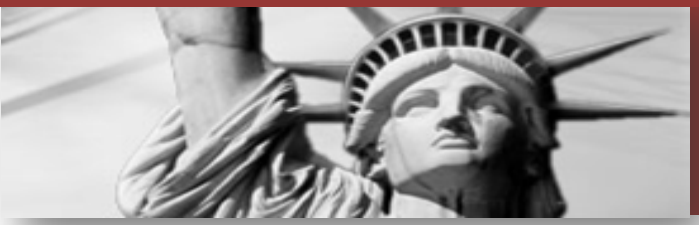

NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Program

Benefit Package Summary

August 31, 2011

Presentation Summary

- **The following areas will be discussed in this presentation:**
  - *MRT vision, guiding principles, and timeline*
  - *General coverage principles: amount, duration, scope of services*
  - *Mandated and optional services*
  - *Medicaid recipient co-payments*
  - *Medicare/Medicaid cost sharing*
  - *Population specific Medicaid programs*
  - *Primary care enhancements*
  - *Statewide Patient Centered Medical Home (PCMH)*
  - *Medicaid Waivers*
  - *New technology*

Vision

- New York Medicaid will have an evidence informed benefit package which promotes high quality, efficient, and effective services that improve health and health care outcomes for its members.
- A transparent, sustainable and iterative process to accomplish this will be created that is inclusive of internal and external stakeholders as well as content experts in health care benefit design, implementation, and evaluation.

Mission/Charge

- 1. Group will review current Medicaid benefits including an overview of coverage criteria (if any), copayments (if any), within Fee-for-Service (FFS) and Managed Care for specific suggestions regarding ways to develop and promote evidence informed, cost effective health care services within the parameter of overall budget neutrality for the Medicaid program.

Mission/Charge

- 2. Group will make specific suggestions regarding the creation of an effective, transparent, efficient, and evidence based/informed process for making future and on-going benefit decisions in response to new codes, new procedures, new technologies, and other advances in medical/behavioral knowledge regarding effectiveness and costs within the parameter of available resources in the Medicaid program.

Guiding Principles

- Transparency
- Empiric/evidence based
- Patient-centered
- Population health focus
- Focus on long term
- Be open to elimination as well as addition
- Consider impact of new delivery models and incentives

Guiding Principles

- Consider impact on
  - Workforce
  - Patient access
  - Health care disparities
  - Safety net institutions

Other Workgroups

- Long term care, behavioral health, disparities, payment/quality, eligibility, etc.
- Recommendations may have benefit design implications
- Benefit Design Workgroup will limit our attention in areas covered by other workgroups

Meeting Schedule

- 1st Meeting - Overview of NYS Medicaid Program and Potential Models for Benefit Redesign
- 2nd Meeting - Review of Specific Benefit Package Change Options and Collection of Ideas
- 3rd Meeting - Discussion and Development of Draft Recommendations
- 4th Meeting - Finalize Recommendations.

MRT Phase 2: Work Group Meetings

- NYC – NYS Department of Health Metropolitan Regional Office
  90 Church Street, 4th Floor, Conference Room A/B, Manhattan
  - *Wednesday, August 31, 10:30am – 3:00pm*
  - *Thursday, September 29, 10:30am – 3:00pm*

- Troy – NYS Department of Health Capital District Regional Office
  Frear Building, One Fulton Street, Saratoga Conference Room, Troy
  - *Tuesday, October 4, 10:30am – 3:00pm*
  - *Wednesday, October 19, 10:30am – 3:00pm*

General Medicaid Program Principles

General Coverage Principles Amount, Duration, and Scope

- Federal regulations require that the state plan specify the amount, duration, and scope of each service that it provides.
  - *Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.*
  - *The Medicaid program may place appropriate limits on a service based on criteria including:*
    - Medical necessity
    - Utilization control procedures

Encouragement of Provider Participation

- Federal regulation 42 CFR 447.204 requires that the Medicaid program's payments "be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."

Encouragement of Provider Participation

- Recent proposed changes to federal regulations will require State Medicaid programs to verify access to care by initiating a number of review steps, including:
  - *Submitting to CMS an "access review" demonstrating sufficient access to care any time payment rates are lowered or re-structured.*
  - *Submitting to CMS a full "access review" for each covered benefit at least once every five years.*
  - *Implementing ongoing mechanisms for beneficiary input on access to care through hotlines, surveys, ombudsmen, or other equivalent mechanisms.*

Mandated and Optional Services

Mandated/Optional Services

- Federal regulation 42 CFR Part 440 describes requirements and limits applicable to all Medicaid covered services.
- State Medicaid programs are required to provide designated "mandated" services to eligible recipients.
- "Optional" services may be provided by State Medicaid programs, but they are not required to do so.
  - ***The Medicaid state plan specifies which specific optional services are covered by the State.***

Mandated Services

Federally mandated services include:

- Inpatient hospital services;
- Outpatient hospital services;
- Rural health clinic and Federally Qualified Health Center services;
- Laboratory and X-ray services;
- Nurse practitioners' services;
- Nursing facility services;
- Home health services;
- Early and Periodic Screening, Diagnosis, and Treatment for individuals under age 21;
- Family planning services and supplies;
- Physicians' services and medical and surgical services of a dentist;
- Nurse-Midwife services.

Optional Services

Federally designated optional services include:

- Prescription/non-prescription drugs
- Free standing clinic (diagnostic and treatment center)
- Private Duty Nursing
- Psychological Services
- Transportation Services
- Physical/Occupational/Speech Therapy
- Dental
- Targeted Case Management
- Chiropractor , Hospice Care, Respiratory Care Services
- Emergency Services provided in non-Medicare participating Hospitals
- Diagnostic, screening, and preventive services

Optional Services

- Optometrists' services, including eyeglasses
- Prosthetic and Orthotic devices, including prescription shoes
- Hearing Aids
- Intermediate Care Facilities for individuals with MR/DD and related conditions
- Inpatient Psychiatric services for individuals under age 21 and those over age 65
- Nursing Facility Services for individuals under age 21
- Personal Care Services, Home Health Services
- PACE All Inclusive Care for the Elderly
- TB-related services
- Emergency services provided in non-Medicare participating Hospitals
- Hospice Care

NYS Medicaid Coverage

- NYS Medicaid covers all federally mandated services.
- NYS Medicaid covers all federally designated optional services, except for:
  - *Podiatry, Chiropractor, and*
  - *Services in Christian Science sanatoriums.*
- Managed care plans are required to cover all mandated and optional services available to fee-for-service recipients.
  - *Plans may cover additional services, e.g., podiatry, chiropractor, at their option.*

Coverage Exceptions

- **Recipients under age 21 – EPSDT**
  - Medicaid must cover all mandated and optional services for persons under age 21 years of age.
- **Qualified Medicare Beneficiaries – QMBs**
  - Medicaid must cover Medicare Part B coinsurance amounts (to the extent permitted under state law) for services provided to QMBs, even if those services are not covered by the Medicaid program.

Service Limits on Physical Therapy, Occupational Therapy, Speech Therapy

- MRT #34 imposes service limits on certain optional services – physical, occupational, and speech therapies provided by private practitioners and hosp outpatient departments/diagnostic and treatment centers.
- Effective October 1, 2011, Medicaid recipients will be entitled to 20 visits each of PT, OT, ST.
  - *This is a hard limit with no exceptions permitted.*
- Exempt recipients include:
  - *Developmentally disabled individuals (identified by the Office of People with Developmental Disabilities)*
  - *Recipients under age 21 (pursuant to federal EPSDT requirements)*
  - *Medicare/Medicaid dually eligible individuals*
  - *Individuals with traumatic brain injury (TBI)*

Service Limits on Physical Therapy, Occupational Therapy, Speech Therapy

- Exempt providers include:
  - *Hospital inpatient services*
  - *Skilled nursing facilities*
  - *PT/OT/Speech Therapy provided to homebound patients through a Certified Home Health Agency*
- CMS state plan approval is pending.

Medicaid Recipient Co-Payments

Co-Payments

- Federal regulation Part 447 grants authority for the Medicaid program to implement recipient cost sharing.
- Co-payment amounts may range from $.60 to $3.40, based on the average state payment for the service.
  - *If the average state payment is $10 or less, a $.60 co-payment may be charged.*
  - *If the average state payment is $50.01 or more, a $3.40 co-payment may be charged.*

Co-Payments

- To help control unnecessary/overutilization of services, Medicaid imposes recipient co-payments for certain services.
- Recipient co-payments were first implemented in 1992.
  - *A number of changes have been made to recipient co-payments over the years, including increasing the annual cap from $100 to $200, and increasing selected co-payments in accordance with the federal schedule.*

NYS Medicaid Co-Pays

- Co-payments and associated dollar amounts apply to the following services:
  - *Clinic - $3.00*
  - *Brand name drug - $3.00*
  - *Generic and Preferred Brand Name Drug - $1.00*
  - *OTC - $0.50*
  - *Laboratory - $0.50*
  - *Radiology - $1.00*
  - *Medical supplies - $1.00*
  - *Overnight hospital stay - $25.00*
  - *Non-emergency ER - $3.00*

Copayment Recipient Exemptions

The following recipient populations are exempt from co-payments:

- Recipients under 21 years of age;
- Pregnant women
- Recipients residing in an Adult Care Facility
- Recipients enrolled in a Home and Community-Based Services (HCBS) waiver or Comprehensive Medicaid Case Management (CMCM) program
- Residents in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
- Recipients living in residences certified by the New York State Offices of Mental Health or Mental Retardation and Developmental Disabilities
- Recipients in managed care plans (except for prescription drugs, which will have a co-payment effective Oct 1, 2011 when pharmacy is bundled into the plan benefit)

Services Exempt from Co-Payments

- Services exempt from co-payments include:
  - *Emergency services*
  - *Family planning services*
  - *TB Directly Observed Therapy*
  - *MMTP*
  - *Mental health clinic visits (Art 31 certified facilities)*
  - *Mental retardation clinic visits (Art 16 certified)*
  - *Alcohol and substance abuse clinic visits (Art 32 certified)*
  - *Psychotropic prescription drugs*
  - *Prescription drugs to treat tuberculosis*

Recipient Co-Payment Protections

- Pursuant to both federal regulation and state statute:
  - *There is a $200 annual cap on recipient co-payments.*
  - *A recipient cannot be denied services based on their inability to pay the co-payment.*
  - *Unpaid co-payment amounts remain the fiscal responsibility of the recipient.*
    - Providers can take whatever legal means they choose to collect unpaid co-payments, including sending the bill to collection.

Medicare/Medicaid Cost Sharing

Medicare/Medicaid Cost Sharing

- Medicaid reimburses limited cost sharing amounts ("patient responsibility") for services provided to Medicare/Medicaid dually eligible individuals.
  - *Medicare Part B traditionally reimburses providers 80% of the approved amount. The 20% Part B coinsurance amount is the "patient responsibility" which can be covered by Medicaid.*
  - *Medicaid does not reimburse practitioners the full 20% Part B coinsurance amount, but instead reimburses 20% of the Part B coinsurance (20% of the 20%) (Section 367-a of Social Services Law).*
  - *Medicaid pays clinics the full 20 percent coinsurance except as modified by MRT #164.*

MRT # 164 - Medicare/Medicaid Cost Sharing

- MRT #164 imposes new Medicare/Medicaid cost sharing limits – for both Article 28 facilities and practitioners:
  - *Effective October 1, 2011, Medicaid will no longer reimburse hospital outpatient departments and diagnostic/treatment centers the full Medicare Part B coinsurance.*
    - If the Medicare payment amount exceeds the Medicaid Ambulatory Patient Group (APG) rate, the facility will be considered to have been paid in full.
    - No additional Medicaid payment will be made to the facility.

MRT # 164 - Medicare/Medicaid Cost Sharing

- Up to the present, Medicaid has reimbursed practitioners the full Medicare Part B coinsurance amount for procedures (defined by CPT code) that are not covered by Medicaid.
- Effective October 1, 2011, Medicaid will no longer pay the Medicare Part B coinsurance amount for non-covered procedures.
  - *If a procedure/CPT code is covered by Medicare but not covered by Medicaid, no portion of the Part B coinsurance to Practitioners will be paid by Medicaid.*

Exceptions to Limited Cost Sharing

- Medicaid reimburses all providers the full Medicare Part B annual deductible amount.
- Medicaid by State law reimburses both ambulance providers and psychologists the full Medicare Part B coinsurance amount (full 20 percent).
- Certain providers may receive Medicare reimbursement that is lower than the Medicaid rate. State law requires Medicaid to pay the difference between the Medicare payment and the Medicaid rate ("higher of"). These include:
  - *FQHCs*
  - *Services provided to individuals with developmental disabilities*
  - *Services provided by Article 31 certified OMH facilities*.
- Note: In those situations where partial or no Medicare Part B coinsurance is reimbursed, providers are prohibited from billing the recipient. They must accept the Medicare/Medicaid payment as full payment.

Population Specific Programs

Recipient Population Specific Programs

- There are a number of programs designed to promote coverage for specific services targeting defined populations.
- These include:
  - *The Family Planning Benefit Program*
  - *Prenatal Care Services*

Family Planning Benefit Waiver Program

- Under a federal waiver, Medicaid reimburses for family planning and related services.
- Eligible recipients are those that are not eligible for regular Medicaid due to excess income, but are below 200% of poverty level.
- Coverage is restricted to federally designated family planning and related procedures and patient diagnosis.
- This waiver program will be moving to a State Plan service in 2012 (pursuant to the recently passed federal Health Care Reform Act).

Prenatal Care Services

- Pregnant women that are not eligible for Medicaid due to excess income but are below 200% of poverty level may be eligible for prenatal care and related services.
- Presumptive recipient eligibility is available for pregnant women.
- The scope of covered benefits is less that what is available for regular Medicaid.

Prenatal Care

- Services not covered include:
  - *Alternate Level Care*
  - *Institutional LTC*
  - *Eye Care*
  - *Durable Medical Equipment*
  - *Abortion*
  - *Physical, Occupational, Speech Therapy*
  - *Hospice*
  - *Long Term Home Health Care*

Primary Care Enhancements

Physician Primary Care Enhancements

- A number of program enhancements to promote accessibility to primary care services have been enacted over the last few years. These include:
  - *Physician/nurse practitioner/licensed midwife fees were increased effective January 1, 2009. The fee increase was approximately 35% above previous levels. Previously, there had been no fee adjustments going back over two decades.*
    - **Payments are now benchmarked to approximately 60% of the Medicare (Mid-Hudson) fee for office based services, and 50% of the Medicare fee for facility based services.**
    - **Nurse practitioners/licensed midwife fees are set at 85% of the fees established for physician services.**

Physician Primary Care Enhancements

- **Expanded "After Hours" Reimbursement**
  - *Effective January 1, 2009, an $8 add-on is available to clinics and private practitioners who provide services "after hours" (scheduled appointments 6:00 pm or later) and on federally designated holidays and weekends.*
- **Enhanced Fee - Health Professional Shortage Areas**
  - *10 percent add-on available to office-based primary care physicians providing care in federally designated HPSAs.*

Additional Primary Care Enhancements

- In addition to the physician targeted primary care enhancements, a number of additional program changes were made in 2009 to promote access to care:
  - *Medicaid fees were increased for psychologists, physical/occupational/speech therapy, eyeglass dispensing.*
- Diabetes and Asthma Education
  - *Effective January 1, 2009, Medicaid implemented coverage for diabetes and asthma education provided by certified educators in clinic and office-based settings.*

Additional Primary Care Enhancements

- **Smoking Cessation Counseling**
  - *Effective January 1, 2009, Medicaid implemented coverage for smoking cessation counseling for pregnant women*.
    - **Coverage was expanded to include adolescents up to age 21 and pregnant women postpartum on January 1, 2010.**
    - **MRT # 55 – effective April 1, 2011, smoking cessation counseling will be available to all Medicaid eligible recipients, regardless of age or gender.**

Additional Primary Care Enhancements

- **Social Worker Counseling**
  - *Medicaid will shortly begin reimbursing Article 28 certified clinics for mental health counseling provided by LCSW/LMSW to adolescents (persons under age 21) and pregnant women (including 60 days postpartum).*
    - Coverage will be retroactive to Sept. 1, 2009.
    - Implementation has been delayed due to CMS state plan approval.
      - SPA approval was issued April 5, 2011.

Statewide Patient Centered Medical Home (PCMH)

Patient Centered Medical Home

- **Authorized under Chapter 58 of the Laws of 2009**
  - *Effective December 1, 2009*
  - *Implements a statewide program, incentivizing development of PCMHs*
- **Goal**
  - *To improve health outcomes through better coordination and integration of patient care.*
- **Medical home standards utilized by Medicaid**
  - *Are consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections .*
- **Incentive payments are available to providers and clinics who achieve NCQA status and serve as a medical home for Medicaid beneficiaries.**
  - *Payment incentive is commensurate with level of NCQA PCMH designation (Level I, II, or III).*

Medical Home Model

- A model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
- The physician led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians.
- Emphasizes enhanced care through open scheduling, expanded hours and communication between patients and their families, physicians and staff.
- Promotes quality and safety for patients to achieve optimal, patient centered quality outcomes using evidence-based medicine and clinical decision support tools.

Health Home

Health Homes: General Information

- Section 2703 of the Patient Protection and Affordable Care Act (ACA) provides states, under the state plan option or through a waiver, the authority to implement health homes.
  - *opportunity to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.*
  - *provides 90 percent FMAP rate for health home services for the first eight fiscal quarters that a health home state plan amendment is in effect; multiple SPAs permitted.*
- NYS Health Homes for managing members with complex behavioral health and chronic medical needs must meet defined provider qualification standards
  - *Applicants must be robust networks with hospitals, community based organizations and managed care plans*
  - *LOIs for prospective applicants due September 7th*
  - *Applications due October 3rd*

For more information:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm

Medicaid Waivers

Section 1915 Waiver Services

Medicaid Waiver Programs

- New York state provides special services for targeted groups, under the waiver authority granted by the federal government.
- A waiver is intended to decrease the risk of institutionalization by providing personalized services in the community.
- Services provided under Medicaid waivers are those that are not traditionally available under Medicaid.
- The package of services available under each specific waiver is tailored to the targeted population served.

Unique Services Provided Under Waivers

- **Examples of unique services provided under waivers include:**
  - *Nutritional Counseling/Education Services*
  - *Congregate and Home Delivered Meals*
  - *Environmental Modifications*
  - *Moving Assistance*
  - *Respite Care, Assistive Technology, Vehicle Modification, Massage Therapy*
  - *Expressive Therapy (music, art and play)*
  - *Independent Living Skills Training and Development (ILST)*
  - *Social Day Care/Social Day Care Transportation*
  - *Community Integration Counseling (CIC)*
  - *Prevocational Services, Supported Employment, Crisis Avoidance*

List of Medicaid Waiver Programs

- There are presently eight Medicaid waiver programs:

Waiver Program	Target Population
OPWDD Home and Community Based Services Waiver	**Adults and children with developmental disabilities**
OMH Home and Community Based Services Waiver	**Children with serious emotional disturbances**
Traumatic Brain Injury	**Individuals 18 – 64 years of age with TBI**
Care at Home (CAH) I/II	**Individuals 18 – 64 years of age who are physically disabled**

continued

List of Medicaid Waiver Programs

Waiver Program	Target Population
Care at Home (CAH) III, IV, and VI	Individuals 18 – 64 years of age who are developmentally disabled and have complex health care needs
Long Term Home Health Care Program (LTHHCP)	Nursing Home without Walls program serving elderly and disabled population
Bridges to Health (B2H)	Children in foster care
Nursing Home Transition and Diversion Waiver (NHTD)	Individuals age 18 or older requiring skilled nursing facility level of care

New Technology

New Technology Requests

- New Technology is brought to the Medicaid Program's attention through a number of different routes, including:
  - *Updates to CPT-4 coding are issued by CMS annually. Medicaid engages in a systematic review to identify new procedures that have been added to the CPT code set.*
  - *OHIP receives ad hoc requests for covering new procedures and technologies.*
    - These requests are initiated by:
      - *Providers*
        - Article 28 hospitals
        - Practitioners
      - *Patients*
      - *DOH internal agency requests, e.g., AIDS Institute*
      - *Other state agencies, e.g., SUNY*
      - *Equipment/device manufacturers*

New Technology Committee

- In 2008, OHIP established a formal New Technology Committee to review coverage requests.
  - *Committee was comprised of OHIP's three Medical Directors and three OHIP clinical staff (RNs).*
- OHIP performs comprehensive review of clinical and peer-reviewed literature.
- Material summarizing clinical staff findings is presented to the New Technology Committee members, who then make a coverage determination.
- Committee meets on an "as needed" basis.

New Technology Literature Review

- Review of clinical and peer-reviewed literature includes:
  - *Hayes, Inc., including Hayes Reports*
  - *Blue Cross Blue Shield Technology Evaluation Center*
  - *National Guidelines Clearinghouse*
  - *Agency for Healthcare Research and Quality*
  - *National Institute for Health and Clinical Excellence*
  - *Centers for Medicare and Medicaid Services (National Coverage Determinations, Technology Assessments, etc.)*
  - *Cochrane*
  - *Institute for Clinical Systems Improvement*
  - *Aetna*
  - *CIGNA*
  - *Blue Shield of Northeastern New York*

New Technology Review Process

- OHIP's New Technology review process incorporates a number of factors, including, but not limited to:
  - *State of the art evidence based decisions*
  - *Review of safety, efficacy, and comparative utility, as well as comparison to existing technologies*
  - *Appropriate use of funds and cost effectiveness*
  - *Examination of fixed and ongoing costs and how those total costs compare to existing technologies and/or interventions*
  - *Reported risks and risk reduction strategies*
  - *Effect on health outcomes*
  - *Input from other insurers*
  - *Binding decisions*
  - *Compassionate use exceptions as appropriate*

New Medical Procedures Recently Reviewed

- Examples of new procedures approved for coverage include:
  - *Endovenous ablation therapy*
  - *Endometrial cryoablation with ultrasonic guidance*
  - *Fetal surgery procedures including: transabdominal amnioinfusion, umbilical cord occlusion*
  - *High energy neutron radiation treatment*
  - *Esophagus, gastroesophageal reflux test, with telemetry electrode placement*
  - *AlloMap test – used to assess cardiac transplant tissue rejection.*
- New procedures not approved for coverage include:
  - *CT Colonoscopy*

Options for Expanding Review of New Technology Coverage – US Preventive Services Task Force

- The US Preventive Services Task Force (USPSTF) conducts scientific evidence reviews of clinical preventive health care services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems.
  - ***These recommendations are published in the form of "Recommendation Statements."***
- The USPSTF assigns health care services grade levels A through D (and I), depending on the weight of current evidence, and levels of certainty regarding net benefit of a medical service/procedure.

Challenges to Current Review Process

- Creating appropriate transparency
- Timeliness
- Volume of new codes/procedures
- Staffing
- Ability to project financial impact of new services/benefits/procedures and integrating with clinical/medical necessity analysis

US Preventive Services Task Force

- "Grade levels" are assigned to medical procedures.
  - *A USPSTF level A or B assignment indicates that the service is recommended and that the net benefit is substantial or moderate.*
  - *A USPSTF level C is not recommended by the Task Force, and should only be covered if other considerations support the offering or providing the service for an individual patient.*
  - *A "high level of certainty" indicates that the available evidence includes consistent results from well-designed, well-conducted studies in representative primary care populations.*
  - *A "moderate level of certainty" indicates that the available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence is constrained by a number of factors including size and/or quality of studies.*

New Technology Decisions and USPSTF

- NYS Medicaid should consider adopting all USPSTF Level A and B recommendations, as well as "high" and "moderate" level of certainty recommendations in the New Technology coverage decision making process.

Other States' New Technology Initiatives Wisconsin

- In 2008, the Clinical Advisory Committee on Health and Emerging Technology (CACHET) was created to review, advise, and integrate "comparative effectiveness research" (CER) into Wisconsin's Medicaid program.
  - *CER includes review of peer reviewed literature to assess new technology.*

Wisconsin CACHET Mission Statement

- Advise the Department on the prioritization of health care services so that resources for the most persons are used most effectively.
- Use evidence-based research to specifically define the appropriate use of a particular service/procedure for a particular condition.
- Advise the Department on how to adjust benefits and control costs using evidence-based medicine, comparative effectiveness research, use of national centers of excellence, appropriate use of step therapy, and overall integration of quality and pay for performance initiatives.

Wisconsin New Technology

- Wisconsin's CACHET:
  - *Meets biannually*
  - *Staff make-up includes:*
    - 12 Medical Directors
    - 1 Doctor of Osteopathy
    - 1 Dentist
  - *Nomination process has term limits.*
  - *The State is considering adding a health ethicist panel and/or health economist and a pharmacist.*

(continued)

Wisconsin CACHET

- To date, Wisconsin's CACHET has reviewed:
  - *CT colonoscopy (this included use of an outside expert)*
  - *Sleep testing*
  - *Dental appliances for sleep apnea*
  - *Certification of licensed midwives*
  - *Genetic testing*

Oregon State Medicaid Evidence Based Decisions Project (MED)

- Oregon Health and Science University (OHSU) has instituted a Medicaid Evidence Based Decision Project (MED) to assist State Medicaid Programs in making coverage decisions for new technology.
- State Medicaid Programs, at their option, may participate in the MED Project (at a cost to the participating state).
- The MED project helps states evaluate the best treatments for improving health outcomes as well as provide information about harmful, ineffective and unnecessary services.
  - *MED project staff sort through various peer reviewed journals, providing detailed research and summary information to participating states on new medical procedures.*

Oregon State MED

Goals of MED project include:

- *Evaluation and dissemination of independent objective evidence to Medicaid policy makers and other state health policy decision makers to develop health policy,*
- *Provide transparent decision-making in the development of state coverage policies,*
- *Promote "Value Based Purchasing" for Medicaid by utilizing the best available evidence,*
- *Maximize use of limited state resources through collaborative efforts and best evidence.*

(continued)

Oregon MED

MED participants have access, in part, to:

- *Immediate policy/evidence consultation with MED staff.*
- *Quick response to research inquiries.*
- *Summaries of existing coverage policies, financial and economic considerations.*
- *Full systematic reviews – Comprehensive reports of existing evidence that systematically identify, critically appraise and synthesize research from all relevant published and unpublished reports.*
- *Direct access to Hayes .*

Washington State Medicaid Health Technology Assessments

- Washington State Medicaid uses health technology assessments to determine coverage of:
  - *New drugs*
  - *New indications*
  - *Existing technology approved by the FDA*
- Health technology assessments are employed when coverage is not mandated by federal or state law.

Washington State Medicaid Health Technology Assessments

- The department reviews available evidence relevant to a medical or dental service or healthcare-related equipment to:
  - *Determine efficacy, effectiveness, and safety*
  - *Determine impact on health outcomes*
  - *Identify indications for use*
  - *Identify potential for misuse or abuse, and*
  - *Compare to alternative technologies to assess benefit vs. harm and cost effectiveness.*

Washington State Medicaid Health Technology Assessments

- The department may determine the technology, device, or technology-related supply is:
  - *Covered;*
  - *Covered with authorization;*
  - *Covered with limitations;*
  - *Non-covered.*
- The department may periodically review existing technologies, devices, or technology-related supplies and reassign authorization requirements as necessary.

Washington State Health Technology Clinical Committee

- Washington State's health technology clinical committee is responsible for health technology assessments.
- Committee members include:
  - *Six practicing physicians*
  - *Five other practicing licensed health professionals who use health technology in their scope of practice*
- Two members of the committee must have experience treating women, children, elderly persons, and people with diverse ethnic and racial backgrounds.

Washington State Health Technology Clinical Committee

- The committee was charged with selecting up to six technologies for review in 2006, and up to eight in the following year.
- Review priority was given to items for which:
  - *There are concerns about safety, efficacy, or cost effectiveness especially relative to existing alternatives.*
  - *Actual or expected state expenditures are high, due to demand or cost.*
  - *There is adequate evidence available to conduct a complete review.*
- Health technologies for which a coverage determination has been made must be considered for re-review at least once every 18 months.

Washington State Health Technology Clinical Committee

- The committee is charged with:
  - *Insuring that the determination process is open, transparent, and includes evidence regarding safety, efficacy, and cost effectiveness.*
  - *Providing an opportunity for public comment.*
  - *Establishing, when necessary, ad hoc temporary advisory groups if specialized expertise is needed to review a particular health technology.*

Pennsylvania's Technology Assessment Group

- Pennsylvania Medicaid's committee, charged with reviewing and determining coverage of new technologies/procedures , is the Technology Assessment Group (TAG).

Pennsylvania's Technology Assessment Group

- The TAG is composed of:
  - *Physicians (vary depending on their specialty and the procedures to be reviewed)*
  - *Nurses*
  - *Non-medical policy staff*
  - *Staff from the Bureau of Managed Care*
  - *Two consumers*

Pennsylvania's Technology Assessment Group

- The Technology Assessment Group meets on a quarterly basis.
- The number of reviews conducted per quarter has varied from three to twelve.

Pennsylvania's Technology Assessment Group

- Policy staff researches, assembles and presents to the group all available clinical and peer-reviewed information on the new technologies/procedures being reviewed.
- The group reviews/discusses the information, but only the physicians in the group make the final decision regarding whether the technologies/procedures will be covered.

Pennsylvania's Technology Assessment Group

- If a technology/procedure is approved for coverage, prior authorization is often required for a period of time before the procedure code is officially added to the fee schedule.
- During this time, the Department monitors:
  - *Number of requests*
  - *Outcomes*

Examples of Opportunity

- No/limited existing benefit
  - *Podiatric care for adult diabetics*
  - *Obesity*
- Underused benefit
  - *Tobacco cessation counseling and products*
- Overused benefit
  - *Percutaneous coronary intervention (PCI)*
  - *Emergency room*