

A review of New York State's Medicaid Super Waiver From a Safety-Net and Low-Income Community Perspective

Introduction

This is a beginning look at some of the pieces of the proposals in New York State's proposed Medicaid waiver amendment which has been submitted to the Center for Medicare and Medicaid Services (CMS). Reports from other organizations will focus on other programs featured in this waiver proposal.

CPHS posted a summary of the components of Medicaid waivers in six states which focus on the safety-net and the uninsured (www.cphsnyc.org/1115_Medicaid_Waiver_safety_net_support-7_17). The goal was to see how New York's proposed waiver compared to that of the six other states. From our perspective, although there are some good components, it does not rate well on these issues. The specific concerns that we have are discussed below. The one bright light in the New York proposal is the section on Public Hospital Innovation in which specific important programs are presented in detail, including: Emergency Department Care/Case Management; Post Acute Care Home Care; and Hot-Spotting Uninsured Patients(matching higher risk patients with tailored care teams. (http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf pg.45).

The proposals contained in the New York waiver are the result of a flawed process of the Medicaid Redesign Team, where the membership was limited, heavily providers, and not representative of the population. The time line for development of the proposals was limited; the second phase for planning was more inclusive but still limited and two major committees – long term care and payment reform – were co-chaired by people from those industries. The major exception to this was the Health Disparities Committee which was set up as a result of a major organizing effort by the Save Our Safety Net- Campaign (SOS-C) and Medicaid Matters (MMNY) that targeted at the lack of diversity in New York State's Medicaid Redesign Team (MRT) process and the recommendations' lack of focus on health disparities impact. NOTE: Throughout the waiver proposal, health disparities/equity words are used, but the actions proposed do not always address equity initiatives.

Although the waiver claims stakeholder involvement in the overall process, the public was given two minutes to speak at hearings making it very difficult to express issues or concerns. In the "consultation" phase for development of the waiver, the location for New York City's hearing was totally not accessible by public transportation, nor was the hearing room itself accessible. The Steering Committee of Medicaid Matters New York pushed for, and finally got, a meeting with Medicaid Director Jason Helgerson to

discuss the waiver. Subsequently, three papers were submitted that provided details on: regional health planning, definition of the safety net, and Medicaid pre-qualification. These papers were not incorporated. MMNY was involved in recruiting Medicaid beneficiaries for focus/discussion groups with Mr. Helgerson. This was very important, but it is difficult to see if anything that was raised at these groups was actually reflected in the waiver proposal. The stakeholders that were heard in this process, as noted by Helgerson **are**: Greater New York Hospital Association; Healthcare Association of New York State; Local 1199; PCDC and CHCANYS. These are not consumer/community groups – they do good things, but have a financial stake in what appears in the waiver.

In addition, a survey instrument was available on the MRT web site. Of the 659 respondents on this survey, only 119 were identified as patients or patient advocate, a mere 18.1%. 86.4% of the respondents identified themselves as White, clearly leaving out a large swath of New York residents. The questions on this survey were complex, using language not commonly understood by the public. Consumers who wrote comments about this survey received responses saying something to the effect that the Department only had a brief time to pull it together. This was a very unwelcoming exercise for even sophisticated advocates, so the ratings of priorities should be reviewed through that prism.

The stakeholder groups listed on page 12 for public reporting and engagement have a limited membership, again not representative of the population, particularly the Medicaid population.

Overview of Concerns

1. There are elements of this proposal that remind us of former 1115 waiver proposal. High on the list is the training component which accounts for \$500 million over 5 years. These proposals come directly from the Workforce Committee of the MRT which was chaired by the President of Local 1199. 25% of the first waiver (CHCCDP) funding of \$1.25 billion was allocated for training to prepare hospitals for managed care with an emphasis on primary care. A review of the use of these funds is available in a CPHS report - <http://www.cphsnyc.org/cphs/reports/chccdp/>. Some of the other funding from this waiver was spent in a questionable way. That waiver was also a “political” document which achieved approval during an election year.
2. Much of the funding in this proposal is directed toward hospitals rather than community-based care and community programs.

3. Although a very welcome focus, the safety net and VAP program initiatives are based on Recommendation #67 of the MRT. This recommendation, proposed by the President of the Greater New York Hospital Association, dangled funding in front of needed providers, but only if they agreed to close/merge/or restructure. The Health System Restructuring Brooklyn Workgroup of the MRT, used this premise to make flawed recommendations, based on some problematic data -- for example, to say there were too many hospital beds in the community -- the wrong denominator was used, for the financially vulnerable hospitals in North Central Brooklyn. But if there is a true recognition of the need for certain health care facilities, proposals for support should be made on that basis, not be contingent on a change in services – although changes can be made. The beneficiaries of these actions, particularly in New York City, are the Academic Medical Centers and large teaching hospitals which hope to gain more patients they can choose from if the safety net providers have to reduce their services. A better approach would be to revise the reimbursement methodology for Medicaid ensuring that high Medicaid usage hospitals are not penalized when there are reductions in reimbursement, and an allocation of DSH/charity care dollars based on high Medicaid and numbers of uninsured – so that the money follows the patient. There is an immediate need for defining the health care safety net, which we have proposed, so that funding does not get side tracked to facilities that don't meet that definition.
4. Although there is a strongly acknowledged need to expand primary care services in the state, not all elements of this program are addressed in this section. At least 2.3 million residents are considered to be underserved in their communities. The focus of spending proposals for primary care is capital expansion and technology (e.g., electronic medical records). Proposals for funding to operate the facilities, particularly for new or developing primary care centers, are dependent on start-up funds and for initial operations, but do not appear to meet the category of eligibility for funding. Four potential uses for these funds are identified: preserve services if hospitals close or are restructured; co-location of primary care in or near Emergency Rooms; integration of behavioral health into integrated system; and telemedicine expansion and sustainability.
5. Many of the public health innovation programs appear promising. However, the proposal for asthma is limited and disappointing. The focus is on indoor air rather than the larger world of triggers for asthmatic attacks. It is not family housekeeping alone that is at fault for asthma problems and many studies have pointed to outdoor air **and** environmental factors, but these are ignored in these proposals. Despite the huge numbers of people affected by asthma, the

proposed funding is limited to \$32.5 million of a total pot of \$395 million.

6. Although a welcome proposal, the details of regional health planning need to be more clearly delineated. A particular focus of the work of regional bodies, as is being done in Finger Lakes, is the focus on identifying and eliminating health care disparities.
7. In the Workforce Training section, (page 80), there is a recognition of the need for 450 additional full-time equivalent physicians. Funding is proposed to go to hospitals to help this to happen. Neglected in this discussion is the role of the medical schools in the state and their mostly abysmal record and interest in training primary care doctors. There is a study that addresses the poor showing of NY medical schools in meeting a social mission, which will be summarized in another report.

Prepared by the Commission on the Public's Health System (CPHS) for the Save Our Safety Net – Campaign (SOS-C).

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