

# VILLAGE CARE PUBLIC POLICY OBSERVER

News and Observation

FROM ALBANY, NEW YORK CITY AND WASHINGTON, D.C.

April 4, 2011

Volume 3, Issue 2

## Summary of FY 2012 State Budget Major Changes to Medicaid Approved

On Thursday, March 31, 2011, the New York State Legislature passed its first on-time budget since 2006. The \$132.5 billion budget, which reduces total spending by two percent, calls for significant cuts to Medicaid, school aid to local governments and the state university system, along with the layoff of 9,800 state employees unless public employee unions concede \$450 million in savings.

This budget is a major win for Governor Andrew Cuomo, who not only persuaded the Legislature to adopt most of his budget proposals, and to act on it before the April 1 deadline.

The Legislature was essentially “trapped” by sky high public approval ratings for the new Governor, along with the knowledge that if they had failed to negotiate a budget by April 1, they would have faced a government shutdown, or be forced to swallow the Governor’s entire budget unchanged as an emergency spending bill. New York has the largest state budget in the nation and is even larger than California’s.

New York’s 2011-2012 budget cuts more than \$1.3 billion from state aid to local school districts and reduces spending on the state’s Medicaid program by \$2.8 billion. All state agencies were required to absorb a 10 percent cut in state general funds, and there were mergers of a few state agencies. The current state budget deficit of \$9.3 billion was achieved almost entirely through cuts and keeps the Governor’s commitment to no new taxes. In addition, future budget deficits are drastically reduced through recurring spending reductions. For example, the FY 2012-2013 budget deficit estimate now falls from \$15 billion to \$2 billion, according to the Governor.

The budget was not passed unchallenged however. A large and outspoken group of advocates protested the various cuts to human services and education, and demanded the extension of the income tax surcharge for high-income New Yorkers. The grassroots Voices Of Community Activists & Leaders, or VOCAL, said in a press release: “Hundreds of people living with HIV/AIDS, students, seniors, and other New Yorkers camped out overnight to protest the austerity budget. We were forced to stay on the floor of meeting rooms in the concourse after being kicked out of the Capitol following the late night votes.” The New York Times noted the protests, saying “At times, the scramble to approve Mr. Cuomo’s budget on Wednesday seemed to be overshadowed by the chaos at the Capitol. In a last hurrah of sorts, hundreds of New Yorkers unhappy about cuts arrived and promised a Wisconsin-style sleepover, even if it seemed far too late for such an effort to matter.”

In the end, however, the Governor got most of what he wanted out of this budget. Inside are some of the details and their impact on health care and social services.

## Medicaid

The final changes to the State's Medicaid program were driven almost entirely by the recommendations that arose out of the Governor's appointed Medicaid Redesign Team. The MRT was charged by the Governor with finding both short-term and long-term cuts and structural improvements to the Medicaid program. In what has proven to be a masterful political move, the Governor managed to secure the active support of the traditionally most vocal opponents to cuts in health care through their engagement and participation in the MRT process.

One of the major changes to the Medicaid program is the enactment of an entirely new concept in the State's Medicaid program – a global spending cap, tied to medical inflation, that limits total growth in spending on the program. Growth in the amount of the cap in future years may not exceed the rate of growth in the CPI-medical services index, currently at about 4 percent. The final budget establishes a global Medicaid spending cap of about \$15.1 billion State funds (\$52.8 billion total dollars when local and federal monies are included) in FY 2011-12.

What happens if Medicaid growth exceeds the cap? The new budget gives the state budget director, in consultation with the health commissioner, the authority to develop and implement a Medicaid Savings Allocation Plan to close the gap.

## Nursing Homes

In an important concession to nursing home providers, the state has agreed to finally implement nursing home rate rebasing, which was supposed to have been enacted several years ago. The final approved plan is a consensus among the major nursing home associations, and includes three mechanisms that will mitigate losses to those facilities that would otherwise experience significant losses due to rebasing and some other provisions. Rebasing essentially resets nursing homes reimbursement rates from a 1983 base year (that has been periodically updated for inflation) to a 2009 base year. In order to take advantage of the enhanced federal Medicaid matching rates that expire on June 30, 2011, the agreement will pay out all positive impacts of rebasing before July 1.

However, nursing homes will receive no "trend factor" (increase in rates due to inflation) between April 1, 2011, and March 31, 2013. Just as other components of the Medicaid program, nursing facilities will be subject to a FY 2011-2012 two percent across-the-board cut in rates (part of global spending cap provision). But in lieu of a rate cut, the executive now has

the authority to find other means to achieve the same dollar savings and is working with associations to find alternatives to a simple rate cut.

The final enacted budget also grants the Executive the authority to implement an entirely new reimbursement methodology for nursing homes starting on October 1, 2011 (may be delayed until January 1, 2012 if necessary). A new statewide pricing methodology will be enacted, eliminating the current system of provider specific reimbursement rates. The goal of the new methodology is to create a statewide base reimbursement for nursing homes, which shall be adjusted for wage costs, the case-mix of patients, and "other factors as determined to be appropriate to recognize legitimate cost differentials".

## Home Care

Major changes have been enacted to the home health care system, many of which take effect immediately. Just as with nursing homes, Certified Home Health Agencies, Long-Term Home Health Care Programs, AIDS home care programs, personal care services programs and Assisted Living Programs would receive no trend factor between April 1, 2011, and March 31, 2013. These programs are also subject to the same two percent across-the-board cut that is part of the global spending cap for Medicaid.

For the next two years (April 1, 2011, through March 31, 2012), agency-specific Medicaid payment ceilings for CHHAs are established, based on the 2009 statewide average per patient Medicaid CHHA claims. Reductions in payments for those agencies that exceed the average per patient claim are effective immediately, April 1, 2011. Unfortunately, for special needs CHHAs, no adjustment or consideration is being given to those programs. This would include VillageCare's HIV special needs CHHA, which serves patients that have substantially higher-than-average claims. By the nature of our special needs license, we serve the more expensive, difficult to serve individuals. This is coupled by the elimination of the case mix adjustment for CHHAs that have received an increase to serve the needs of people living with AIDS. The impact of these changes on our own CHHA will exceed \$12 million.

The final adopted budget language also includes the creation of a CHHA episodic payment system, which has been proposed in past budgets but was never adopted until now. It was included in the MRT recommendations. Starting on April 1, 2012, through March 31, 2015, Medicaid payments to CHHAs will be based upon episodic payments covering 60-day episodes of care. These payments would be based upon a statewide base price that is then adjusted by a regional wage index and an individual case mix index. This approach is similar to the new statewide pricing meth-

odology for nursing homes, with one big exception – there is no exclusion or adjustment for special needs programs.

The noticeable absence of opposition from SEIU1199 to cuts in health care can be attributed to a major win and concession made to the unions as part of the final MRT package of “reforms.”

Starting on April 1, 2012, home health aides, personal care aides and home attendants will receive a living wage (to be phased in) as determined by local statute, with some adjustments (currently only New York City and Nassau, Suffolk and Westchester counties have such a law). Providers that receive Medicaid funding will have to provide these wages to their home aide workers and ensure that subcontracted agencies also pay a living wage to their home aide staff.

Perhaps the biggest area of debate and disagreement between the Executive and home health care providers was a proposal brought forth by the Medicaid Redesign Team, which was strongly supported by the Governor, which requires individuals over 21 in need of home health care services to be enrolled in Managed Long Term Care (MLTC) or other program models that “support coordination and integration of services” as determined by the state health commissioner. The original proposal required individuals to be enrolled in MLTCs if they needed 120 days or more of home health care, but the enacted budget language leaves that open to determination by health commissioner. Many CHHAs and Long-Term Home Health Care (also known as Lombardi) providers were concerned that this provision would effectively result in the end of these programs in favor of a new, insurance-based model of home health care. The final adopted language allows for LTHHC programs to be considered coordinated care plans, as long as they meet specific guidelines applicable to MLTC plans, including financial responsibility.

## Managed Care

The adopted budget would greatly expand the role of managed care in the State’s Medicaid system, as most exempt and excluded groups would be required to join a managed care plan. The auto-assignment grace period has been reduced from 60 to 30 days, which means beneficiaries will have a very short window in which to select a plan voluntarily before one is assigned to them. The benefit package in managed care will now also include personal care services.

## Pharmacy

In addition, as proposed by the MRT, the pharmacy benefit would now be included in the managed care plan’s capitation rate. For HIV special needs plans,

which by their nature have beneficiaries with expensive pharmacy claims, this will be a major change in policy and have significant financial implications. Exempt classes of drugs, such as HIV anti-retroviral medications and anti-psychotics, are no longer exempt from the preferred drug list and the “prescriber prevails” language has been stricken. This is intended to give the State more leverage in negotiating better rates for medications in the previously exempt class of drugs, but also now gives the state the authority to deny coverage for these medications. The Medicaid wrap around for Medicare Part D medications has also been eliminated, which could have serious consequences for those dually eligible. The budget also limits opioid prescriptions to four fills per 30 days.

## Other

- » The proposal in the MRT to eliminate “spousal refusal” was rejected in the final budget package.
- » The proposal to limit use of physical therapy, occupational therapy and speech therapy to no more than 20 visits per year was approved (except for children and the developmentally disabled).
- » In a move consistent with the federal Patient Protection and Affordable Care Act, the final budget allows the Department of Health to establish a voluntary multi-payer Patient-Centered Medical Home program. It will provide enhanced payments to clinics and clinicians certified as medical homes for the purpose of improving health care outcomes and efficiency through patient care continuity and coordination of health services. The program could also provide additional payments to medical homes that meet specified process or outcome standards and could test alternative payment methodologies. The budget also establishes a Medicaid Health Home Demonstration Program to provide integrated services for Medicaid enrollees with multiple chronic conditions. The budget also provides authorizing language for the creation of Accountable Care Organizations. The Centers for Medicare and Medicaid Services (CMS) has just release its Proposed Rule for Accountable Care Organizations (ACOs) pursuant to the Affordable Care Act.
- » One provision that was sought by Medicaid Matters was adopted: new language to require DOH to make federal Medicaid waiver requests and plan amendments public, including drafts.

## Social Services

- » The third installment of the 10 percent Public Assistance grant increase was delayed for one year to July 2012. This proposal was widely condemned by advocacy groups for the poor.
- » Elderly Pharmaceutical Insurance Coverage (EPIC) Program has been dramatically altered; starting on January 1, 2012, EPIC will only provide payment for drugs when an enrollee has entered into the Medicare Part D coverage gap. But the proposal by the Governor to eliminate EPIC support for Medicare premiums was rejected in the final package.
- » A number of proposed cuts were restored: Title XX funding to Senior Centers - \$34.6 M, Summer Youth Employment funding - \$15.5 M, and the final budget rejected the proposed Full Family Sanction of the children in sanctioned households receiving welfare - \$7.4 M. The proposal to eliminate state funding for senior centers had received widespread media coverage in New York; this proposal was rejected.

## Medical Malpractice

One of the biggest sticking points in the completion of the health care component of the state budget was the proposal to significantly reform the state's medical malpractice lawsuit system. The Governor, as part of the MRT, had proposed to curtail court award limits in cases of medical malpractice. While the State Senate, which is controlled by Republicans, had supported the Governor's language, the Assembly strongly rejected these proposals. The last few weeks of budget negotiations focused extensively on this issue. The final medical malpractice package contains a medical indemnity fund, coming out of an appropriation from the State's Health Care Reform Act (HCRA), to pay for future health and related costs of neurologically-impaired infants. The previously proposed cap on non-economic damages of \$250,000 was not included in the final budget, although the package includes mandatory settlement conferences, supervised by judges, early in the litigation process.

For more information,  
please contact:  
Matthew Lesieur  
Director of Public Policy  
154 Christopher Street  
New York, NY 10014  
matthewl@villagecare.org  
(212) 337-5601