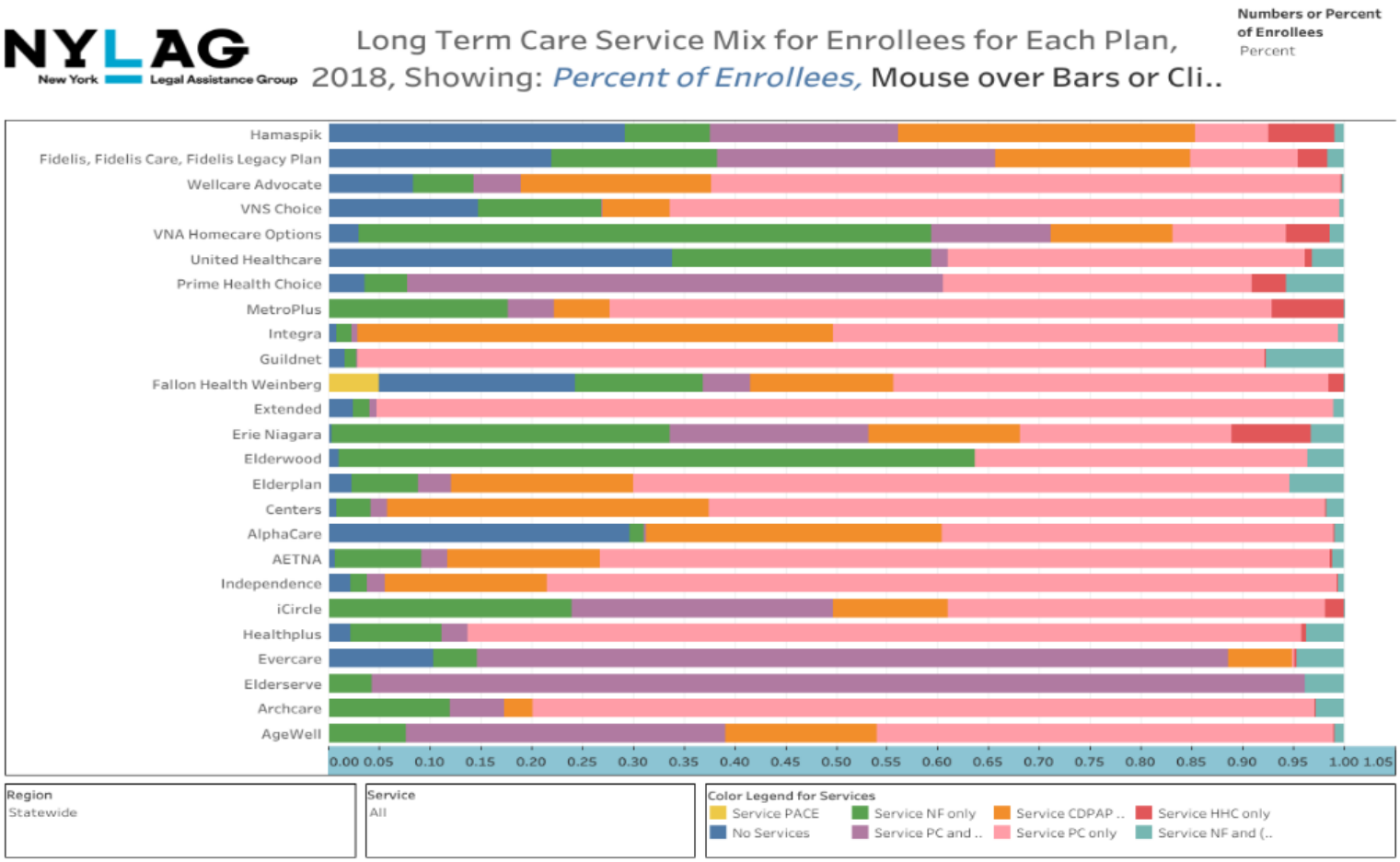
[10] 2022 Alzheimer's Disease Facts & Figures, Alzheimer's Association, available at https://alz-journals.onlinelibrary.wiley.com/doi/epdf/10.1002/alz.12638, p. 716, accessed May 14, 2022.

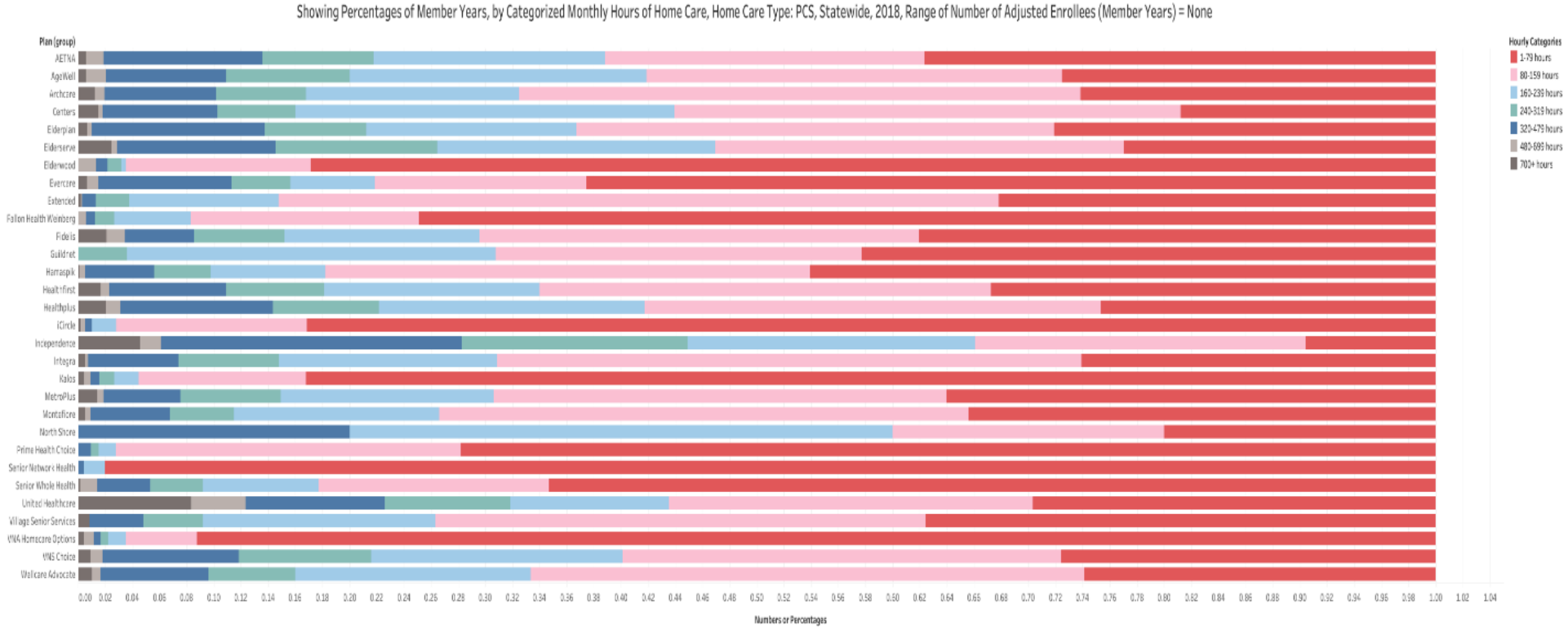
APPENDIX A



Source: MMCOR Data 2018, obtained by Freedom of Information request, on file with NYLAG. Table shows that Independence Care Systems and Guildnet had the lowest percentage of members receiving solely Nursing Facility services in 2018.

NYLAG
New York Legal Assistance Group

APPENDIX B



Data from 2018 MMCOR Data, on file with NYLAG. Independence Care Systems and United Health Care had highest percentage of member years with members authorized for the two highest ranges of hours -- over 400 hours/month.