PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 5

Proposal: Reduce and Control Utilization of Certified Home Health Agency Services

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** **Statutory Change:** Yes
State Plan Amend: Yes **Federal Waiver:**

Proposal Description:
To control utilization and reduce costs, the proposal will transition long-term CHHA patients to Managed Long Term Care by implementing:

- Provider-specific aggregate annual per-patient spending caps for Certified Home Health Agency (CHHA) services (effective April 1, 2011).
- An Episodic Pricing System which is similar to current Medicare Prospective Payment system (effective April 1, 2012). The Episodic Pricing System will remain in place for all short-term CHHA patients (those that are anticipated to require less than 120 days of care).

  The proposal will immediately address significant growth in utilization. Total paid CHHA claims in New York State have increased from $760 million in 2003 to $1.35 billion in 2009. More than $1.2 billion of the 2009 spending was in New York City, where paid claims per patient grew from $11,867 in 2003 to $23,253 in 2009 – a 96% increase per patient.

CHHA Spending Trends							
	2003			2009			
	# Recipients	Total Spending	Spending Per Recipient	# Recipients	Total Spending	Spending Per Recipient	% Change Per Recipient Spending
Statewide	92,553	$760.3M	$8,215	86,641	$1.349B	$15,570	+89.5%
New York City	53,770	$638.1M	$11,867	52,171	$1.213B	$23,253	+95.9%

Although CHHA services are authorized by a physician, the level of services provided is open-ended and is determined by the CHHA provider. The current Medicaid rate setting methodology established provider-specific, fee-for-service rates. The rates are based upon a rolling cost base which is updated annually (e.g., 2010

rates are based upon 2008 reported costs), and includes no incentive to control costs or achieve efficiencies. The rate methodology is not rationalized by patient acuity and there is no incentive to control the amount or level of services provided.

Provider Spending Limits (Effective April 1, 2011): The provider spending limits would be based on a weighted average of the provider's average claims per patient during the 2009 base period and the statewide average for all CHHAs during the same period. The limit would be adjusted for the provider's Case Mix and for regional differences in labor costs. Case Mix would be based on a New York State Medicaid Grouper which was developed by the Department in conjunction with outside consultants (ABT Associates) and presented to the Home Care Work Group. Payments would later be reconciled using actual paid claims and updated Case Mix. Providers that reduced their aggregate per patient spending levels below the limit would receive a payment and providers that did not adjust their spending levels would have their payments further reduced. Please see Attachment #1 for an example of how the provider limits would be calculated.

It is anticipated that about 2,000 CHHA recipients will move to MLTC in 2011-12. The Financial Impact shown below does not include estimated savings from shifting patients into the MLTC program (see proposal #90 for additional information).

Episodic Pricing (Effective April 1, 2012): Effective April 1, 2012, the Episodic Pricing System would make provider payments that are based on 60-day episodes of care. A statewide base price would be established, based on paid Medicaid claims data during a specified base period. The price would be adjusted for Case Mix to reflect differences in patient acuity and regional labor costs. The methodology would include outlier payments, which are risk-sharing adjustments to the price that provide a CHHA with partial reimbursement for exceptionally high-cost cases within each Case Mix group (see Attachment #2).

CHHA patients under the age of 18 would continue to be reimbursed on a fee-for-service basis. Low utilization claims (under $500/less than 25 hours of care in a 60-day period) also would be FFS for patients who were not in MLTC.

It is anticipated that roughly 17,000 CHHA recipients will move to MLTC over the three-year period 2012-13 through 2014-15. The Financial Impact shown below does not include estimated savings from shifting patients into the MLTC program (see proposal #90 for additional information).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-100	$-70	$-31	$-12
Total Savings	$-200	$-140	$-62	$-24

Benefits of Proposal:

- Provides a structure that immediately controls utilization while the State transitions long term CHHA patients to MLTC.
- Costs per patient in 2011-12 would be reduced to their 2006/2007 levels.
- Better alternative to achieve targeted savings than across-the-board reductions that would impact efficient providers.
- Both the provider limits and the Episodic Pricing model adjust for differences in wages and case mix with a wage equalization factor and case mix grouper methodology created specifically for NYS Medicaid patients.
- Creates stronger correlation between reimbursement levels and patient needs.

- Includes provisions for high-cost cases in the form of additional outlier reimbursement. Outlier thresholds were modified based on the recommendations of the Home Care Reform Work Group to provide greater reimbursement for high-acuity cases.
- Enhanced care management and service capability.
- Fosters provider fiscal stability and planning.
- Redirects Medicaid spending from New York City (where over-utilization of CHHA services has driven rapid increases in per-patient costs) to other areas of the State where additional resources can be used to meet staffing needs.
- Opportunity to enhance patient access and quality of care.

Concerns with Proposal:

- Provider limits may provide agencies an incentive to "cherry pick" patients by serving only those with lower acuity and less intense needs. However, the Case Mix adjustment component of the provider caps and the transition to Episodic Pricing should mitigate this incentive.
- Providers have expressed concern that the grouper employed to determine Case Mix may not adequately reflect all aspects of patient need, including chronic illness, psycho-social factors, and special needs populations. To address these issues, the Department designed a new grouper specifically for New York State Medicaid patients, and made significant changes to the clinical and functional scoring mechanisms to better reflect the needs of this population.
- Provider groups have expressed concern about the time required to implement Episodic Pricing. To address this concern, the Department has pushed back the proposed effective date to April 1, 2012.
- The proposal does not include funding for rewarding provider quality and performance. However, alternatives for providing financial incentives to meet clearly defined quality standards were presented to the Home Care Reform Work Group and can be implemented in the future.

Impacted Stakeholders:

- Consumers
- Health personnel
- Providers

Based on the most recent available Medicaid paid claims data for 2009 and a savings assumption of $200 million annually, the provider per-patient limits would impact only 23 of 139 CHHAs. These 23 agencies billed a combined average of $33,421 per patient during calendar year 2009 or $17,851 more than the statewide average. The $192 million impact on New York City providers represents about one-third of the $575 million increase in CHHA spending in New York City from 2003 to 2009.

Provider Limits: Gross Fiscal Impact by Region	New York City	Other Downstate	Upstate	Total ($ millions)
Negative Impact ($ millions)	-$192.3	-$2.1	-$5.6	-$200.0
Negative Impact: # of providers	16	4	3	23
No Impact: # of providers	13	27	76	116
Total # of providers	29	31	79	139

Under the Episodic pricing proposal, which reflects the continued shift of patients to Managed Care, Medicaid spending outside New York City would increase by more than $20 million.

Episodic Pricing: Gross Fiscal Impact by Region	New York City	Other Downstate	Upstate	Total ($ millions)
Negative Impact: # of providers	22	10	6	38
Negative Impact ($ millions)	-$184.4	-$4.1	-$4.6	-$193.1
Positive Impact: # of providers	8	21	72	101
Positive Impact ($ millions)	$22.8	$5.9	$24.6	$53.3
Total # of providers	30	31	78	139
Total Net Impact ($ millions)	-$161.6	$1.8	$20.0	-$139.8

Additional Technical Detail:

The proposed Medicaid grouper uses OASIS data (currently collected by all CHHAs for nearly all Medicaid patients) to evaluate clinical and functional characteristics of patients. The grouper also considers the age of the patient and whether the episode is "start of care" or recertification.

Regional labor cost indices will be based on Occupational Employment Statistics reported by the Federal Bureau of Labor Statistics for the 10 labor market regions defined by the New York State Department of Labor and presented to the Home Care Work Group.

Gross annual savings of approximately $200 million would require a provider-specific weight of 60% and a statewide weight of 40% (adjusted for Case Mix and regional labor cost index). Under these assumptions, the statewide average spending per recipient would be reduced to the 2006/07 level of $13,285 (impacts based on 2009 claims and 2009 Case Mix Index for each provider).

The most recent Episodic Pricing model is based on 2008 claims and Case Mix. The Department is in the process of updating the model to reflect 2009 claims and 2009 Case Mix/OASIS data.

System Implications:

Provider limits will not require any changes to the eMedNY system or modifications in billing procedures.

The episodic proposal will require significant changes to the eMedNY billing system to accommodate the transition from hourly and per-visit billing to episodic pricing. The Medicaid billing system also will need to track costs for hours/visits in order to compute amounts due for outlier and low utilization claims. The Department has begun to assess the required systems implications. Providers will need to update their patient information and billing systems.

Metrics to Track Savings:

For provider limits, paid Medicaid claims data for each 12-month period will be used to determine whether each provider was under or over its calculated spending limit. Combined totals for all providers will allow calculation of statewide savings.

After implementation of the episodic proposal, paid Medicaid claims data will be used to compare the amounts paid to providers under the episodic system with amounts previously paid through the traditional fee-for-service model.

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Viability: S

Modified Delphi Scoreable: True

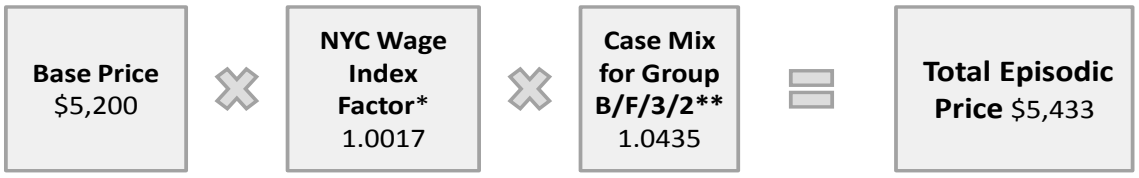
Modified Delphi Score:

ATTACHMENT #1: Example of CHHA Provider Cap and Reconciliation

	Base Period (2009) Provider A	4/1/11-3/31/12 Spending per Recipient Equal to the Cap Scenario 1	4/1/11-3/31/12 Spending per Recipient Less Than the Cap Scenario 2	4/1/11-3/31/12 Spending per Recipient Exceeds the Cap Scenario 3
CHHA Recipients	**1,000**	**1,000**	**1,000**	**1,000**
Total Cost	**$32,000,000**	**$27,000,000**	**$26,000,000**	**$28,000,000**
Cost per Recipient	**$32,000**	**$27,000**	**$26,000**	**$28,000**
Provider Cap	**$27,000**	**$27,000**	**$27,000**	**$27,000**
Percent Decrease in FFS	**-15.625%**			
RECONCILIATION:				
Reconciliation Payments		**$0**	**$1,000,000**	**($1,000,000)**
Total Final Costs		**$27,000,000**	**$27,000,000**	**$27,000,000**
Total Savings		**$5,000,000**	**$5,000,000**	**$5,000,000**

ATTACHMENT #2: Example of CHHA Episodic Payment Calculation

CHHA Episodic Payments: Example (NYC Provider)
Patient is in Clinical Group B (moderate); Functional Group F (moderate);
Age Group #3 (ages 70-74); Reason for assessment #2 (Recertification).



Calculation of Total Reimbursement to CHHA under 2 cost scenarios				
Total cost of visits/hours	**Outlier Threshold**	**Episodic Payment**	**Outlier Payment**	**Total Payment**
$4,000	$9,556	$5,433	$0	$5,433
$11,000	$9,556	$5,433	$722	$6,155

* Applied to 77% of Base Price
** Applied to 100% of Base Price

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 6

Proposal (Short Title):
Reduce Medicaid Managed Care and Family Health Plus Profit (from 3% to 1%)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Reduce the profit component included in the plan rates from 3% to 1% for the Medicaid and Family Health Plus managed care programs.

As a result of this change, the phase-in schedule for reaching the 12.5% maximum contingent reserve requirement contained in Part 98 of the NYCRR will be modified to apply a 7.25% contingent reserve requirement on net premium income from Medicaid and Family Health Plus for one year. (Note: contingent reserve requirements are deemed to be met if the managed care plan's net worth equals or exceeds the contingent reserve requirement.) The existing phase-in schedule for the contingent reserve requirement would continue to apply to net premium income from all other lines of business.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-94.00	$-100.00	$-100.00	$-100.00
Total Savings	$-188.00	$-200.00	$-200.00	$-200.00

Benefits of Proposal:
Medicaid and Family Health Plus premiums will approximate $11 billion in SFY 2011, of which 3% or approximately $300 million is an allocation for profit and reserves. Reducing the allocation to 1.0% will save $200 million and will still allow the MCOs adequate protection against adverse experience and preserve the MCOs' ability to meet statutory reserve requirements in the long run. The state's consulting actuaries who certify to the actuarial soundness of the premium rates to CMS, have advised that this proposal is reasonable under the current enrollment growth trends and would not jeopardize the actuarial soundness of the rates.

Concerns with Proposal:
It will be argued that a 1.0% profit allocation is inadequate to provide the MCOs with sufficient margin to cover the cost of catastrophic health events or to maintain reserves or solvency in the event of sustained losses. Health care margins are already small and the reduced profit component will make them dangerously low.

Impacted Stakeholders:
NYS Department of Health; and consumer advocates will support the proposal.

MCOs and corresponding associations will oppose the proposal.

Additional Technical Detail: (if needed, to evaluate proposal)
None

System Implications:
None

Metrics to Track Savings:
No metric needed as the rates established by the Department will have the proposed 1.0% allocation for profit.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 10

Proposal (Short Title):
Eliminate Direct Marketing of Medicaid Recipients by Medicaid Managed Care Plans

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Eliminate funding included in Medicaid and Family Health Plus premiums for direct marketing of Medicaid recipients for Managed Care.

As of October, 2010 the penetration rate of eligible Medicaid recipients enrolled in managed care was 84% statewide (77% upstate and 88% NYC). In the early implementation of the program, it was important to allow plans the ability to market in order to increase the level of enrollment in managed care since many counties were voluntary. At this time, the program is mature, and those persons not enrolled are generally exempt or excluded from the program or reside in voluntary counties. Marketing costs are largely spent by health plans to attract members of other plans; they do not focus on enrolling the uninsured. In addition, by March 2011, the State will only have 7 non mandatory counties where enrollment in managed care remains an option. Recipients in mandatory counties must enroll or be auto-assigned into a managed care plan (MCP), which greatly reduces the need for marketing. Only a few states, including New Jersey, continue to allow direct marketing by Medicaid managed care plans.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-22.50	$-22.50	$-22.50	$-22.50
Total Savings	$-45.00	$-45.00	$-45.00	$-45.00

Benefits of Proposal:
The State has or will in the near future simplify the eligibility and enrollment process which will make it easier for individuals to obtain eligibility and for eligible recipients to enroll in managed care. With the elimination of the face to face interview for new Medicaid applicants, the implementation of the SDOH Enrollment Center, 12 month continuous enrollment, and due to the high penetration of enrollment of persons currently eligible, there is little reason to continue reimbursing MCPs for direct marketing activities. In fact, over the past few years as fewer recipients remain fee for service, MCPs have implemented aggressive marketing activities, especially in New York City, where law enforcement officials have intervened along with the local district. This has resulted in a marked increase in occurrences of confused recipients attempting to enroll in multiple plans, as well as the inappropriate marketing to persons already enrolled in a health plan.

At this juncture, MCPs should focus their efforts on retention activities and current members through assistance with the eligibility recertification process.

Concerns with Proposal:
It will be argued that marketing activities are needed to maintain the enrollment base due to churning and recertification. Also, advocates may want marketing to continue in order to educate consumers on their options for enrollment.

Impacted Stakeholders:
NYS Department of Health, New York City HRA and CDOH/MH, Local Social Services Districts, and consumer advocates would be concerned with the elimination of marketing. Health Plans and corresponding associations would be opposed to the elimination of marketing.

Additional Technical Detail: (if needed, to evaluate proposal)
None

System Implications:
None

Metrics to Track Savings:
Savings will be realized through reduction in payment to plans.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 11

Proposal Author:
GNYHA; CNYHSA; Onondaga County; NYS Catholic Conference; MRT member Jeffrey Sachs; NY State Health Plan Association; Coalition of NY State Public Health Plans

Proposal (Short Title):
Bundle Pharmacy into MMC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
Move the NYS Medicaid Pharmacy program under the management of Medicaid Managed Care to leverage additional clinical and fiscal benefits.

The NYS Medicaid Program covers prescription drugs dispensed by pharmacies under the Medicaid Pharmacy fee-for-service program for nearly all Medicaid beneficiaries, including Medicaid managed care (MMC) enrollees. This has allowed NYS to take advantage of available Federal rebates on prescription drugs, thereby lowering their net cost. However, recently passed health care reform law includes equalization provisions that give Medicaid managed care plans the same rebates as the fee-for-service program. A number of recent reports have indicated that States can achieve significant savings in pharmacy expenditures by improving management of the pharmacy benefit with tools widely used in commercial health insurance. This can be done by including both prescription and over-the-counter medications in the benefit package provided by managed care plans for Medicaid beneficiaries.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-50.00	$-100.00	$-100.00	$-100.00
Total Savings	$-100.00	$-200.00	$-200.00	$-200.00

Benefits of Proposal:
With passage of the Affordable Care Act, Federal rebates for prescription claims paid for by Managed Care Plans are equal to the Federal rebates available to the Medicaid fee-for-service (FFS) program. Additionally, Managed Care Plans use Pharmacy Benefit Managers (PBMS) that employ utilization management tools that steer volume to the lowest cost clinically effective product. Management of the prescription drug benefit by the managed care plans will also enable access to pharmacy data which can improve their ability to manage patient care.

Concerns with Proposal:
NY State currently receives $1.5B in federal rebates and $190M in supplemental rebates. Putting the responsibility for collection of these rebates with the managed care plans could put this revenue at risk

for the following reasons:

- Purchasing power will be fragmented across multiple plans
- Lack of transparency due to plan reliance on Pharmacy Benefit Management companies
- Issues of accuracy and consistency of data for multiple plans

Impacted Stakeholders:
Pharmacies, Prescribers, managed care plans, beneficiaries

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
This proposal will require system changes to prevent FFS payment at the pharmacy, and redirect the pharmacy to the applicable managed care plan for payment.

Metrics to Track Savings:
No metric needed, the Department will build the savings into the plan's capitation premium.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 13

Date Submitted: 01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Preschool/School Supportive Health Services Program (SSHSP) Cost Study

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Increase Federal Medicaid Funding by determining actual costs incurred by school districts and counties providing Preschool/School Supportive Health Services (SSHSP).

The Preschool/School Supportive Health Services Program (collectively "SSHSP") State Plan Amendment (#09-61) was approved by the Centers for Medicare and Medicaid Services (CMS) on April 26, 2010, retroactive to September 1, 2009. Reimbursement rates were benchmarked at 75% of the 2010 Medicare rates for the mid-Hudson region. The proposed cost study will determine whether these rates provide appropriate compensation for services furnished under SSHSP and for special transportation costs. Approved SSHSP SPA #09-61 requires the State to conduct a transportation cost study, assessing direct and indirect costs within the parameters of OMB circular A-87, to establish new rates for special transportation, and to demonstrate to CMS that the new rates do not exceed actual costs. The medical services subject to a cost study will be expanded to include all services reimbursed to SSHSP providers, including physical/speech/occupational therapy, nursing, psychology, and physician services. Depending on the cost study results, consideration may also be given to enhancing the services delivered under this program.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-50.00	$-100.00	$-100.00	$-100.00
Total Savings	$-50.00	$-100.00	$-100.00	$-100.00

Benefits of Proposal:
Medicaid reimbursement for services will be appropriate to service provided.

Concerns with Proposal:
None

Impacted Stakeholders:
SSHSP practitioners, school districts, counties and section 4201 schools, and Medicaid recipients

Additional Technical Detail: (if needed, to evaluate proposal)
Eastern Suffolk BOCES provider notes difficulty in implementing SSHSP billing rules retroactively to September 2009. This creates billing difficulties for the school district. The State is presently being litigated on this issue (Suffolk, Nassau, and Rockland Counties).

System Implications:
Will depend on model for capturing CPE dollars.

Metrics to Track Savings:
Increase in Federal Revenue Billed through the program.

Contact Information:

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Viability: S

Comments:
Was included in DOB's scorecard for 11/12 Budget

Laura Merritt (Rochester) - position is that schools should not use Medicaid funds for reimbursement for therapy within school settings

Modified Delphi Scoreable: False
Modified Delphi Score:

Proposal Number: 14

Proposal:
Restructure Reimbursement for Proprietary Nursing Homes
Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium

Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:**	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver**

Proposal Description:
Eliminate the "return on" and "return of" equity and residual reimbursement provided in the capital nursing home rate for proprietary nursing homes.

The current capital rate setting methodology for nursing homes is based upon two types of ownership structure - private, for-profit homes (i.e., proprietary homes) and not-for-profit, homes (i.e., public (including county and State-operated homes) and voluntary homes).

● Proprietary (for-profit) providers receive mortgage amortization and interest on real property. In addition, they receive "return on" equity (3.72%) and return of equity. Proprietary providers with facilities that are at the end of their useful life are paid residual reimbursement (one-half of the amount they were paid in the last year of useful life of a facility from the return on and return of equity).
● Voluntary and public providers receive depreciation and mortgage interest on real property (i.e., buildings) for both new construction and renovation.

This proposal would amend the capital nursing home rate setting methodology to eliminate "return on" and "return of" equity and residual reimbursement for proprietary nursing homes.

Proprietary facilities receive a "return on" equity that pays them a rate of return for investing in the home (i.e., mitigates the loss from forgoing the option of an alternative investment (outside the home) that pays a higher rate of return). Similarly, proprietary facilities receive a return on equity for investments in moveable equipment and working capital.

Proprietary facilities also receive a "return of" equity which reimburses them (dollar-for-dollar) on their real property equity investment.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-43.50	$-43.50	$-43.50	$-43.50
Total Savings	$-87.00	$-87.00	$-87.00	$-87.00

Benefits of Proposal:

● Eliminating the return on equity eliminates a State payment for which there is no reported costs.
● Provides for an approach to reimbursing capital costs that is consistent across sponsorship by eliminating a benefit in the methodology that is now available to only proprietary facilities.

Concerns with Proposal:

● Not all proprietary facilities are reimbursed for mortgage amortization and interest (i.e., the terms of the mortgage were not approved by the Department and costs are not reimbursed). Eliminating return of and return on equity for these homes would limit reimbursement to capital costs related to only moveable equipment.
● Removes the incentive for proprietary facilities (many of whom are low cost providers) to make investments in the facility. This could be a concern going forward as many facilities are in need of repair or replacement and will discourage proprietary facilities from making such investments.
● This proposal conflicts with legislation enacted in 2009 to authorize the recalculation of the capital rate for proprietary facilities that are at the end of their useful life (i.e., they are and being paid residual reimbursement) and that make capital investments that protect and maintain the health and safety of patients or make capital improvements or renovations to an existing facility for the purpose of converting beds to alternative care uses. The State Plan Amendment to implement this law has recently been approved by CMS.

Impacted Stakeholders:

As shown in the table below, there are 191 proprietary facilities that are paid a return of and return on equity and 59 proprietary facilities that are paid residual reimbursement.

NYPHRM Region	# of Proprietary Facilities Impacted	Impact of Eliminating Return of and On Equity and Residual Reimbursement (Savings in Millions $)
Central	17	(3.5)
Long Island	44	(23.2)
New York City	62	(25.5)
Northeastern	18	(4.0)
Northern Metropolitan	42	(17.6)
Rochester	23	(3.0)
Utica	15	(2.3)
Western	28	(7.6)
Total	**249**	**($86.7)**

Additional Technical Detail: (if needed, to evaluate proposal)

N/A

System Implications:

No systems changes to EMedNY would be required. Minimal programming changes to the capital rate setting system would be required.

Metrics to Track Savings:
Adjustments to capital rates excluding these costs and changes in capital rates would be used to track savings.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 15

Proposal Author:
NYSCHP;DOH;Blossom View Nursing Home;PSSNY;NYSHFA;NYSCAL;Scott C. Amrhein;CLLC; Robert J. Murphy - NY State Health Facilities Association;Island Nursing and Rehab Ctr; Effie Batis, Southern New York Association; Leonard Russ of Bayberry Nursing Home and Aaron Manor Nursing and Rehab Center; Ron Zito of Our Lady of Peace Nursing Care Residence;MRT Member (Steve Acquario NYSAC); HANYs; NACDS; Gregory Blass (Suffolk Co DSS Commissioner);MRT Member Dr. Nirav Shah

Proposal (Short Title):
Consolidate all pharmacy fee-for-service proposals into a comprehensive reform package.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
Consolidates all pharmacy fee-for-service proposals into one reform package which includes several initiatives that optimize rebate opportunities, reduce waste, rationalize coverage and reimbursement, or remove statutory limits that drive cost.

The following proposals would be implemented on various dates between 4/1/2011 and 1/1/2012:

- Enhance NYS leverage for supplemental rebates - Provides savings through the acceleration of the collection of supplemental rebates for certain drug classes and provides the Commissioner of Health with greater flexibility in targeting negotiations with pharmaceutical manufacturers.

- Tightening the early refill process - Tightens up the requirements for obtaining authorization to fill a prescription when it is denied because it has been "refilled too soon."

- Reduce pharmacy reimbursement and dispensing fees - Reduces pharmacy ingredient cost and dispensing fee reimbursement amounts to align with levels achieved in other State Medicaid Programs and commercial payers. Eliminates HIV Specialty pharmacy designation and associated higher drug reimbursement. Evaluate Average Acquisition Cost as a benchmark for pharmacy pricing.

- Increase the number of immunizations that a pharmacist may administer - Current law allows pharmacists to administer influenza and pneumococcal vaccines by certified pharmacists to patients age 18 and above. This proposal would allow certified pharmacists to administer all vaccines recommended by the CDC for patients ages 11 and above.

- Rebuild the NY Preferred Drug List (PDL) - Changes the way the preferred drug list is developed in order to increase savings by eliminating the "Prescriber Prevails" provision, having designated State staff chair the P&TC rather than a committee member, having State staff make recommendations to the P&TC, which they can accept or modify, and having the State Medicaid Director act on behalf of

the Commissioner to make final PDL determinations.

- Implement a voluntary mail order program - Create a mail order pharmacy benefit for maintenance drugs, to take advantage of higher discounts.

- Eliminate the Part D Drug Wrap - Eliminate Medicaid coverage and reimbursement of drugs that are available to Medicaid/Medicare dual eligible beneficiaries through their Medicare Part D plans.

- Allow Prior Authorization (PA) for the following drug classes: anti-depressants, atypical anti-psychotics, anti-retrovirals and immunosuppressants. Allowing PA in these classes would maximize supplemental rebate revenue and is comparable to what other states are doing.

- Implement Preferred Drug Program (PDP) prior authorization requirements based on effective date - Accelerate the collection of rebates through the immediate enforcement of a drug's non-preferred status. Current enforcement is based on the status of the drug on the date the prescription was written. This proposal would require prior authorization immediately (according to the effective of a drug's non-preferred status), regardless of when the prescription was written.

- Reimbursement changes for clotting factor products - Change the reimbursement methodology for clotting factor products to pay at the lesser of acquisition cost or the Medicaid established state maximum allowable cost (SMAC). This will provide the State with the authority to enforce and audit the acquisition cost for blood products.

- Limit opioids to four prescriptions every thirty days - Will deter "doctor shopping" and the inappropriate prescribing of controlled substances may lead to drug diversion and abuse by individuals who seek drugs for other than legitimate medical use.

- Proper disposal of unused meds and waste reduction through short cycle dispensing and re-dispensing - Would set requirements for proper disposal of unused medications and for the re-dispensing and appropriate crediting to Medicaid for medications that can be re-used, and requires that long term care pharmacies dispense drugs in smaller quantities (per the provisions of the Affordable Care Act (ACA) for Medicare Part D.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-89.40	$-44.70	$-44.70	$-44.70
Total Savings	$-175.90	$-87.95	$-87.95	$-87.95

Benefits of Proposal:
Refer to Attachments 15A- 15L

Concerns with Proposal:
Refer to Attachments 15A- 15L

Impacted Stakeholders:
Refer to Attachments 15A- 15L

Additional Technical Detail: (if needed, to evaluate proposal)
Refer to Attachments 15A- 15L

System Implications:
Refer to Attachments 15A- 15L

Metrics to Track Savings:
Refer to Attachments 15A- 15L

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15A

Proposal Author:
DOH

Proposal (Short Title):
Enhance NYS Leverage for Supplemental Rebates

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Allow the Commissioner of Health more flexibility to add drugs/classes to the PDP and in negotiating with manufacturers.

This proposal provides savings through the acceleration of the collection of supplemental rebates for certain drug classes; and by providing the Commissioner of Health with greater flexibility in targeting negotiations with pharmaceutical manufacturers.

1. Accelerate the collection of direct supplemental rebates by allowing the Commissioner of Health to add certain drugs/classes to the PDP (Eff. 7/1/2011).

Generally, the Medicaid Pharmacy and Therapeutics (P&T) Committee meets four times a year to review drug classes and make recommendations to the Commissioner of Health regarding the selection of preferred and non-preferred drugs within certain drug classes for which there is clinical comparability. This process (which is required by State statute) enables the posting of a drug as preferred on the Preferred Drug List, and the collection of supplemental rebates. Through the use of a Preferred Drug List and receipt of supplemental manufacturer rebates, the NY State Preferred Drug Program promotes access to the most effective prescription drugs, while reducing costs.

There are still some drugs and classes of drugs that have not yet been scheduled for P&T Committee review, and therefore; supplemental rebates are not being collected. These are either "one drug" classes or classes that have not been prioritized for a P&T Committee review because of the need to review other, larger drug classes for which there is greater utilization and clear clinical comparability. This proposal will allow the Commissioner to add such drugs to the PDL and designate them as preferred until such time that the P&T Committee may conduct their review; thereby accelerating the collection of supplemental rebates.

2. Allow the Commissioner of Health more flexibility when directly negotiating with manufacturers (Eff. 4/1/2011).

PHL Article 2-a section 272 11 (b) authorizes the Commissioner of Health to directly negotiate supplemental rebate agreements with pharmaceutical manufacturers and to non-prefer all of the manufacturers' drugs when an agreement cannot be reached. This proposal would provide the State

with greater leverage when directly negotiating supplemental rebates with drug manufacturers by allowing the State to select which of a manufacturer's drugs to non-prefer if an agreement cannot be reached.

The condition that all of a manufacturer's drugs must be identified as non-preferred has unintended negative consequences on the program. For example, mandating that all of a manufacturer's drugs be non-preferred could result in a shift to more expensive drugs made by another manufacturer. Amending current legislative language will allow a more targeted negotiations approach, taking into consideration any potential negative impact to the Medicaid program.

Permitting the Commissioner the discretion to select which drugs and/or drug classes to target for supplemental rebate negotiation will increase the likelihood of reaching successful supplemental rebate agreements with pharmaceutical manufacturers and will increase overall cost savings for the program.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.83	$-.415	$-.415	$-.415
Total Savings	$-1.66	$-.83	$-.83	$-.83

Benefits of Proposal:
This proposal will:

1. Accelerate the collection of supplemental rebates by adding certain therapeutic classes to the Preferred Drug Program where clinical comparability within the class is not well established (i.e. anticonvulsants), until such time that the P&TC may review.

2. Encourage drug manufacturers to enhance supplemental rebate offers; thereby increasing revenue for the State.

Concerns with Proposal:
#1 - This would not impact stakeholders, as all drugs within the therapeutic class would be determined to be preferred until such time the drug/class may be reviewed by the Pharmacy and Therapeutics Committee.

#2 - Pharmaceutical manufacturers will oppose this as it will reduce their leverage in negotiations.

Impacted Stakeholders:
Manufacturers, Prescribers and Pharmacies will be impacted by #2. However, with the ability to target negotiations, NY State will be able to reduce the impact of prior authorization requirements on pharmacies and recipients.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
This proposal can be implemented without modification to established systems.

Metrics to Track Savings:
Metrics to estimate savings will be based on measuring supplemental rebates and market share movement within affected therapeutic classes.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15B

Proposal Author:
DOH

Proposal (Short Title):
Tightening the Early Refill Process

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Tighten up requirements for obtaining authorization to fill a prescription when it is denied because it has been "refilled too soon."

The Department of Health can require prior authorization for any refill of a prescription when less than 75% of the previously dispensed amount has been used. Prescribed changes in therapy (increased dose, or changes in frequency) bypass the early fill edit. Based on the "75% rule," over the course of 360 days, the beneficiary is able to obtain an extra 60 day supply of medication.

When the early fill edit was originally implemented, pharmacists were able to override denials at the point of sale when medically necessary. Early fill overrides were allowed for lost/stolen medication, "04" and for vacation supply "03". Since implementation of the early fill edit, Medicaid program staff has monitored claims activity and determined that overrides were being over utilized, and quality of care and program integrity (including patterns of abuse, fraud or diversion), were not being effectively addressed. Therefore, effective July 26, 2010, New York Medicaid eliminated the ability for the pharmacist to override the early fill edit for vacation supply, and replaced it with the requirement for recipients to call to obtain authorization for an early fill.

In the near future, New York Medicaid will implement a similar procedure for recipients to obtain an override of the early fill edit due to lost or stolen medication. The goal of this initiative is to maintain program integrity in terms of quality of care, protection of public health, and fiscal responsibility, while giving prescribers and pharmacies the ability to handle urgent early fill requests with no interruption of therapy.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.60	$-.30	$-0.30	$-0.30
Total Savings	$-1.20	$-.60	$-.60	$-.60

Benefits of Proposal:

The proposal will reduce overutilization of the override process while allowing for identification of inappropriate/misunderstood drug regimens. Patterns of abuse, fraud, or diversion will be identified.

Concerns with Proposal:
Advocacy groups may express concerns as it could be perceived as limiting access to medication.

Impacted Stakeholders:
Beneficiaries, prescribers, pharmacists

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
A system change is needed to modify the early refill edit for lost/stolen medications so that it can only be overridden by a prior authorization.

Metrics to Track Savings:
Savings will be tracked by analyzing claims data pre and post implementation.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15C

Proposal Author:
DOH

Proposal (Short Title):
Reduce Pharmacy Reimbursement and Dispensing Fees

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Reduction in pharmacy ingredient cost and dispensing fee reimbursement amounts to align with levels achieved in other State Medicaid Programs and commercial payers.

The changes being proposed are as follows:

- Decrease the reimbursement level for brand drugs from Average Wholesale Price (AWP) less 16.25% to AWP less 17%.

- Decrease the dispensing fees paid for generic drugs from $4.50 to $3.50.

- Evaluate Average Acquisition Cost as a benchmark for pharmacy pricing.

- Eliminate the HIV specialty pharmacy designation and associated higher drug reimbursement. Currently, pharmacies that meet criteria as defined in Social Services Law, receive a higher reimbursement rate of AWP-12% for both brand-name and generic drugs.

The enhanced HIV Specialty Pharmacy rate was originally developed to support the provision of specific counseling for HIV medications and special packaging of medication. However, many pharmacies now offer these value added services for their patients with serious, chronic diseases, including HIV/AIDS, without enhanced reimbursement. There is currently only one pharmacy (MOMS Pharmacy) that has met all qualifications and has been designated as an HIV Specialty Pharmacy.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-30.20	$-15.10	$-15.10	$-15.10
Total Savings	$-60.40	$-30.20	$-30.20	$-30.20

Benefits of Proposal:

This proposal will position NYS Medicaid fee-for service pharmacy reimbursement levels on par with the most competitive rates in the commercial sector and other State Medicaid Programs. It will also ensure consistency of reimbursement rates for all pharmacies.

Concerns with Proposal:
Pharmacy organizations will argue that these reductions to the reimbursement rate will result in pharmacies disenrolling from the Medicaid program and pharmacy closures. Further, pharmacy organizations will assert that patient access to prescription drugs will become impeded with fewer Medicaid enrolled pharmacies.

Impacted Stakeholders:
Pharmacy providers and Medicaid enrollees.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
Comparative analysis of reimbursement at proposed levels versus previous levels would be conducted on a regular basis to determine savings.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15D

Proposal Author:
NYSCHP

Proposal (Short Title):
Increase the Number of Immunizations that a Pharmacist May Administer

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Pharmacy

Effective Date: 08/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
This proposal will allow pharmacists to administer all vaccines recommended by the CDC for patients ages 11 and above.

Pharmacists' scope of practice was increased in 2008 to include administration of influenza and pneumococcal vaccines by certified pharmacists to patients age 18 and above. Changing the scope of practice as proposed will increase the number of people receiving recommended vaccines, which will result in decreased costs for treatment of diseases such as Hepatitis A and B, Shingles and Tetanus.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:

Concerns with Proposal:

Impacted Stakeholders:
Beneficiaries ages 11 and above who require vaccines and enrolled pharmacists.

Additional Technical Detail: (if needed, to evaluate proposal)
The influenza vaccine saves $182 in medical costs for every person age 65 and older who is vaccinated.
Vaccinating adolescents against meningitis could save up to $18 million nationwide.

System Implications:
None known.

Metrics to Track Savings:

Contact Information:

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15E

Proposal Author:
MRT Member (Steve Acquario NYSAC); HANYs; NACDS, Gregory Blass (Suffolk Co DSS Commissioner)

Proposal (Short Title):
Rebuild NY Preferred Drug List

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 05/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Change the way the preferred drug list is developed, in order to increase savings.

The Preferred Drug Program promotes the use of less expensive, equally effective prescription medication when medically appropriate through the use of a Preferred Drug List (PDL). The PDL consists of therapeutic classes where drugs are grouped into classes because they produce a similar clinical effect or outcome. The development of the Preferred Drug List (PDL) is based on recommendations made by the Pharmacy and Therapeutics Committee (P&TC). Recommendations are presented to the Commissioner of Health for final determination.

Savings associated with the PDP are realized through the collection of supplemental (which are over and above base federal rebates), and market share movement to less expensive drugs. Market share movement to preferred/less expensive drugs is achieved by requiring prior authorization for non-preferred drugs. State statute includes language which allows the prescriber to prevail for all PDP prior authorization requests. When a prior authorization is requested for a non-preferred drug, the State must ultimately authorize the request.

This proposal would change the PDL process as follows:

- A bid review will be conducted by the State to initiate direct negotiation with manufacturers

- Designated State staff will chair the P&TC.

- State staff will make a recommendation to the P&TC and the P&TC will either accept or modify that recommendation.

- The State Medicaid Director, acting on behalf of the Commissioner will make final determinations.

- The "Prescriber Prevails" provision will be eliminated.

The savings for this proposal are "standalone" and independent of the savings projected for Proposal

#11 - "Bundle Pharmacy into Managed Care." Preliminary savings are based on an increase in generic dispensing rate from 65% to 70%. Final savings will be calculated based on a class by class review, comparing New York's PDL to Wisconsin's PDL.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-42.20	$-21.10	$-21.10	$-21.10
Total Savings	$-84.30	$-42.20	$-42.20	$-42.20

Benefits of Proposal:
By conducting more aggressive direct negotiations with manufacturers, greater supplemental rebates will be obtained. Additionally, by designating a State staff member to chair the P&T Committee, the State would enhance its role in the development of P&T Committee recommendations. Eliminating the "prescriber prevails" provision may provide additional leverage needed to promote equally efficacious and more cost effective drugs with each therapeutic class. It will also encourage drug manufacturers to enhance supplemental rebate offers.

Concerns with Proposal:
Prescribers, advocacy groups and drug manufacturers will oppose the elimination of the "prescriber prevails" provision as it will be perceived as limiting access to non-preferred drugs. Given the elimination of the "prescriber prevails" provision, prescribers may need to attribute more time associated with obtaining prior authorization associated with providing clinical justification for a non-preferred drug.

Impacted Stakeholders:
Prescribers, Pharmacies, Recipients, Manufacturers

Additional Technical Detail: (if needed, to evaluate proposal)
Eliminating the "prescriber prevails" provision will require the development of process to evaluate and resolve appeals associated with denied prior authorization requests.

System Implications:
It is recommended that the following system enhancements be implemented:
- Support the grandfathering patients stabilized on non-preferred drugs
- Increase the time that a prior authorization valid (i.e. from 6 months to one year)

Metrics to Track Savings:
The following metrics would be used to track savings:
- Generic Fill Rate
- Levels of supplemental rebates
- Market share movement to lower cost drugs

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Viability: Merged with Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15F

Proposal Author:
DOH

Proposal (Short Title):
Implement a Voluntary Mail Order Program

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Create a mail order pharmacy benefit for maintenance drugs, to take advantage of higher discounts.

By implementing this proposal, NY State Medicaid would take advantage of discounts offered by mail order pharmacies, which are typically higher than current Medicaid discounts. This would be a voluntary mail order program where recipients could obtain up to a 90 day supply of maintenance medication through the mail. The mail order pharmacy benefit would be achieved by enrolling/credentialing any willing provider that agrees to accept a reduced reimbursement rate.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-5.00	$-2.50	$-2.50	$-2.50
Total Savings	$-10.00	$-5.00	$-5.00	$-5.00

Benefits of Proposal:
This proposal would enable NY State to take advantage of higher discounts that are typically available through mail order pharmacies. This would also be convenient for beneficiaries, as they would only need to re-order every 90 days and medication would be delivered to their homes.

Concerns with Proposal:
Independent pharmacies will strongly oppose the use of mail order pharmacies for Medicaid beneficiaries. They will claim that mail order pharmacies are unable to provide the same level of service and/or that prescriptions will not be appropriately and safely delivered. They will also be concerned that this proposal will prompt Medicaid recipients to use mail instead of retail, and they will lose them as customers.

Impacted Stakeholders:
Pharmacies and Beneficiaries

Additional Technical Detail: (if needed, to evaluate proposal)
Credentialing criteria and provider agreements will need to be developed.

System Implications:
System enhancements will need to ensure that mail order pharmacies are differentiated and paid at the appropriate reimbursement rate.

Metrics to Track Savings:
The cost of claims provided by mail order pharmacies will be tracked and will be compared to the cost if they were provided at a non-mail order pharmacy.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15G

Proposal Author:
DOH

Proposal (Short Title):
Eliminate Part D Drug Wrap in Medicaid

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Eliminate Medicaid coverage and reimbursement of drugs that are available to Medicaid/Medicare dual eligible beneficiaries through their Medicare Part D plans.

Medicaid currently provides State-only funded "wrap-around" coverage of four drug classes for beneficiaries also eligible for Medicare Part D (dual eligibles). These drug classes are: atypical antipsychotics, antidepressants, antiretroviral drugs used in the treatment of HIV/AIDS and immuno-suppressants used for organ and tissue transplants.

Medicare Part D plans must ensure beneficiaries receive clinically appropriate medications and must provide a broad range of medically appropriate drugs. The Federal Centers for Medicare and Medicaid Services (CMS) designates six classes of drugs to be of clinical concern: antidepressants, antipsychotics, anticonvulsants, anticancer, immunosuppressant and HIV/AIDS drugs. This means that access to "all or substantially all" of the drugs in these specific categories must be covered by plan formularies. During the first two years of Medicare Part D implementation, the NYS Medicaid program addressed concerns over patient drug access by providing additional, though duplicative, drug coverage for Part D enrollees for four of the six classes. This coverage is provided at 100% State share.

The Medicare Part D program is now entering its sixth year of operation and significant improvements have been made to the program to assure Part D drug access. CMS continues to provide strong guidance to Part D plans to assure coverage of drugs, specifically in the categories of clinical concern. NYS Medicaid has continued to provide duplicate coverage despite the fact that issues of access have been addressed by CMS. With adequate and appropriate outreach by NYS Medicaid, prescriptions for drugs in the four Medicaid wrap-around classes can be safely transitioned to the dual eligible's Part D plan.

Less than 1% of the total dual eligible population is impacted. There is no effect on 99% of this population. In addition, CMS Part D rules assure access at the counter for new enrollees and enrollees who change plans.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15

State Savings	$-2.80	$-1.40	$-1.40	$-1.40
Total Savings	$-2.80	$-1.40	$-1.40	$-1.40

Benefits of Proposal:
Patients' medications can be better managed when administered through a single plan (for example, avoiding therapeutic duplications and adverse events). A comprehensive drug profile will also be useful in Part D plans meeting CMS' requirement for medication therapy management programs for their Medicare beneficiaries with chronic diseases.

Concerns with Proposal:
The population served by the Medicare Part D drug wrap is considered to have serious, chronic diseases and this proposal would eliminate the State's "safety net" coverage. In addition, pharmacy associations may oppose due to the loss of NYS Medicaid's more generous reimbursement for these drugs, along with less cumbersome administrative process to obtain coverage, and speedier payments.

Impacted Stakeholders:

Beneficiaries, Part D plans, Pharmacies

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
Compare State-only funded wrap claims data in year prior to implementation with claims data post implementation.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15H

Proposal Author:
DOH, MRT Member Dr. Nirav Shah

Proposal (Short Title):
Prior Authorization for Exempt Drug Classes

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Allow prior authorization under the Preferred Drug Program (PDP) for the following drug classes: anti-depressants, atypical anti-psychotics, anti-retrovirals and immunosuppressants.

Drugs in these four classes account for 50% of the spending for the top 25 drugs (based on dollars). The use of prior authorization would leverage better prices through the collection of supplemental rebates, while also promoting quality and efficacious drug treatment.

Generally, the Medicaid Pharmacy and Therapeutics (P&T) Committee meets four times a year to review drug classes and make recommendations to the Commissioner of Health regarding the selection of preferred and non-preferred drugs. All drugs in the Preferred Drug program remain available. Drugs designated as non-preferred can be accessed through the PA process. Through the use of a Preferred Drug List and receipt of supplemental manufacturer rebates, the NY State Preferred Drug Program promotes access to the most effective prescription drugs, while reducing costs.

Allowing PA in these classes would maximize supplemental rebate revenue and is comparable to what other states are doing. In a survey of 28 states, 25 responded that they include antidepressants in their PDP and 17 include atypical anti-psychotics. Since the implementation of the PDP, NY State has successfully leveraged supplemental rebates for the classes that allow PA. The current PA exempt classes represent an untapped opportunity to further reduce costs through increased supplemental rebates and market share movement to preferred drugs, which have been deemed clinically comparable to higher cost nonâ€“preferred alternatives.

This proposal could be enhanced with the development of funding for adherence interventions that focus on highest value medications.

The fiscal estimate for SFY 11 12 is based on an assumption that approximately 35% to 40% of the estimated full annual state savings of $17.1 million can be achieved due to:

- the required review and approval time associated with the P&TC process;
- the lag in receipt of anticipated (additional) supplemental rebates

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-6.40	$-3.20	$-3.20	$-3.20
Total Savings	$-12.80	$-6.40	$-6.40	$-6.40

Benefits of Proposal:
The proposal will provide the leverage needed to promote equally efficacious and more cost effective drugs with each therapeutic class. The proposal may encourage drug manufacturers to offer or enhance supplemental rebate amounts.

Concerns with Proposal:
Prescribers and advocacy groups will oppose as this proposal as it will be perceived as limiting access to non-preferred drugs.

Impacted Stakeholders:
Prescribers, Recipients and Pharmacies

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
It is recommended that the following system enhancements be implemented:
- Support the grandfathering of patients stabilized on non-preferred drugs
- Increase the time that a prior authorization valid (i.e. from 6 months to one year)

Metrics to Track Savings:
Metrics to track savings would be based on an evaluation of supplemental rebates and market share movement to more cost effective drugs.

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15l

Proposal Author:
DOH

Proposal (Short Title):
Implement Preferred Drug Program prior authorization requirements based on effective date

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Accelerate the collection of rebates through immediate enforcement of a drug's non-preferred status.

Currently, when a drug becomes non-preferred it can be dispensed without a prior authorization as long as the prescription was written before the prior authorization requirement became effective. A prior authorization may not be necessary for a newly classified non-preferred drug for up to 6 months/180days (original prescription and 5 refills).

This proposal would require prior authorization immediately (according to the effective of a drug's non-preferred status), regardless of when the prescription was written by the prescriber. Therefore, new prescriptions and refills of existing prescriptions would require prior authorization even if the prescription was written by the prescriber before the drug was determined to be non-preferred.

The PDP currently has a very effective outreach and education program aimed at notifying providers of changes to a drug's preferred status. Prescribers are targeted for outreach and education, based on their history of utilizing newly determined non-preferred drugs. This education/outreach program would also be used to notify prescribers of the changes contained in this proposal.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.39	$-0.195	$-0.195	$-0.195
Total Savings	$-0.78	$-.39	$-.39	$-.39

Benefits of Proposal:
Accelerates the collection of supplemental rebates by enforcing a drug's non preferred status according to effective date.

Concerns with Proposal:
Providers will have concerns with this propsoal, as it will be perceived as being administratively burdensome.

Impacted Stakeholders:
Prescriber, Pharmacists, and Beneficiaries.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
A system change would be needed to correctly enforce prior authorization requirements based on the effective date of a drug's status.

Metrics to Track Savings:

Contact Information:

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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15J

Proposal Author:
DOH

Proposal (Short Title):
Reimbursement Changes for Clotting Factor Products

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 11/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Change the reimbursement methodology for clotting factor products to pay at the lesser of acquisition cost or the Medicaid established state maximum allowable cost (SMAC).

Medicaid beneficiaries with bleeding disorders require the infusion of clotting factor products for the prevention and treatment of bleeding episodes. These clotting factor products are often provided by a Hemophilia Treatment Center (HTC) or by a pharmacy and are dispensed for in home use. For state fiscal year 2009-10, Medicaid reimbursement for clotting factor exceeded $29 million dollars, for the treatment of 142 beneficiaries.

This proposal would require the following reimbursement changes:
- Providers would be required to provide actual acquisition cost with claim submissions.
- Claims would be paid at the lesser of submitted acquisition cost or the SMAC.
- An appeal process (similar to the existing SMAC appeal process for multi-source generic drugs) would be established so that providers have a mechanism to appeal situations when their acquisition cost is greater than the upper limit.

An initial analysis by State staff indicates that acquisition cost is greater than the current SMAC for blood products. While this proposal may be cost neutral, it will provide the State with the authority to enforce and audit the acquisition cost for blood products.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Implementation of an actual acquisition cost methodology would provide transparency in the payment of clotting factor products, and would result in savings to the state.

Concerns with Proposal:

Pharmacy providers may be reluctant or unwilling to provide invoice or actual acquisition cost to the state, and therefore the number of willing providers that dispense clotting factor products may be reduced.

Impacted Stakeholders:
Beneficiaries with hemophilia or bleeding disorders, prescribers, and pharmacy providers

Additional Technical Detail: (if needed, to evaluate proposal)
This would require that a contractor specializing in pharmacy pricing to be responsible for the following functions:
- Determine pricing through surveys and/or other available mechanisms
- Administer an appeal process
- Provide updates to pricing tables in the claims processing system

System Implications:
System changes would be required to alter the reimbursement methodology for clotting factor products.

Metrics to Track Savings:
Comparison of unit cost for clotting factor products pre and post reimbursement methodology changes.

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
Phone: 518-473-0919
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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15K

Proposal Author:
DOH

Proposal (Short Title):
Limit opioids to a four prescription fill limit every thirty days.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 12/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Limit opioid prescriptions to a four prescriptions fill limit every thirty days for Medicaid beneficiaries.

Opioid analgesics, are also known as narcotics or opiates, and include morphine, codeine, oxycodone (OxyContin), hydrocodone (Vicodin, Lortab) and fentanyl (Duragesic patches). Opioid analgesics are generally prescribed to treat severe pain. The pain can be acute (short-term) pain, such as that associated with accidents and surgery; chronic (long-term) pain, due to cancer or terminal illness; and chronic pain, due to long-term conditions that are not terminal, such as back pain or headaches. Every month the New York State Department of Health identifies thousands of patients who obtain controlled substance prescriptions from multiple prescribers within the same month, an activity often referred to as "doctor shopping." Patients engaged in this illegal activity obtain controlled substances for their own addiction and/or street sale of the controlled substances. Additionally, the inappropriate prescribing of controlled substances may lead to drug diversion and abuse by individuals who seek drugs for other than legitimate medical use. Between 1992 and 2003, the rate of increase of prescriptions for controlled substances (154%) rose far in excess of both the U.S. population (13%) and the prescriptions for non-controlled substances (57%).

While opioid analgesics play a significant role in pain management, there has been a significant increase in opioid prescribing in NYS and nationally. As the utilization of opioid analgesics increases, evidence demonstrates that fraud, misuse, diversions and overuse also increases. According to BNE data, 46% of all oxycodone prescriptions obtained by Medicaid patients in 2010 were obtained by patients that exhibited doctor shopping behavior (obtained prescriptions from 2 or more practitioners and 2 or more pharmacies in same month).

This proposal would limit opioid prescriptions to a four prescription fill limit every thirty days for Medicaid beneficiaries. Prescription claims for beneficiaries that exceed the four opioid prescription limit would be denied at the pharmacy. If the prescriber feels that an override of the four prescription limit is medically necessary, then the prescriber would need to request an override for the additional opioid prescription.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15

State Savings	$-0.20	$-.10	$-0.10	$-0.10
Total Savings	$-0.40	$-.20	$-.20	$-.20

Benefits of Proposal:
Significant public health benefits would be realized by deterring the inappropriate prescribing of controlled substances and the "doctor shopping" behaviors that lead to overuse and diversion of opioid analgesics. By limiting the use of opioids to four prescriptions every thirty days, we can deter inappropriate utilization without impacting most of the recipients using opioid analgesics (only 946 recipients are affected out of the 121,946 that are using Opioids).

Concerns with Proposal:
Advocates and affected prescribers and beneficiaries may oppose limits citing concerns with appropriate treatment of pain.

Impacted Stakeholders:
Prescribers, pharmacies and beneficiaries

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
Point of sale pharmacy claim editing would need to be developed to deny opioid prescription drug claims that exceed the four prescriptions per thirty day limit. A system authorization and override process would also need to be developed for extenuating circumstances where it has been determined that an additional opioid analgesic prescription is medically necessary. It is also recommended that a system enhancement be implemented to support the editing of claims for certain diagnoses and/or utilization in order to automatically bypass the four prescription limit.

Metrics to Track Savings:
Savings would be evaluated by comparing utilization for opioid analgesics pre and post implementation of a system edit that would enforce four opioid prescriptions in a thirty day time period.

Contact Information:

Organization: Division of Financial Planning & Policy
Staff Person: Greg Allen
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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Attachment 15L

Proposal Author:
Blossom View Nursing Home, PSSNY, NYSHFA, NYSCAL,Scott C. Amrhein, CLLC; Robert J. Murphy, NY State Health Facilities Association, Island Nursing and Rehab Ctr., Effie Batis, Southern New York Association; Leonard Russ of Bayberry Nursing Home and Aaron Manor Nursing and Rehab Center; Ron Zito of Our Lady of Peace Nursing Care Residence

Proposal (Short Title):
Proper disposal of unused meds and waste reduction through short cycle dispensing and re-dispensing

Theme: Better Align Medicaid with Medicare and ACA

Program Area: Pharmacy

Effective Date: 01/01/2012

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Ensure the appropriate disposal and/or return of unused medications and require long term care (LTC) pharmacies to dispense in quantities less than 30 days

Ensure appropriate disposal of unused medications by:

-Convening an oversight group of appropriate state officers and agencies to adopt and approve a practical set of standards for pharmaceutical waste management program.

-Allow Long Term Care (LTC) facilities to transport or relinquish custody to a State approved agent to transport controlled substances for the purpose of disposal and destruction. Enact legislation stipulating that LTC facilities shall not be subject to criminal prosecution, liability tort or other civil action for injury death or liability after relinquishing authority for these substances.

-Designate an appropriate and safe location as a community drug take-back site.

-Set up a group to approve appropriate options for the disposal of controlled substances; i.e. state approved on-site disposal, state approved mail disposal program, off-premise community take-back program, reverse distributor program.

-Pass "Karon's Law" which would allow long term healthcare facilities to donate (as opposed to destroying) unused, properly packaged medications for the needy (including Medicaid recipients). Appropriate recycling reimbursement for providers and pharmacies should be included.

-Create a system to appropriately return unused, properly packaged medications to vendors for a credit, and require that the Medicaid program be appropriately credited.

- Implement short cycle dispensing, consistent with provisions in the Affordable Care Act (ACA) for Medicare Part D, which requires long term care pharmacies to dispense smaller quantities of all drugs

(Currently, most prescriptions for Medicaid beneficiaries in long term care (LTC) facilities are for a 30 day supply.

Proposed Medicare Part D rules, scheduled to be effective 1/1/2012 for short cycle dispensing are:

- Dispense brand-name meds in LTCFs in no greater than 7-day increments;
- Exclusions:
- Drugs difficult to dispense in 7-day or less increments (eye drops, nasal sprays, etc);
- Drugs dispensed for acute illnesses i.e. 10- or 14-day course of antibiotics;
- LTC pharmacy contracts must include requirement for unused drugs to be returned to pharmacy and reported to plan sponsor; address contractual obligations for disposal; and address whether return for credit and reuse is authorized where permitted under State law.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.80	$-.40	$-.40	$-.40
Total Savings	$-1.60	$-.80	$-.80	$-.80

Benefits of Proposal:
- Dispensing smaller quantities of medications to in long term care will result in less waste. Additionally, by being consistent with ACA provisions it will conform to the system and operational changes that long term care pharmacies and facilities will be making to accommodate Part D plans.

Concerns with Proposal:
- The involvement of multiple state agencies add to complexity related to the authority of regulatory jurisdiction.

- Use of the reverse distributer for purposes of destruction is often very costly and geographically challenging for nursing home providers.

- Community take-back programs require the presence of law enforcement and the transport of medications by a non licensed reverse distributor.

- The Department of Environmental Conservation (DEC) continues to work with the Department of Health (Bureau of Narcotic Enforcement, LTC, Acute Care) and the NYS Board of Pharmacy to determine appropriate and safe disposal options for controlled substances.

- Passage of Karon's law could result in significant health care concerns for individuals if proper safeguards are not applied to the re-dispensing of medication.

- Pharmacies may request reimbursement for the extra work involved in short-cycle dispensing. Short cycle dispensing may also be seen as an additional administrative burden for nursing home staff because they must receive and order medications more often.

Impacted Stakeholders:
Pharmacies, NYS nursing homes, Article 28 hospitals, health care consumers (public), pharmaceutical companies, licensed reverse distributors, NYS Board of Pharmacy, Department of Health (Bureau of Narcotic Enforcement, OLTC, and Acute care), Federal Drug Administration (FDA), Department of Environmental Conservation (DEC), and the Office of the Attorney General (OAG).

Additional Technical Detail: (if needed, to evaluate proposal)
The NYS Department of Environmental Conservation has already convened an interagency pharmaceutical task force to explore the development of law and regulations to address drug disposal by ultimate users. The next meeting is scheduled for early 2011. The group will focus on safe and efficient alternatives for medication destruction including reverse distribution, chemical compounds to render the medications unrecoverable and beyond reclamation. In March 2009, the Department made

multiple recommendations to the Federal Drug Enforcement Agency that would allow patients and facilities to effectively dispose of controlled substances in a manner that is both secure and environmentally sound.

Not all components of this proposal are within the purview of the Department of Health.

System Implications:
System changes would need to be made to accommodate "partial fills" and apply appropriate dispensing fees.

Metrics to Track Savings:
- Comparison of claims data and/or costs for long term care pharmacy claims pre and post implementation.

- Annual RHCF Cost Reports

Contact Information:

Organization: Division of Financial Planning and Policy
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Viability: Merged into Proposal #15 Pharmacy

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 17

Date Submitted:01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Reduce fee-for-service dental payment on select procedures

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 05/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Fee-for-service dental payments should be reduced to match rates paid by managed care providers on high volume dental procedures.

Medicaid spending for the top 50 highest volume dental procedures for calendar year 2009 was $237 Million. This proposal recommends decreasing the amount paid per procedure in the dental fee schedule for these high volume procedures to that of the average Medicaid Managed Care payment amount. The recommended decrease in fee-for-service (FFS) payments would generate a projected savings of $60.4 Million ($30.2 Million state share). Note: Children's preventative dental procedures (i.e., D1120, D1203) were not included with this fiscal and are not subject to reduction under this proposal.

Full impact estimates have been reduced for each fiscal year by 5%, 15%, 20%, and 25% to account for movement for MMC.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-26.28	$-25.66	$-24.15	$-22.64
Total Savings	$-52.57	$-51.32	$-24.15	$-45.28

Benefits of Proposal:
Rationalizes payment between fee-for-service and managed care Medicaid.

Concerns with Proposal:
Other than services coded with D1120 and D1203, fiscal may include some services provided to individuals under 21 years of age. Proposal could result in some dental access issues.

Impacted Stakeholders:
Dentists in the office setting. Dental clinics do not bill against the dental fee schedule and, as such, would not be impacted.

Additional Technical Detail: (if needed, to evaluate proposal)
None

System Implications:
Minor

Metrics to Track Savings:
Dental claim data from the eMedNY claims database

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Comments:
Based on Medicaid Managed Care (MMC) payment data

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 18

Proposal Author:
MRT Member (Eli Feldman, Metropolitan Jewish Health System), HANYS, NYSFHA, NYSCAL, Web, Suffolk Co. DSS; Jamaica Hosp. NH;Onondaga Co., HANYs; Website richherman@gmail.com 2- Website anonymous, OPWDD; Joan Travan; Onondaga County; Senate Medicaid Reform Task Force

Proposal (Short Title):
Eliminate spousal refusal.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Eligibility

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Eliminate the loophole that allows legally responsible relatives (spouse, parent) to refuse to financially support them in order for the other relative (spouse, child) to obtain Medicaid.

Federal law and regulations require that the income and resources of legally responsible relatives residing in the same household as the Medicaid applicant be counted in determining the applicant's eligibility for Medicaid. A legally responsible relative is the spouse of an applicant and a parent of a child under the age of 21. Income and resources of parents are counted for a blind or disabled child up to age 18. Currently, under State law, a legally responsible relative living with a Medicaid applicant may refuse to make his/her income and resources available to the applicant. Under such circumstances, Medicaid eligibility for the applicant is determined based on only the applicant's income and resources. Local departments of social services may pursue a recovery of Medicaid paid from the non-contributing spouse/parent.

This proposal would count the income and resources of a legally responsible relative who is living with an applicant for purposes of determining the applicant's eligibility for Medicaid.

While aggregate data on the number of spouses who refuse to make their income and resources available to their spouse is not available, local districts report that spousal refusal to obtain home care is relatively common, with more spouses refusing downstate than upstate. The financial impact of the proposal is based on limited data and assumes 45% of home care recipients are married, and of those, 75% (8,419 cases) refuse to make their income and resources available to their spouse so that spouse can qualify for Medicaid.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-28.30	$-56.50	$-56.50	$-56.50
Total Savings	$-56.60	$-113.00	$-113.00	$-113.00

Benefits of Proposal:
This proposal would bring State law into compliance with Federal law and regulations. Currently, New York State is not in compliance with Federal law and regulations and is at risk of an increased error rate and the loss of federal financial participation. The proposal would also eliminate local district and State resources currently used to pursue Medicaid repayments through court action which would no longer be necessary of the income of both all legally responsible relatives were counted in determining eligibility. The proposal would maintain program integrity and state wideness. The degree to which spousal refusal cases are pursued is largely dependent on the available resources of the local department of social services and outcomes can vary widely by districts. Court decisions also vary widely by county. For individuals who require health care coverage for costly long-term care services, the Medicaid program has home and community-based waiver programs available. Under the waiver programs, couples are afforded the same income and resource protections as those allowed under the spousal impoverishment provisions for nursing home residents. Waivers for disabled children disregard parental income and resources in determining the eligibility of the child. There are increased slots available for the Care at Home Waiver program.

Concerns with Proposal:
The proposal would require legally responsible relatives to support their dependents; some persons receiving Medicaid may lose eligibility.

Impacted Stakeholders:
Consumers
Local Departments of Social Services
Long-term Care Providers
Elder Attorneys

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
None

Metrics to Track Savings:
Decline in legally responsible relatives refusing to support spouse/child

Contact Information:

Organization: Division of Coverage and Enrollment
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Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 21

Proposal:
Streamline the Processing of Nursing Home Rate Appeals

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** **Statutory Change:** Yes
State Plan Amend **Federal Waiver**

Proposal Description:
This proposal would streamline the processing of nursing home rate appeals by prioritizing and amending processing timeframes, authorizing negotiated settlements, and temporarily capping the annual dollar amount of appeals authorized to be processed.

To streamline the processing of the backlog of over 5,800 nursing home rate appeals and achieve Financial Plan savings, this proposal would temporarily cap the annual impact of processing nursing home rate appeals to no more than $80 million annually for the next four years. In addition, the proposal would permanently authorize the Commissioner to:

- Establish priorities and amend timeframes for processing all outstanding appeals by taking into consideration the fiscal condition of facilities and other factors deemed appropriate (e.g., appeals that shift facilities from budget to cost based rates, rebasing appeals and significant capital projects),
- Enter into arrangements with facilities to negotiate the settlement of multiple pending appeals, and
- Reduce negotiated settlement amounts payable to a facility by any outstanding amounts (e.g., assessments) owed to the State.

Under current regulations, the Department is required to process all appeals within one year of receipt. Although the Department has processed over 11,000 appeals and makes every effort to annually process as many appeals as possible, litigation and limited staff resources make it difficult to reduce the backlog.

In determining if a facility is financially challenged, the Department would consider (among other things) a facility's net operating profit or loss as reported in its most recent cost reports; its current cash flow position and its ability to meet daily operating expenses, its outstanding liabilities (including those owed to the State), and if its eligible for Financially Disadvantaged payments.

To expedite the processing of outstanding appeals, the Department would be authorized to enter into negotiated settlement agreements with facilities. Facilities that agree to negotiate a reasonable and justifiable value of outstanding appeals would be required to enter into a legal agreement/stipulation with the Department that requires:

- All or a portion of the proceeds from the appeals would be first used to offset their outstanding

assessments,

● The facility to agree not to appeal the settlement, and that all such outstanding appeals are deemed processed and finalized, and

● If relevant, the facility to remain current/timely with the payment of all future assessments, and if such facility is not timely, agree to allow the Department to reduce its Medicaid payments by the amount of outstanding assessments.

A similar proposal was implemented in 2010-11 Enacted Budget, but only remains in effect through March 31, 2011. The Department anticipates that it will exceed (but will only process) appeals equal to the $80 million cap in 2010-11. Due to the use of staff resources to program and calculate rates, and process financially disadvantaged, rebasing and budget-to-cost based rate appeals, the Department to date has not entered into any negotiated settlements. However, the Department has developed a standard negotiated settlement agreement, has begun to work with a test-case facility and anticipates it will be able to expand the use of this tool in 2011-12.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	-$20.0	-$20.0	-$20.0	-$20.0
Total Savings	-$40.0	-$40.0	-$40.0	-$40.0

Benefits of Proposal:

● Provide limited staff resources a tool to help expedite the processing of the backlog of over 5,800 outstanding NH appeals (comprising over 13,000 individual issues of appeal).

●Authorizing the Department to prioritize appeals for financially distressed facilities will help ensure that limited resources for appeals are earmarked to those with the greatest financial need.

●Authorizing the Department to establish timeframes for the processing of outstanding appeals will help insulate the Department from burdensome litigation. The Department has been sued 400 times in the past ten years (i.e., challenging the complex rate setting methodology or compelling the Department to process outstanding appeals). The processing of litigation is a time consuming effort that diverts staff from efforts to address the backlog and to process appeals for financially distressed facilities. The Department does not have the staff or financial resources to satisfy a court ordered mandate that could require it to process a substantial portion (or all) of the backlog.

Concerns with Proposal:

●Many nursing homes have been waiting for a significant period of time to have their outstanding appeals processed and will object to placing dollar limits and fiscal condition criteria on the appeals that can be processed. However, limited staff naturally constrains the number of appeals that can be processed.

●Not all appeals can be negotiated (e.g., budget-to-cost based rate appeals, rates for new facilities, significant approved capital project costs, Medicaid Allowable Transfer Prices). However, the ability to enter into negotiated settlements for many other appeals will help expedite the processing of the backlog of appeals.

Impacted Stakeholders:

Nearly all nursing homes have outstanding appeals.

Additional Technical Detail:

None

System Implications:
None

Metrics to Track Savings:
Monitor and track the impact of appeals processed traditionally and through negotiated settlement process.

Contact Information:

Organization: Division of health Care Financing
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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 24

Proposal Author:
DOH

Proposal (Short Title):
Payment for Enteral Formula with Medical Necessity Criteria

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
This proposal would provide coverage of enteral formula to individuals who cannot obtain nutrition through any other means.

As a medical supply item, enteral formula is carved out of Medicaid Managed Care so all payment is through Fee For Service. Medicaid expenditures are over $60 million gross and rising. Under this proposal, coverage would be limited to three uses: tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube, individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means and for children who require medical formulas due to mitigating factors in growth and development. A fourth coverage could be included (with lower savings) to include adults whose Body Mass Index (calculated by ratio of height to weight) is considered underweight by the Centers for Disease Control measures. This proposal would eliminate payment for formula consumed as a convenient food substitute

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-15.40	$-16.80	$-16.80	$-16.80
Total Savings	$-30.80	$-33.60	$-33.60	$-33.60

Benefits of Proposal:
This proposal preserves the benefit for those most in need. For adults who can consume food orally, dietary needs can be met through nutrition education to purchase and prepare readily available foods and consistencies. Newer anti-wasting drugs are now available which mitigate the need for nutritional

supplementation used previously in treatment. An alternative would allow coverage for underweight adults who can also consume table food, with savings reduced to $10.95 million State/$21.9 million Total for 2011-12 and $11.95 million State/$23.9 million Total for 2012-13 and thereafter.

Concerns with Proposal:
Enteral formula is marketed for oral use to enhance nutritional status in the elderly and in various diseases, including diabetes, renal disease, HIV and cancer. If individuals do not have access to targeted nutritional formulas or adequate food for special diets, their overall health status could suffer. This proposal would eliminate coverage for these individuals who face challenges in preparing or obtaining appropriate food and nutrition.

Impacted Stakeholders:
Pharmacy and DME providers dispensing formula would be negatively affected economically. Beneficiaries for whom coverage would be eliminated would face challenges in preparing or obtaining appropriate food and nutrition. Practitioners may see issues with patient compliance with nutritional treatment plans that include enteral formula as a preventative measure or convenient food supplement. Allowing coverage for underweight adults would minimize impact.

Additional Technical Detail: (if needed, to evaluate proposal)
The eMedNY Data Warehouse was accessed to summarize total claims for SFY 09-10 (n=278,197) for adults receiving oral enteral formula who were not diagnosed with an inborn metabolic disease (n=45,196). The automated prior authorization reporting system was accessed to determine those who had a Body Mass Index considered underweight by CDC measures (n=13,092).

System Implications:
Necessary changes to eMedNY system can be accomplished quickly. DOH will need approval of funding for programming hours for its contractor to update the telephone prior authorization system algorithm. It is expected that the necesary changes may not be in place until May 1, 2011.

Metrics to Track Savings:
Claims by enteral procedure code will be tracked through the Data Warehouse and eMedNY Mobius reports, along with associated diagnoses reported by providers. Weight and height data inputed by practitioners on the prior authorization system will be reported and analyzed.

Contact Information:

Organization: DOH-OHIP-DPRUM
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Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 25

Proposal Author:
DOH

Proposal (Short Title):
Remove Physician Component from Ambulatory Patient Group (APG) Base Rates

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Remove physician related reimbursement from hospital ambulatory patient groups (APGs) payment/rate structure.

Built into the current rate computation for hospital clinic and emergency department services under the APG methodology is $30M in physician cost. This amount can be removed from those rates because all hospital physician services were carved out of APGs on February 1, 2010 and then became billable separately against the Medicaid physician's fee schedule. The providers now submit a clinic claim against the APG base rates and another claim against the physician's fee schedule. Therefore, these services are double funded (since the physician cost is included in the APG base rate) and can be removed from the APG payment.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-15.00	$-15.00	$-15.00	$-15.00
Total Savings	$-30.00	$-30.00	$-30.00	$-30.00

Benefits of Proposal:
There would be an immediate reduction in Medicaid payments for hospital outpatient services once the APG base rates are adjusted to exclude the $30 million in physician costs. Since all physician services in hospitals are now billable against the Medicaid fee schedule, the $30 million should not be included in the APG rate.

Concerns with Proposal:

Hospitals will argue that they are funded below actual cost and these dollars should remain in their rates.

Impacted Stakeholders:
Hospital outpatient providers of service.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
The APG base rate of hospital outpatient services would be reduced.

Metrics to Track Savings:
Not necessary. The savings that would result from the rate reduction would be established upon adjustment of the rates. The impact could be confirmed using the eMedNY claims database.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 26

Date Submitted: 02/03/2011

Proposal Author:
OMH/OASAS/OPWDD; Nassau County DSS; Suffolk County DSS

Proposal (Short Title):
Utilization Controls on Behavioral Health Clinics

Theme: Eliminate Fraud and Abuse

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Under this proposal, mental hygiene clinic rates would be lowered at two outlier threshold levels based on the number of clinic visits a given patient receives during a 12 month period. This would reduce overall payment levels to providers with higher visits per patients, than peers.

The mental hygiene agencies are the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People With Developmental Disabilites. Mental hygiene clinic claims that exceed the lower threshold would be paid at a 25% discount. Claims that exceed the higher threshold would be paid at a 50% discount. The current proposed threshold values (visits in a 12 month period) are:

OASAS 65/85
OMH 30/50 (these are OMH's own suggested values)
OPWDD 90/120

Under this proposal, each mental hygiene agency would be given the option of developing a different, but similar, methodology, so long as it is targeted at high utilizing patients or providers and is not an across the board cut. Each agency has already been provided with the targeted impact levels of this proposal. Most of the proposed impact is on the OMH and OASAS systems.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-13.30	$-13.30	$-13.30	$-13.30

Total Savings	$-26.60	$-26.60	$-26.60	$-26.60

Benefits of Proposal:
It will help control overutilization of these services.

Concerns with Proposal:
Some of the apparent overutilization may be warranted, but the thresholds will be set so high above the norm that the clinically detrimental effect of this proposal will be minimal. Additionally, there would be nothing to prevent a given visit from being provided, but it would have to be provided at the discounted payment level if it were over the threshold limit.

Impacted Stakeholders:
Mental hygiene clinics, especially OASAS and OMH. The OPWDD gross impact is only $2.4M

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
A systems project would be required to implement this proposal

Metrics to Track Savings:
eMedNY data queries

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Comments:
This was one of the original savings proposals submitted to DOB.

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 29

Date Submitted: 01/28/2011

Proposal Author:
MRT Member (Steve Acquario NYSAC); HANYs; Website (Joanne Buschor jobuschor@ yahoo.com); Timothy Lisberg clintonp@rochester.rr.com , Clinton Pharmacy Services Janice Benedek shack23@roadrunner.com,Finger Lakes Health Systems Agency aka Sage Commission, Excellus Health Plan, Tom Ayers (We Care Transportation), Laura E.Staff MD. (DOH),

Proposal (Short Title):
Reduce Transportation Costs through Regional Management Recommended Targeted Fee Actions

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Transportation

Effective Date: 01/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
Achieve Medicaid transportation savings through state procured regional management and resulting targeted reimbursement adjustments.

-Accelerate the Department of Health's (DOH) procurement of regional transportation management contracts in the Hudson Valley, NYC, and other related common medical marketing areas using authority provided by 2010-11 budget that amends SSL 365-h to give DOH authority to contract for the management of transportation services without a competitive bid procurement.

-Carveout transportation from the managed care benefit package to reduce costs and administrative burdens through state management contracts and volume discounting.

-Develop a program for emergency responders dedicated to working with repeat "frequent flyer" 911 callers to help them solve their problems before calling, and thereby avoid unnecessary ambulance transport and emergency room visits.

State procured regional transportation management identified targeted fee adjustments including:
-Reducing the ambulette dialysis transportation reimbursement fee to the level paid for Adult Day Health Care (ADHC) program transportation.
-Upon recommendation of transportation manager, competitively bid dialysis trips in a region to reward the lowest bidder, thereby reducing fees to the group ride level.

-Standardizing transportation fees, including for mileage, among contiguous counties under regional transportation management to achieve cost savings through enlarging the pool of potential providers and eliminating unwarranted individual county fee levels.
-Developing greater group ride transportation alternatives to major medical centers, thereby reducing higher cost individual transports.
-Freezing county transportation fees, including mileage reimbursement, at their current 20l1 level.
-Reducing non emergency county mileage reimbursement to the $2 county average fee.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-30.50	$-37.10	$-37.10	$-37.10
Total Savings	$-61.00	$-74.20	$-74.20	$-74.20

Benefits of Proposal:
Benefits would include: Medicaid cost savings; improved delivery of Medicaid transportation with the most appropriate mode of transportation; greater quality assurance for enrollees; better alignment of the State's fiscal and program accountability; and mandate relief for counties, including removing the administrative burden of both procuring transportation managers and managing transportation services.

Concerns with Proposal:
-With State procured regional transportation managers, some existing county transportation managers will likely lose their local contracts. Also, certain Medicaid transportation providers have opposed previous attempts to manage transportation services because they are concerned with revenue losses.

-The transition to a fee-for-service transportation carveout from managed care will need to be coordinated with each managed care organization, their members, and DOH.

-Competitively bidding dialysis transportation services would eliminate an enrollee's freedom to choose among participating providers, which will require a comprehensive State Plan Amendment or Federally-approved Freedom of Choice waiver.

-Transportation fee reductions may force some transportation providers to eliminate services, especially in rural areas.

Impacted Stakeholders:

Medicaid enrollees using fee-for-service transportation, ambulette and other Medicaid transportation providers, counties and Local Social Services Districts, transportation management companies with current county contracts and managed care organizations would be impacted by the proposal.

Additional Technical Detail: (if needed, to evaluate proposal)
The New York State Medicaid Transportation Management Initiative Hudson Valley Funding Availability Solicitation (FAS) is currently posted in the RFP section of the DOH Grants and Procurement website. An FAS for a transportation management procurement for NYC is expected to be posted on the DOH website this spring.

System Implications:
There are no expected systems changes necessary to implement the Medicaid Transportation Management Initiative for the Hudson Valley, New York City or the rest of state. eMedNY systems changes would be needed to implement new ambulette rates and scope of benefit changes for managed care.

Metrics to Track Savings:
Medicaid transportation expenditures will be monitored for expected reductions in areas where transportation managers have been procured, and the proposal's other resulting cost savings.

Contact Information:

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Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 30

Proposal Author:
DOH

Proposal (Short Title):
Align Payment for Prescription Footwear with Medical Necessity

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
This proposal would update the Medicaid footwear benefit coverage criteria and payment methodology, reducing over utilization and administrative burden.

Coverage for footwear and associated inserts would be limited to growth and development problems in children, diabetics (Medicare coverage) and when a shoe is attached to a lower limb orthotic brace. Over half of utilization is for individuals without these medical needs and who can purchase off the shelf shoes in retail stores in various styles, widths, depths and sizes to address minor foot problems. In addition, modernizing the payment methodology by the establishment of standardized fees for shoes would reduce administrative burden on providers and DOH.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-7.35	$-8.00	$-8.00	$-8.00
Total Savings	$-14.70	$-16.00	$-16.00	$-16.00

Benefits of Proposal:
In order to protect this benefit, the updated coverage criteria addresses serious medical conditions for which prescription footwear is an integral component of a successful treatment plan. In 2009 and 2010, nearly all of the over 40,000 paper claims pending for manual pricing were approved by DOH. The elimination of the need for paper claims and manual pricing of shoes and inserts can be achieved by authorizing DOH to establish maximum fees similar to durable medical equipment. Maximum fees would enable electronic billing by providers and automated pricing through the claims processing system.

Concerns with Proposal:
In the elderly especially, appropriately fitted shoes are important in maintaining ambulation and foot health and can prevent complications. These individuals may not be able to afford to purchase appropriate shoes in retail stores.

Impacted Stakeholders:
Shoe vendors and manufacturers and beneficiaries would be negatively affected economically. Practitioners may see increased challenges with their patient's compliance with recommended footwear choices.

Additional Technical Detail: (if needed, to evaluate proposal)
Regulations would have to be changed to reflect the updated payment methodology and adequate provider notice given, reducing first year savings.

System Implications:
The proposed coverage criteria and payment methodology can be enforced through editing in the current system.

Metrics to Track Savings:
Claims by footwear procedure code will be tracked along with associated diagnoses reported by providers and beneficiary age.

Contact Information:

Organization: DOH-OHIP-DPRUM
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 31

Proposal Author:
DOH

Proposal (Short Title):
Eliminate worker recruitment and retention

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
The Worker Recruitment and Retention add-on to Medicaid rates should be eliminated due to the significant investment in ambulatory care rates through the implementation of APGs.

Beginning April 2002, certain Diagnostic and Treatment Centers (D&TCs) have been paid Worker Recruitment and Retention (WRR) rate add-ons totaling $13 million annually. This funding was aimed at helping D&TCs throughout the State provide quality care by recruiting and retaining non-supervisory workers at healthcare facilities and other workers with direct patient care responsibilities. Though D&TCs were prohibited from using the funds for any other purpose, these monies were especially important to D&TCs because most of them were being paid Medicaid rates that had been frozen since 1995.

Eligible D&TCs for purpose of this WRR fund are Voluntary not-for-profit D&TCs which provide a comprehensive range of primary health care services; operators of approved programs under the Prenatal Care Assistance Program (PCAP); programs sponsored by a university or dental school; family planning clinics; and providers of services to individuals with developmental disabilities as their principal mission.

With the advent of a new ambulatory care reimbursement system (Ambulatory Patient Groups â€“ APGs) for Drug and Treatment Centers (D&TC) effective September 1, 2009, Medicaid rates for D&TCs are no longer frozen and significant additional resources have been shifted from inpatient services to D&TCs and other ambulatory services. Consequently, WRR funding can be eliminated.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-6.50	$-6.50	$-6.50	$-6.50

Total Savings	$-13.00	$-13.00	$-13.00	$-13.00

Benefits of Proposal:
Eliminating D&TC Worker Recruitment and Retention funds will save $6.5 million of State funds as well as reduce DOH administrative work by eliminating the need to develop and promulgate an annual add-on for clinics to the developed APG price.

Concerns with Proposal:
Reduced WRR add-on could cause eligible D&TCs to lose ground in recruitment and retention of health care workers who are critical to quality care.

Impacted Stakeholders:
Comprehensive Primary Care clinics, PCAP providers, School Based Dental clinics, Family Planning clinics, and Cerebral Palsy/Developmentally Disabled clinics.

Additional Technical Detail: (if needed, to evaluate proposal)
This is an easy proposal to implement.

System Implications:
No eMedNY system change is required.

Metrics to Track Savings:
D&TC Medicaid rates will be reduced by WRR add-ons and eMedNY queries will allow tracking of savings

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 34

Reform?: Yes

Proposal Author:
DOH

Proposal (Short Title):
Establish Utilization Limits for Physical Therapy, Occupational Therapy, and Speech Therapy/Pathology

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 10/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
Establish Utilization Limits for Physical Therapy, Occupational Therapy, Speech Therapy and Speech-Language Pathology forpractitioner and clinic.

Physical Therapy, Occupational Therapy, and Speech-Language Pathology are federal optional Medicaid services. NYS Medicaid presently covers these rehabilitation services with no limits. There are currently no utilization limits on file for these services. Utilization limits will be set to a maximum of 20 visits in a 12 month period for physical therapy, occupational therapy, and speech-language pathology.

Enrollees under age 21 and the developmentally disabled population will not be subject to the limit.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-2.47	$-4.94	$-4.94	$-4.94
Total Savings	$-4.94	$-9.88	$-9.88	$-9.88

Benefits of Proposal:
Eliminates opportunity to provide excessive service. The proposed service limits are in line with those imposed by some commercial insurance payers.

Concerns with Proposal:
It is possible that some persons may require service in excess of the limit.

Impacted Stakeholders:
Service providers and Medicaid recipients

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
While edits should be built into the sytem, this could initially be implemented via a written policy and pay and chase auditing.

Metrics to Track Savings:
eMedNY data queries.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 37

Proposal:
Eliminate Case Mix Adj for AIDS Nursing Svcs in CHHA and LTHHCP Programs

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes
State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
This proposal will eliminate the case mix adjustment factor for AIDS Nursing Services provided by Certified Home Health Agencies and Long Term Home Health Care Programs.

Since 1990, reimbursement rates for home care nursing services provided to patients with AIDS have been increased by a fixed Case Mix Adjustment of 1.2988. There is no evidence that the average costs of nursing services provided to AIDS patients exceed the average costs of nursing services provided to other patients.

Statistics from the certified cost reports filed by 111 CHHAs and 104 LTHHCPs for calendar year 2009 indicate average allowable costs per nursing visit of $119.03 for AIDS patients and $123.07 for all other patients.

The impacts listed below reflect the movement of CHHA and LTHHCP patients into Managed Care beginning April 1, 2012, and the implementation of episodic pricing for CHHA services effective April 1, 2012 (see proposals #5 and #90).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-2.01	$-0.31	$-0.21	$-0.16
Total Savings	$-4.01	$-0.62	$-0.42	$-0.32

Benefits of Proposal:
The proposal would achieve cost savings and would eliminate a rate adjustment for which there is no empirical justification.

Concerns with Proposal:

Providers with significant numbers of AIDS nursing patients will see a decrease in total Medicaid reimbursement.

Impacted Stakeholders:
According to cost report data, 28 CHHAs and 25 LTHHCPs provided AIDS Nursing Services in 2009. The estimated impact of this proposal would be concentrated in New York City, where providers would see a decrease of $3.7M in 2011-12. Impact in the rest of the state totals $0.3M in 2011-12. Four NYC providers account for $3.3M of the first-year gross impact of $4.0M.

Additional Technical Detail:
None

System Implications:
No system modifications are required. AIDS Nursing rates are computed manually and transmitted to the eMedNY payment system.

Metrics to Track Savings:
Paid Medicaid claims for the AIDS Nursing rate codes can be totaled to compute savings.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 41

Proposal Author:
DOH

Proposal (Short Title):
Establish the Public Health Services Corps

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Establish a new program called the Public Health Services Corps.

The Public Health Services Corps would be modeled after the U.S. Public Health Service Commissioned Corps and provide funding to support full-time, well-trained, highly qualified public health professionals dedicated to delivering New York's public health promotion and disease prevention programs in exchange for a two-year service obligation in an underserved community. The Corps would fill essential public health leadership and service roles within New York. The Corps would include many professions, including:
- Physician- all clinical specialties
- Mental health specialist, including clinical psychologist and clinical social worker
- Dentist and dental hygienist
- Podiatrist
- Optometrist
- Nurse practitioner and physician assistant
- Nurse
- Pharmacist
- Occupational therapist, physical therapist, speech-language pathologist, and audiologist

Locations where the Public Health Services Corps could provide services would be in New York's underserved areas and include rural health clinics, public health department clinics, community health centers, hospital-affiliated primary care practices, managed care networks and prisons.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$1.00	$2.00	$2.00	$2.00
Total Savings	$1.00	$2.00	$2.00	$2.00

Benefits of Proposal:
The Public Health Services Corps would provide vital health care services immediately to underserved populations in NYS, including those in geographically isolated areas. The Corps would provide a large pool of healthcare professionals willing to address New York's needs in areas that lack essential health care services. Utilizing trained and diverse health care professionals from the Corps will ensure that variant public health care needs are addressed by of variety of necessary health care professionals.

Public Health Service Corps professionals would have opportunities for mobility among organizations and career advancement in diverse work settings. These professionals would also gain varied experiences and deal with the challenges of improving public health. Furthermore, the Corps would place professionals in jobs at a time when jobs are most needed in these communities.

Concerns with Proposal:
None

Impacted Stakeholders:
Will result in improved access to health care services for people residing in medically underrepresented and underserved areas.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

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Staff Person: John Ulberg
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Viability: s

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 42

Proposal Author:
DOH

Proposal (Short Title):
Limit Medicaid coverage for compression stockings to the Medicare criteria and include coverage during pregnancy.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
This proposal limits Medicaid coverage for stockings to the Medicare criteria and includes coverage during pregnancy.

Support and compression stockings are ordered by practitioners and currently paid by Medicaid for treatment and/or prevention of open wounds, poor circulation, varicose veins and discomfort. In pregnancy especially, circulation can become compromised. However, stockings are covered by Medicare for treatment of open wounds only. Pregnancy and open wounds account for 25% of utilization by diagnoses. Other uses for stockings currently provided by Medicaid include improving circulation, comfort and wound prevention but cannot be easily differentiated from those ordered for comfort or convenience. However, stockings for these uses can be purchased off the shelf at various retail stores.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-1.07	$-1.07	$-1.07	$-1.07
Total Savings	$-2.13	$-2.13	$-2.13	$-2.13

Benefits of Proposal:

Pregnancy and open wounds account for 25% of utilization by diagnoses. This proposal protects this benefit for these individuals. In cases when a stocking is suggested by a practitioner for improved circulation, varicose veins and overall comfort, the individual can obtain these stockings by purchasing off the shelf products at various retail stores. In addition, improved diet, exercise and weight loss results in positive outcomes for lower limb circulation and discomfort.

Concerns with Proposal:
Stockings can be used to improve circulation and prevent wounds in elderly, diabetics and sedentary individuals who do not have open wounds. These individuals may not have the funds to purchase appropriate leggings in retail stores.

Impacted Stakeholders:
DME and pharmacy providers, stocking manufacturers and beneficiaries will be negatively affected economically. Practitioners may see issues with patient compliance with treatment plans that use stockings as a preventative or comfort measure.

Additional Technical Detail: (if needed, to evaluate proposal)
The eMedNY Data Warehouse was used to total stocking claims by procedure and diagnosis, and the fiscal estimate includes FFS and MMC savings.

System Implications:
The payment controls supporting the updated benefit coverage can be implemented quickly within the current claims processing system.

Metrics to Track Savings:
Claims by stocking procedure code will be tracked along with associated diagnoses reported by providers.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 49

Date Submitted: 01/30/2011

Proposal Author:
DOH - Dr. Gus Birkhead

Proposal (Short Title):
Reimburse Art 28 clinics for HIV counseling/testing using APGs

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Medicaid will incorporate payment to Article 28 clinics for HIV counseling and testing services into the Ambulatory Patient Group (APG) payment structure.

The HIV Primary Care Program was designed to increase access to HIV counseling and testing and other primary care services in exchange for enhanced Medicaid payments. Medicaid implemented APGs in December 2008. At that time, all HIV services reimbursed to HIV Primary Care Program care providers was incorporated into APGs, other than HIV counseling and testing, which continued to be paid through a per visit rate. Medicaid payment for HIV counseling and testing through APGs is less than the carveout clinic per visit rate, reflecting the lower service intensity and provider costs associated with HIV counseling and testing. Incorporating these payments into APGs will result in rate reform and cost savings for the Medicaid Program.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.20	$-0.80	$-0.80	$-0.80
Total Savings	$-0.40	$-1.60	$-1.60	$-1.60

Benefits of Proposal:
Medicaid payment will reflect the cost of service delivery.

Concerns with Proposal:
Some providers have expressed concern about the lower APG payment for HIV counseling/testing. The APG rates have been updated effective April 2011 to reflect the provider costs associated with service delivery.

Impacted Stakeholders:
HIV clinic providers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
None

Metrics to Track Savings:
eMedNY data base

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Comments:
The estimated fiscal impact will be a reduction in Medicaid expenditures of $1.6M ($800,000 State funding only) for the SFY 2011-2012.

The HIV Primary Care Program was implemented to increase access to HIV counseling and testing and other primary care services in exchange for enhanced Medicaid payments. DOH's implementation of the Ambulatory Patient Group (APG) system of reimbursement eliminated the enhanced prices for clinical services, leaving only enhanced prices for HIV counseling and testing services in place.

Based on calendar year 2008 activity, this facilities participating in this program were paid $13.87 million ($4.72 million State funding only) for providing HIV counseling and testing services.

This proposal can be made effective January 2011, a reduction Medicaid expenditures will be realized during SFY 2011-2012.

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 54

Date Submitted: 01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Adjust 340B Drug payment in 340B-eligible clinics via Ambulatory Patient Groups (APGs)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: N/A
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Adjust payment downward for 340B Drugs in 340B-eligible clinics, under APGs.
Some clinics (both hospital and free-standing) are designated as 340B providers and are eligible for large discounts on drugs. Currently NYS pays the 340B provider the same amount for drugs that they pay other providers. The 340B discount is at least 30% and approximately $2M dollars per year is reimbursed in clinics for 340B drugs. There is a mechanism in APG clinic reimbursement to lower the payment for 340B drugs can be reduced by a fixed percentage. The estimated savings for this proposal is $600,000 per year (all shares).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.25	$-0.25	$-0.25	$-0.25
Total Savings	$-0.50	$-0.50	$-0.50	$-0.50

Benefits of Proposal:
Greater accuracy in payment. Savings.

Concerns with Proposal:
None

Impacted Stakeholders:
Mostly hospitals.

Additional Technical Detail: (if needed, to evaluate proposal)
The systems work to implement this initiative has already been performed.

System Implications:
None

Metrics to Track Savings:
eMedNY queries

Contact Information:

Organization: Division of Financial Planning and Policy
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Viability: S

Comments:
The APG grouper pricer already has the capability to pay these at a discount. It is estimated that a 30% discount would result in $600 K+ in savings annually.

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 55

Proposal Author:
MRT Member (Linda Gibbs City of New York); American Heart Assoc.; American Stroke Association; American Lung Asso; Kim Bank, RN, Pfizer Inc; Buffalo Psychiatric Center

Proposal (Short Title):
Increase coverage of tobacco cessation counseling

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:**	**Statutory Change:** X
	State Plan Amend:	**Federal Waiver:**

Proposal Description:
Expand existing tobacco cessation counseling coverage in Medicaid to include all women (not only pregnant women) and men.

This proposal seeks to expand smoking cessation counseling, when needed, to Medicaid adult non-pregnant women and men (6 sessions within any 12 month contiguous period). The 08/09 budget authorized smoking cessation counseling for pregnant women (6 sessions during their pregnancy) effective January 2009. The 09/10 budget expanded this benefit to postpartum women (6 sessions up to 6 continuous months from the date of delivery) and to adolescents 10 to 21 years (6 sessions within any 12 month contiguous period) effective January 2010.

Smoking cessation therapy consists of most FDA approved prescription and non-prescription agents. Covered agents include nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the-counter nicotine patches and gum.

In July of 2006, Massachusetts Medicaid adopted a comprehensive tobacco cessation benefit. The benefit included behavioral counseling and all medications approved for tobacco cessation treatment by the FDA. Between July 2006 and December 31, 2008, a total of 70,140 unique Massachusetts Medicaid subscribers used the available benefit. Experience in Massachusetts indicates that smoking rates for recipients decreased 26% in the first 2.5 years, saving the state more than $10 million in hospitalization costs. A $5.1 million investment in cessation efforts returned $2.00 for every dollar spent.

It is important that the program and insurers invest in a multi-media campaign to inform beneficiaries and providers about the benefit and encourage its use. Authors of the Massachusetts study said: "It is unlikely that

our finding would have reached significance without the high utilization rate of the Massachusetts Medicaid tobacco cessation benefit. Nearly 40% of subscribers used the benefit in the first 2.5 years after implementation. This rate was achieved, in part, by heavy promotion of the benefit in Massachusetts during the first 18 months after implementation."

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.31	$0.47	$0.00	$0.00
Total Savings	$0.62	$0.94	$0.00	$0.00

Benefits of Proposal:
Tobacco use continues to be the leading cause of preventable disease and death in the United States. Smoking can attribute to, and exacerbate, a host of diseases and generally diminishes the health of smokers (Centers for Disease Control). In March of 2005, the Centers for Medicare & Medicaid Services (CMS)determined the evidence was adequate to conclude that smoking and tobacco-use cessation counseling, based on the U.S. Public Health Service Guideline, was reasonable and necessary to cover smoking cessation counseling services. Medical evidence supports quitting smoking has immediate as well as long term affects in lowering risk of heart disease, stroke, lung disease and other conditions caused by smoking (the Public Health Service Guideline for Treating Tobacco Use and Dependence: 2008 Update). Approx 25,500 New Yorkers die each year from tobacco use. Health care costs attributable to smoking in NYS are $8.1 billion, with $5.4 billion paid by Medicaid.

Concerns with Proposal:
The Department's Tobacco Control Program (TCP) stated that the six-month abstinence rate associated with six sessions of counseling is 21%, and the estimated abstinent rate associated with 0 to 1 session is 12%. Although promising, these statistics validate the inherent risks of not being able to quit smoking after receiving smoking cessation counseling services. In addition, the TCP estimates an average reduction in lifetime healthcare costs for each adult who quits smoking, compared to a smoker who does not quit, is $10,700. Due to the nature of these lifetime projected savings, it is not expected that the State will realize any short term savings.

Impacted Stakeholders:
Medicaid enrollees who smoke, smoking cessation programs, physicians, clinics and hospitals.

Additional Technical Detail: (if needed, to evaluate proposal)
Nothing needed at this time.

System Implications:
Modification of current edits to allow smoking cessation counseling for adult non-pregnant women and men.

Metrics to Track Savings:
Hospitalizations and ED visits associated with smoking such as asthma, COPD, lung cancer, etc.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 60

Proposal Author:
GNYHA, DOB; Strong Memorial;

Proposal (Short Title):
Delink Workers Compensation and No Fault Rates from Medicaid

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Worker's Compensation and No Fault (WCNF) rates can be delinked from the Medicaid fee-for-serice (FFS) inpatient rates and not receive the benefits of the Medicaid reimbursement cuts enacted in Medicaid. In addition, a short term solution to assist in preserving essential community hospitals can also be implemented by requiring commercial insurers to pay rates that are no lower than the delinked WCNF rates.

Under current statute, WCNF rates for hospital services are tied to Medicaid FFS rates. This means that WCNF carriers benefit from any reimbursement cuts enacted in the Medicaid program, except when statutory exclusions are enacted.

In accordance with 2807-c, WCNF rates were delinked for state fiscal year 2010/11 from Medicaid reductions. For state fiscal years after April 1, 2010, the delinking can be continued and implemented in the same manner as in SFY 2010/11. Strong Memorial requests that this delinking be made permanent.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:

There is no State fiscal based on this proposal for WCNF nor is there an increase in payments for WCNF. The affect for WCNF is that they will not benefit from the Medicaid reductions in the rates. The proposal would negate any fiscal benefit WCNF would get from linking to Medicaid rate reductions, but provide a more adequate rate to hospitals for services provided to patients with WCNF coverage.

The commercial insurer proposal would assist hospitals to sustain essential services in all communities while restructuring plans are developed.

Concerns with Proposal:
Additional rate programming needed requiring DOH staff time for WCNF rate calculations.

Consumers may be affected by increased premiums.

Impacted Stakeholders:
Hospitals, WCNF carriers, Commercial Insurers, Consumers and Employers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
None

Metrics to Track Savings:
Not applicable

Contact Information:

Organization: DHCF
Staff Person: John E. Ulberg
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 61

MRT Number: 227

Reform?: Yes

Date Submitted:01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Home Care Worker Parity - CHHA / LTHHCP / MLTC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
This proposal will significantly help reduce turnover in the home and community based long term care system. This proposal requires as a condition of provider enrollment in the Medicaid program that all CHHAs, LTHHCPs, and MLTC comply with any local living wage law within a geographic area in which they serve Medicaid recipients. This requirement will be to attain local living wage level over a 3-year period. This proposal will raise direct care worker compensation and help stabilize this vital workforce.

Preliminary Financial Impact (Dollars in Millions):

2011-12	Minimum	Average	Maximum
State Savings	$	$	$
Total Savings	$	$	$

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00

Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
The proposal is intended to address the inconsistency in wages among home care workers. The requirement to comply with local living wage laws and a certain direct care worker percent will improve the ability to recruit and retain workers therefore improving quality of care for recipients.

Concerns with Proposal:
This proposal will redistribute costs for certain home care providers and managed long term care plans. Any costs however will substantially be offset by a reduction in turnover and training expenses. This proposal may have a ripple effect to other providers as CHHAs, LTHHCPs and MLTCs may be sponsored by hospitals, nursing homes or other entities.

A mechanism would need to be established so DOH would be notified of the status of a provider's compliance with local living wage law. The agencies responsible for monitoring compliance need to be identified (e.g., Department of Labor, local social services district). The exact percentage may have to be modified after additional analysis.

MLTC rates will have to meet CMS's requirement to be actuarially sound, including the living wage requirement.

Impacted Stakeholders:
Home care workers and their unions, CHHAs, LTHHCPs, MLTC plans as well as any sponsors of these organizations.

Additional Technical Detail: (if needed, to evaluate proposal)
Determine the number of local governments that have living wage requirements and the exact definitions of direct care expense.

System Implications:

Metrics to Track Savings:
Turnover rate of community based providers

Contact Information:

Organization: OHIP/OLTC
Staff Person: OHIP Lana Earle, Valencia LLoyd , OLTC Mary Ann Anglin.
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Viability: S

Comments:

This proposal will need additional analysis and the compliance will be difficult to measure

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 67

Reform?: Yes

Date Submitted:01/28/2011

Proposal Author:
MRT Member (Ken Raske, GNYHA); Empire Justice Center, NYS Catholic Conference, Grace Otto, RN; Kings County Hospital; Ed Davila - Harlem Hospital Community advisory Board; Coler Specialty Hospital and Nursing Facility,Bronx Health Link; DC37;Anne Bove, RN; Joann Casado, The Bronx Health Link, Inc; Medicaid Matters, Step-by-Step Inc.

Proposal (Short Title):
Assist Preservation of Essential Safety-Net Hospitals, Nursing Homes and D&TCs

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Provide operational and restructuring assistance to safety net hospitals, nursing homes and clinics to make critical decisions to either close, merge or restructure. Potential sources of assistance are Medicaid, HEAL, debt restructuring capacity and temporary operator.

Hospital, nursing home, and clinic closures negatively affect surrounding communities because needed health care services may no longer be readily available, and surviving providers in the community must absorb displaced patients. In other instances, a provider at risk for closing may be able to survive through right sizing and/or a change in its mission. In certain of these instances the Commissioner may determine that he/she needs to intervene to assure access to essential services of safety net providers. A safety net provider could range from a sole community provider in a rural area of the State to an urban hospital that provides a disproportionally large number of services to the uninsured.

It is recommended that a process be put in place whereby significantly troubled hospitals, nursing homes and clinics may submit applications to the Department seeking assistance to facilitate an orderly closure, merger, or restructuring. Such applications must be accompanied with a highly specific plan enumerating the financial and programmatic challenges facing the facility, a transition plan for merger, closure or restructuring, the type and amount of resources needed to accomplish the plan, and the anticipated impact of the plan on the overall community.

As part of this initiative, the Department will use the expertise of the Public Health and Health Planning Council (PHHPC) to assess such applications and how well they meet community health care needs. The Department will also routinely report to provider communities regarding the monies used to close, merge, and restructure services, and the associated impacts on the community's health care delivery system. Additionally, the Department will assign staff resources from throughout the Agency to accomplish this initiative. The Department will also seek sole source authority to quickly initiate contracts that will provide strategic advice to the Department and the PHHPC.

In order to facilitate this overall initiative, consideration should be given to providing the Commissioner authority to use the following short and long term tools:

(1) To facilitate the closure of a provider, reimbursement rate increases on a short term basis could be provided to providers, to ensure they have adequate resources to transition services and patients to their facilities. These funds would enable the surviving providers to cover costs related to additional staff, service reconfiguration, moving medical residents to other programs, increased patient volume, and enhancing IT systems. This approach could also be used to facilitate mergers.

(2) Use of up to $300m in HEAL capital funds.

(3) Explore use of other capital/debt assistance.

(4) Explore use of State oversight to establish partnerships free from anti-trust problems.

(5) Allow for DOH to appoint temporary operators of facilities. This will allow arrangements whereby a management team is assigned to a provider in an effort to develop an evolution plan, which may involve downsizing the existing facility, merger with another provider, or outright conversion from one provider type (hospital) to another (D&TC; free standing ED/urgicenter; primary care center).

(6) Direct workforce retraining funds to assist restructuring.

(7) Appropriate a fixed amount of money for these purposes.

(8) Provide hospitals with financial incentives to voluntarily reduce excess staffed bed capacity and redirect Medicaid resources to expand outpatient/ambulatory surgery capacity. Hospitals opting into this program may receive an APG rate enhancement.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
This proposal would provide stability to patients served by providers who must make significant organizational changes to become more efficient, including rightsizing, mission re-evaluation, and restructuring or closing. Through this process incentives for cost efficiencies and improved quality will be created. The proposal will also provide an orderly redesign of healthcare services in communities with struggling essential providers. This will

allow them to make needed changes and in some cases close in an orderly fashion versus due to bankruptcy. Further this proposal is partially funded by much needed Medicaid federal financial participation.

Concerns with Proposal:
The cost of the proposal is difficult to quantify, given that the number of providers that will need assistance is unknown and the intervention required for each will vary substantially based on their particular problems and assets. The targeted investments described above certainly represent a cost. On the other hand, savings should be realized from right sizing, merging, and closing inefficient health care providers.

Impacted Stakeholders:
Hospitals, nursing homes, D&TCs and the communities they serve.

Additional Technical Detail: (if needed, to evaluate proposal)
Safety net providers generally exist in communities with somewhat challenging demographic conditions, poorer underlying health status, and higher hospitalizations. Along with these factors also comes a low percentage of commercial insured patients, which can result in serious financial problems. These providers also have extremely limited access to capital, making infrastructure investments that would greatly contribute to their sustainability a tremendous challenge.

System Implications:
There should be no system implications for this proposal.

Metrics to Track Savings:
The Department will track the investments and savings associated with these actions.

Contact Information:

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Viability: S

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 68

Proposal Author:
HANYs

Proposal (Short Title):
Repatriate Individuals in Out of State Placements

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 01/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
This proposal will identify spending on out-of-state placements in nursing homes and seek to repatriate these individuals within 3 years

Currently there are over 700 NYS Medicaid recipients residing in out of state nursing facilities. Those recipients include: pediatric and adult ventilator dependent residents, individuals with neurobehavioral disorders, residents with advanced Huntington's Disease and brain injury. The majority of the residents are placed for neuro behavioral disorders.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
The benefits of this program are two-fold and include spending NYS Medicaid funds within the boundaries of the state which in turn would allow NY to more closely monitor the quality of care and services delivered to this uniquely defined population. NYS nursing home providers would also benefit from the constant flow of

potential admission candidates. The Department of Health currently supports repatriation through a contract consultant to case find and develop plans to return individuals to New York facilities or community.

Concerns with Proposal:
Repatriation of all NYS Medicaid recipients will likely increase the average length of stay (ALOS) for hospitalized individuals who meet and are in need of nursing home care and services. The increase would be directly attributed to a decrease in the number of available NYS nursing home beds for individuals affected by brain injury; those requiring artificial life support, and those with specialized neurobehavioral needs. Presently, a significant percentage of the out of state placements result from NYS providers' inability to secure and educate competent staff to care for the comprehensive needs of this population.

Impacted Stakeholders:
NYS Medicaid recipients, NYS nursing homes, NYS Article 28 general hospitals, Office for People with Developmental Disabilities and Office of Mental Health. Currently there are 707 NYS Medicaid recipients residing in out of state nursing facilities.

Additional Technical Detail: (if needed, to evaluate proposal)
Amend the Memorandum of Understanding between the Department of Health, Office of Mental Health and the Office of People with Developmental Disabilities regarding prior approval Medicaid placements and the need for additional alternative housing and waivered service options.

System Implications:
Reprogramming of EMedNY. Additional resources to assure repatriation of individuals.

Metrics to Track Savings:
Quarterly report analysis based on the nursing home provider's submission of the Minimum Data Set (MDS) 3.0 in addition to existing tracking mechanisms currently utilized by the Division of Provider Relations & Utilization Management within the Office of Health Insurance Programs.

Contact Information:

Organization: Division of Residential Services
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

Proposal Number: 69

Proposal Author:
MRT Member (Eli Feldman, Metropolitan Jewish Health System); HCA of NYS; MRT Members (Senator Kemp Hannon Carol Raphael, Visiting Nurse Service Linda Gibbs City of New York); HANYs; GNYHA, Wm Smith/Michael Irwin of Aging in America; Jewish Home Lifecare; Ann Marie Moran of Eddy's Long Term Home Health Care Program; Kathy Benner of All About You Home Care Agency , and others who testified at the hearings

Proposal (Short Title):
Develop and Implement a Uniform Assessment Tool (UAT) for LTC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
7.80This proposal will develop and implement a Uniform Assessment Tool (UAT) for long Term care services.

The Uniform Assessment Project currently underway at DOH, will initially automate the needs assessment for Medicaid eligible individuals receiving home and community based services (including managed long term care (MLTC) plans, personal care, consumer directed personal assistance program, adult day health care, assisted living program and DOH HCBS waivers (LTHHCP, TBI and NHTD)). Funding for the related training for nurse assessors, program administrators and authorizing agencies has also been approved. The implementation will standardize individual needs assessment across

programs and support the creation of an integrated, statewide information system.

The assessment measures an individuals' health, functional, cognitive and other abilities. It results in a list of needs, risks for decline and/or opportunities for improving health status to inform care planning and program determination. The new data source will be used for policy decisions surrounding access, quality and cost that are currently unavailable to state policymakers. It will provide mechanisms for state managers and provider agencies to manage quality and productivity and create opportunities for streamlining.

The design of the current project allows alignments with future connections between acute care and long term care referrals such as nursing home and home care placements, the Health Information Exchange (HIE) infrastructure and other State Agency programs. In order to expand the current project to implement service planning and program determination features the 2011-2012 appropriation would need to be increased from
$4,806,000 to $6,750,000 and to $7,800,000 in 2012-2013 with an ongoing appropriation of approximately $4,500,000 to maintain.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$1.85	$7.80	$4.80	$0.00
Total Savings	$1.85	$7.80	$4.80	$0.00

Benefits of Proposal:
Provide standardization across Medicaid Home and Community Based Services (HCBS) and MLTC programs under Department of Health purview; create data set to allow for payment based on severity; improve nursing home level of care designations; increase quality assessments; streamline process of program oversight; and improve consistency related to program eligibility.

Concerns with Proposal:
Providers and consumers concerned about impact on service delivery changes resulting from substituting existing assessment tools with standard tool.

Impacted Stakeholders:
HCBS providers, consumers, MLTC plans.

Additional Technical Detail: (if needed, to evaluate proposal)
Changes in program design and payments can only be made after data is generated by implementation of new assessment.

With DOB approval of contract, DOH can proceed with contracting for implementation of software development, beta and pilot testing for system to occur in an 18 month cycle. Savings can only be generated after system has been implemented and tested. The data that will be generated will determine that level of program savings, other states using such a mechanism have generated 2% savings.

This is an investment in infrastructure in the short term.

System Implications:
Significant IT system will be built to accommodate this change it will require system support from the Data Warehouse and other DOH IT systems (i.e. security, storage, etc)

Metrics to Track Savings:
Analysis of hours authorized; severity levels of participants; outcome analysis of recipients.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 70

Proposal Author:
Elizabeth Swain, CHCANYS/ PCC, HANYS, NYASHA, Assembly Richard Gottfried,Housing Works, Nassau-Suffolk Hospital Council, Community Health;Primary Care Coalition/Dvmt Corp; NCBHN;NYSCHP, Mary Kargbo, Sheehan Health Network, Douglas Melzer, Long Beach Medical Center, Anne Nolon, Community Health;Leah Farrell, Center for Disability Rights, Gus Birkhead,FEGS, MSSNY

Proposal (Short Title):
Expand current statewide Patient-Centered Medical Homes (PCMH)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:**	**Statutory Change:** X
	State Plan Amend: X	**Federal Waiver:** X

Proposal Description:
Expand the current Statewide Patient Centered Medical Home Program (PCMH) to more payers and over 1 million more members.

This proposal will enhance the State's current PCMH efforts by 1) providing statewide anti-trust protection to any regional multi-payer medical home initiative agreeing to state supervision in order to permit greater collaboration between payers and providers in creating programs to enhance primary care and medical home capacity; 2) providing technical assistance to facilitate the formation of shared care management/care coordination services among discrete practices within current legal boundaries to facilitate medical home development for smaller to mid-size practices; 3) testing new models of payment to high volume Medicaid primary care medical home practices which incorporate risk adjusted global payments with care management and pay for performance payments; 4) including Child Health Plus payers in the statewide medical home incentive program; 5) setting up a workgroup between DOH, GOER, State Insurance Department and Office of Civil Service to explore joint initiatives between public insurance products and state and local health insurance for state employees to create additional leverage to promote medical home development including ways to bring employers (including self insured) and other commercial insurers to the process; 6) creating an advisory group to the Commissioner to make recommendations for the development of infrastructure, including high priority quality/safety/efficiency measures, which will make use of emerging health information exchanges and data warehouses to support practice level performance measurement for medical home 'pay for performance' demonstration programs using electronic health record data; 7) exploring with CMS (and Center for Innovation) inclusion of dually eligible members to participate in the medical home program; 8) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of on-going continuity relationship with provider/practice and providing more reliable care

management payments to those providers which are independent of specific visit types.

Medical home is a model of care where each patient has an ongoing relationship with a personal physician, nurse practitioner, pharmacist or clinic. Medical homes organize care around patients, working in teams and coordinating and tracking care over time to assure that patients receive appropriate care when and where it is needed. Medical homes use open scheduling, expanded hours and communication between patients, providers, and staff to improve care. Care is also managed through use of registries, information technology, health information exchange, and other means to assure patients obtain proper care.

New York's Medicaid program has two medical home programs. The Patient Centered Medical Home (PCMH) Incentive Program provides financial incentives to practices that are certified by the National Committee for Quality Assurance (NCQA) to provide PCMH services. The Adirondack Regional Medical Home Pilot is a collaborative effort by health care providers and public and private insurers to transform health care delivery in the Adirondack region. The Adirondack Regional Medical Home Pilot emphasizes preventive care and enhanced management of chronic conditions. In addition to these programs, the Medicaid program is currently pursuing opportunities within the federal Affordable Care Act (ACA) that supports medical home features such as care coordination and care management, especially for enrollees with chronic medical and behavioral health needs.

To expand the use of medical homes within the Medicaid program, factors that should be considered include additional financial incentives to practices including pay for performance, the provision of technical support to help practices adopt and sustain changes and expedite implementation of medical homes, the ability for commercial payers to participate including Child Health Plus, ability for other reputable accrediting bodies that have developed medical home standards to serve as accrediting bodies in addition to NCQA, as determined to be appropriate for the goals and providers in New York, and inclusion of the Medicare/Medicaid dually eligible population.

The fiscal only includes the cost of the medical home incentive payments - Any service savings are currently included in health home and pay for performance proposals. Fiscal also does not include Child Health Plus impact; that is still under review.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$17.41	$31.15	$49.32	$54.25
Total Savings	$34.82	$62.30	$98.64	$108.50

Benefits of Proposal:
The Medicaid program is well positioned to expand its use of medical homes as many activities are already taking place or being considered through existing programs and Affordable Care Act provisions. The medical home model has widespread support by health care providers and associations on both a national and State level as a successful tool in improving patient outcomes and reducing costs. Medical homes support an ongoing relationship between patient and practitioner who takes responsibility for the health of the patient and form the basis for the creation of more expansive 'health homes' which support coordination with specialty, behavioral health, and community providers. Medical homes facilitate partnering among hospitals, primary care practices, and the community. Quality of health care is improved as practitioners monitor patient status. Patients have enhanced access to their physicians through open scheduling, expanded hours, and new means of communication. Medicaid financing is focused on preventative care and use of appropriate, cost effective services. Medical homes also support early diagnosis and treatment of disease which avoids more costly care in the future. Creating incentives and removing barriers for payers to work in a coordinated fashion to improve

primary care creates medical home programs that are more likely to successfully engage the provider community.

Concerns with Proposal:
There are challenges with expanding medical homes. The number of primary care practitioners is decreasing and financial incentives may be needed to encourage health care practitioners to become primary care practitioners. The use of health care technology and information exchange can be expensive and difficult to implement, especially within smaller practices. Improvements in patient outcomes and cost savings can be difficult to measure and often happen gradually over time while the cost of providing care is immediate which presents challenges in developing financing models. Commercial carriers may be reluctant to participate in the current economic climate. There may be limits on mandating commercial insurers' participation due to ERISA.

Impacted Stakeholders:
Medicaid enrollees, office-based practitioners, clinics, managed care organizations, and hospitals.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
While it is expected that there will be system changes, the extent of these changes are unknown at this time but may be significant.

Metrics to Track Savings:
Reduction in inpatient hospital admissions, ED visits, and monitoring of quality of care indicators.

Contact Information:

Organization: Division of Financial Planning and Policy
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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 82

Proposal Author:
DOH

Proposal (Short Title):
Reduce Reimbursement for Hospital Acquired Conditions (HACs) and Potentially Preventable Conditions (PPCs)

Theme: Pay Providers Based On Performance

Program Area: Hospital

Effective Date: 07/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Establish a performance-based payment system that reduces hospital reimbursement for Hospital Acquired Consitions and potentially preventable conditions (e.g. Congestive Heart Failure and Urinary Tract Infection).

The Patient Protection & Affordable Care Act (HR 3590) requires States to implement a policy for Medicaid that addresses Hospital Acquired Conditions (HACs) by July 1, 2011. According to CMS, HACs are conditions it deems to be reasonably preventable with the implementation of evidence based guidelines. Such conditions include: foreign object left in patient after surgery; air embolism; and blood incompatibility, to name a few. For Medicare, 10 categories of HACs were identified and became effective for discharges occurring on or after October 1, 2008. Since then hospitals have not received additional payments for cases in which one of the ten selected conditions was not present on admission.

The Secretary of HHS is required by PPACA to issue Medicaid regulations (proposed regulation issued on February 17, 2011), effective July 1, 2011, prohibiting federal payments to States for any amounts expended for providing medical assistance for health care-acquired conditions. Such regulations require States to implement the same HACS as used for Medicare, but it also authorizes States to identify other provider-preventable conditions for which Medicaid payment would be prohibited. CMS believes that establishing Medicare as the minimum for the application of this policy is appropriate and allows for further State innovation as determined by each State.

Consistent with the federal opportunity to go beyond HACS, the State could establish a performance-based payment incentive that seeks to better align payments with high quality of care measures. The newly implemented All-Patient-Refined DRG payment system enables the use of Potentially Preventable Complications (PPCs). PPCs are harmful events (accidental laceration during a procedure, improper administration of medication) or negative outcomes (hospital acquired pneumonia) that may result from the process of care and treatment rather than from a natural progression of the underlying disease. PPCs extend

the scope of vigilance against complications beyond HACs to a much larger group of complications. Complications increase costs of care and are a direct impact on resource utilization.

3M Health Information Systems has developed a clinically-based PPC classification system that identifies inpatient acute care hospital complications that are potentially preventable. The PPC classification system identifies in-hospital complications using primary and secondary diagnoses identified as not present on admission by utilizing the present on admission (POA) indicator that hospitals are now required to use. The purpose of the POA indicator is to differentiate between conditions present at the time of admission from those conditions that develop during the inpatient admission.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-2.00	$-2.00	$-2.00	$-2.00
Total Savings	$-4.00	$-4.00	$-4.00	$-4.00

Benefits of Proposal:
This proposal will improve quality and result in a reduction in cost related to preventable complications of care.

Concerns with Proposal:
Some stakeholders have expressed a desire to only implement the Federal requirement (Hospital Acquired Conditions) and not to go further by implementing a broader complication policy such as PPCs.

Impacted Stakeholders:
The hospital industry and its Medicaid patients.

Additional Technical Detail: (if needed, to evaluate proposal)
There are multiple approaches to implementing a PPC payment policy, which includes a risk adjusted, hospital specific rate reduction based on historical data (similar to PPRs) or a policy that redacts the complication code prior to determination of the DRG/severity level.

System Implications:
If an approach that uses real-time claims data is utilized, it would require the current billing system (eMedNY) to be modified.

Metrics to Track Savings:
Comparison of payments with and without an adjustment for PPCs.

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Viability: S

False

Modified Delphi Scoreable:

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 83

Proposal Author:
Carl Hatch-Feir, OASAS; NYS ASAP

Proposal (Short Title):
Expand SBIRT for alcohol/drug to hospital clinic, DTC and office settings.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 09/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Expand screening, intervention and referral to treatment (SBIRT) for alcohol/drug use beyond the ER setting. Untreated addictions drive up hospital readmissions and over-utilization of ERs.

The implementation of SBIRT in primary health care settings (hospitals, outpatient clinics and private physician offices) will allow for the early detection of risky alcohol and drug use. SBIRT is an evidence-based practice model which is proven to be successful in modifying the consumption/use patterns with at-risk substance users and in identifying individuals who need more extensive, specialized treatment. Applied as a comprehensive, integrated, public health approach it will result in early interventions before more severe health consequences occur. The reduction of risky behaviors will also have a positive impact on public safety including the consequences of risky use such as motor vehicle accidents and DWI's.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.85	$-1.70	$-1.70	$-1.70
Total Savings	$-1.70	$-3.40	$-3.40	$-3.40

Benefits of Proposal:
Early detection of risky behaviors before negative consequences occur and referral to needed treatment for dependent patients.

Concerns with Proposal:
time to show a savings with increased insurance billing as an upfront expense, healthcare provider reluctance to deliver the service and fidelity of the service being delivered

Impacted Stakeholders:
Healthcare workers will have to learn new skills. The improvement in overall health is a positive if the service is delivered correctly.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
APGs already include SBIRT payment for clinics. These codes would need to be added to practitioner fee schedule.

Metrics to Track Savings:
Comparison of overall healthcare costs of alcohol and drug related medical/surgical consequences at time of implementation and at regular intervals thereafter.

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 89

Proposal Author:
HANYS, GNYHA, Senator Kemp Hannon, Mike Hogan, Steve Acquario,Dr. Nirav Shah; Dr. Gus Birkhead; Empire Justice Center, Thomas Santulli, Eli Feldman, Metro Jewish Health System); Ken Raske, HCA; Robert E Detor Jr, Long Island Home, FLHSA, HHS; Nassau-Suffolk Hosp. Council; NY Hospital Queens; NAMI; NYSPA, MHA of Nassau Co, OASAS, Carl Hatch-Feir; NYAPRS, Housing Works,Beacon Health Strategies; AmidaCare; MHA-NYC;NYP, NCBHN,RRHA, Joseph B Stamm, NY County Health Services Rev. SNYA, MedicaidMatters

Proposal (Short Title):
Implement Health Home for High-Cost, High-Need Enrollees

Theme: Ensure That Every Medicaid Member is Enrolled in Care Management

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
High cost, high need patient management can be addressed through the provision of care coordination (health home) services funded with 90% federal financial participation through the ACA.

Provider networks meeting state and federal health home standards will be assigned (on a mandatory or opt out basis) high risk patients for care management. This care management will range from lower intensity patient tracking (post inpatient and ER discharge) to higher intensity care/service management depending on patient needs. The provision of prioritized housing and integrated (one stop shopping) physical and behavioral health services will also be critical components of the health home program. The focus of the program will be reducing avoidable hospitalizations and ER visits.

Historically, a large proportion of Medicaid annual expenditures have been utilized by a small percentage of Medicaid enrollees with complicated combinations of physical illness and behavioral health issues. To date, most efforts to manage these individuals have been focused on a single chronic condition and have failed to manage the whole patient successfully. With a relatively small number of Medicaid enrollees consuming a vast amount of resources, appropriately managing these services is essential in controlling future health care costs.

States may provide, through a state plan amendment (SPA) or waiver program, health home services to Medicaid recipients with chronic medical and/or mental health conditions and/or substance abuse disorders. These care coordination efforts are eligible for a 90% federal match for the first eight (8) quarters of the approved SPA. Populations will be enrolled beginning in the summer of 2011 and will continue to be enrolled until all populations that qualify, are assigned into a health home care management structure.

Health home services, including both care coordination and service integration, are essential in managing the utilization of health care services by Medicaid beneficiaries who have complex, chronic, high-cost conditions. Data shows sixteen percent (16%) of the total Medicaid population has two or more chronic illnesses, one of which is often mental illness. Average monthly enrollee costs for this population range from $2,300-$3,900 compared to an average of $890/enrollee/month cost across the total Medicaid population. This population drives fifty percent (50%) of all Medicaid costs, most attributable to hospital inpatient stays.

Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

Health homes require strong community ties to social service providers to address the numerous social barriers to health care that Medicaid enrollees may encounter, particularly for those with co-occurring mental illness and chemical dependency. Effective care management for high needs individuals with mental illness requires outreach, engagement, face to face evaluations, planning and coordination with the individual and multiple providers of service. Health homes are an opportunity to transition Targeted Case Management populations based on both a determination of need and the availability of capacity that meets the federal health home requirements.

Many of the consumers who are enrolled in HIV Comprehensive Medicaid Case Management have chronic illnesses that are not able to be addressed by the case management team. Health homes is an opportunity to include health care professionals to address such issues as adherence to medications (not just HIV) resulting in more stability in the life of the individual and family network. DOH and other state agencies are evaluating similar models for health homes for other special populations. (Data will play a key role in measuring the success of health homes. Participating providers must have access to electronic health records that include all Medicaid-covered services for participating beneficiaries. The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) tool for access to psychiatric medication information could be very helpful in health home patient management. Costs associated with bringing this tool to additional providers could reach $1.5M.

The Department of Health, Office of Mental Health, Office of Alcohol and Substance Abuse Services, and Office for People with Developmental Disabilities will collaborate on a single set of operating and reporting requirements for health home providers that facilitates and supports integration of physical health, behavioral health, and developmental disability services in licensed facilities.

Health homes can build off the Chronic Illness Demonstration Projects (CIDPs), Patient Centered Medical Home and other initiatives like the one in Chemung County - the lessons NY has learned from these experiences will facilitate the development and implementation of health homes.

Ideas on patient engagement include offering primary care clinician stipends, waiving copayments of evidence-based treatments, and giving patients monetary incentives to achieving certain medical milestones such as blood pressure control.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-33.20	$-112.40	$-119.20	$-95.10
Total Savings	$-46.30	$-162.90	$-186.40	$-165.60

Benefits of Proposal:
Health home services are expected to reduce Medicaid inpatient and emergency room costs while improving enrollee health outcomes through improved management of their medical and behavioral health needs.

Concerns with Proposal:
Provider capacity to establish health homes for Medicaid's chronically ill complex population.

Impacted Stakeholders:
Providers and administrators of services to Medicaid beneficiaries (e.g., hospitals, clinics, physicians, managed care organizations, behavioral health care service providers, nursing homes and long term care providers, health care systems); industry associations (e.g., Healthcare Association of New York State, Greater New York Hospital Association, Mental Health Associations, Community Health Care Association of New York, Visiting Nurse Association of New York, New York State Association of Counties); as well as social community support and service providers (e.g., housing/shelters, food pantries, vocational and legal service, etc).

Additional Technical Detail: (if needed, to evaluate proposal)
The US Department of Health and Human Services (HHS) is establishing an intensive state-based peer-to-peer collaborative within the new CMS Innovation Ctr. to test and share info. about different models. The option which was available January 1,2011 could result in immediate savings, given the enhanced match, as well as a path for learning how to establish effective care coordination systems for people with chronic conditions.

System Implications:
There are significant systems implications in the development of health homes including: connecting beneficiaries with health homes; providing health homes access to beneficiaries' Medicaid utilization data for providing care management and coordination services; development of a real time notification system between hospitals and health homes; development of a reporting system for transmitting required outcomes data to DOH; and system modifications for enrollment and payment of health home providers.

Metrics to Track Savings:
CMS expects states to collect and report information required for the overall evaluation of the health home service delivery, and recommends that states collect individual level data for the purpose of comparing the effect of the health home model across sub-groups of those Medicaid beneficiaries that participate in a health home and those who do not. CMS also requires that states track avoidable hospital readmissions, and calculate cost savings that result from improved coordination of care and chronic disease management and monitor the use of HIT to improve service delivery and coordination across the continuum of care. States are also expected to track emergency room and skilled nursing facility admissions.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 90

Proposal (Short Title):
Mandatory Enrollment in MLTC Plans/Health Home Conversion

Theme: Ensure That Every Medicaid Member is Enrolled in Managed Care

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
Transition Medicaid recipients age 21 and older in need of community-based long term care services into Managed Long Term Care (MLTC) plans.

Three models of MLTC are available in New York - partially capitated plans, Medicaid Advantage Plus and the Program of All Inclusive Care for the Elderly.

Medicaid spending for long term care services continues to grow at a significant rate while the total number of Medicaid recipients receiving long term care services has remained flat. Between 2003 and 2009, Medicaid long term care expenditures increased by 26.4% from $9.8 billion to $12.4 billion annually.

Beginning in April, 2012 in New York City, where MLTC capacity is adequate, individuals who need community based long term care services for more than 120 days would be required to enroll in MLTC plans. This would include those currently served in personal care, Long Term Home Health Care, Certified Home Health Agencies, as well as people who are new to long term care. Mandatory enrollment would expand throughout the rest of the State as MLTC plans become available. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office of People with Developmental Disabilities would be exempted from mandatory enrollment.

Partially capitated plans will expand their target population beyond those who are nursing home eligible to include all Medicaid recipients in need of long-term, community based services. Necessary changes will be made to permit Consumer Directed Personal Assistance Program services to be made available through the MTLC plans.

Plan enrollment will be facilitated by removing the Local Department of Social Services from the enrollment process and implementing a post enrollment audit function. Additional MLTC plans must be approved or existing ones expanded to accommodate the growth this proposal will necessitate. All three models of MLTC are expected to expand and grow as a result of this initiative.

A Workgroup will be established to provide input on the implementation of this proposal.

In addition, the Department has submitted an application to CMS in response to their "State Demonstrations to Integrate Care for Dual Eligible Individuals". If funded, the initial contract would provide money for planning activities to enable the Department to evaluate program options for people

who are dually eligible for Medicare and Medicaid. A second round of applications would potentially lead to a demonstration initiative which could include ways to enhance enrollment in Medicaid Advantage, Medicaid Advantage Plus and PACE.

Effective October 1, 2011, MLTC plans are expected to qualify as a Health Home for Enrollees with Chronic Conditions pursuant to the federal Affordable Care Act. Enrollment in MLTC will allow the State to take advantage of the increased federal reimbursement (90%) for the care management functions of the MLTC plan beginning in October, 2011.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-8.33	$-42.53	$-67.33	$-84.24
Total Savings	$-16.65	$-85.05	$-134.65	$-168.48

Benefits of Proposal:
Mandatory enrollment of eligible individuals into MLTC from open-ended fee for service is expected to reduce and control costs by providing care management. In addition, consumers and caregivers will have the benefit of having a single entity that is responsible for assessing, implementing and monitoring plans of care. The MLTC is at risk financially and has an incentive to implement a plan of care that meets the member's needs in the least restrictive setting to improve health or prevent further decline or acute illness.

Increased enrollment will allow plans to achieve greater administrative efficiency permitting the State to reduce the administrative component of the MLTC rates.

Concerns with Proposal:
Implementation will require a State Plan Amendment and/or waiver from the federal government. Long term care providers will likely oppose as their programs are affected or phased out over time.

Impacted Stakeholders:
Home care providers
Nursing home providers
Long Term Care Consumers and caregivers
Consumer Advocates
Managed Long Term Care Plans

Additional Technical Detail: (if needed, to evaluate proposal)
Savings assumptions based on savings off the fee-for-service costs for all personal care and home health care recipients in FFS (assumed 2,000 new enrollees per month for 36 months, beginning on April 1, 2012). Savings estimates are preliminary pending further review by State actuaries.

Assumes an increase in FMAP for health home to 90% beginning in October 2011 for eight quarters.

Assumes a decrease in administrative costs from $231 per member per month (pmpm) to $215 pmpm in Year 1, $200 pmpm in Year 2, and $175 pmpm in Year 3 and beyond, due to economies of scale resulting from increased enrollment.

The following is a summary breakdown of the savings impact by component: (Dollars in Millions).

SFY 2011-12:
New Enrollees: 0

Enrollment into MLTC: -$0.0M
90% Share F-MAP: -$17.5M
Reduced Admin: -$0.0M
Staff resource/external review agent cost: +$0.8M
TOTAL SAVINGS: -$16.65M

SFY 2012-13:
New Enrollees: 24,000
Enrollment into MLTC: -$31.90M
90% Share F-MAP: -$48.9M
Reduced Admin: -$5.8M
Staff Resource/external review agent cost: +$1.6M
TOTAL SAVINGS: -$85.05M

SFY 2013-14:
New Enrollees: 48,000
Enrollment into MLTC: -$90.80M
90% Share F-MAP: -$34.2M
Reduced Admin: -$11.3M
Staff resource cost/external review agent: +$1.6M
TOTAL SAVINGS: -$134.65M

SFY 2014-15:
New Enrollees: 72,153
Enrollment into MLTC: -$149.7M
90% Share F-MAP: -$0.0M
Reduced Admin: -$20.4M
Staff resource cost/external review agent: +$1.6M
TOTAL SAVINGS: -$168.48M

Savings estimates do not include the impact of FFS claim lag payments.

Additional staff resources are needed to implement. These costs are reflected in the savings estimates.

System Implications:
Expect significant systems implications as we will need to develop a mechanism for auto-assigning recipients to MLTC plans and payment edits..

Metrics to Track Savings:
Enrollment growth in plans will be used to measure savings.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 93

Proposal Author:
OMH; OASAS; MHA of Nassau Co; NAMI; NYSASAP; NYS Conference of Local Mental Hygiene Directors; NYAPRS; Catholic Charities Brooklyn/Queens, Baltic Street AEH, Dolly Sanchez; MHA-NYS; MHA-NYC; LICBHP,Horizon Health; Advocates for New Yorkers with Behavioral Health Conditions; Medicaid Matters of NY; Addiction Treatment Prov. Assn; LI Coalition of Behavioral Health Providers; NYSARC Oneida-Lewis; NYS Psych. Assoc; Fulton County MH; Monroe Co. MH; Rochester Reg. Healthcare Advocates;UJA-Federation

Proposal (Short Title):
Establish interim behavioral health organizations to manage carved-out behavioral health services while moving toward integrated care financing and delivery models

Theme: Ensure That Every Medicaid Member is Enrolled in Managed Care

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:**

Proposal Description:
OMH and OASAS recommend establishment of Behavioral Health Organizations (BHOs) to manage behavioral health services not "covered" under the State's various Medicaid Managed Care (MMC) plans. BHOs would exist on an interim basis; by April 1 2013 establish Special Needs Plans for high-need enrollees with behavioral health problems where the capacity exists for specialized plans, or develop fully capitated arrangements directly with integrated provider systems with demonstrated capacity to serve the behavioral and physical health needs of enrollees.

The following illustrates the <u>current benefit</u> structure:

<u>TANF/Safety Net Enrollees</u>
Must join a plan
Managed Care Benefits
- Physical Health
- Mental Health
- Detox
- CD Inpatient Rehab

Carved out FFS Benefits
- Outpatient CD
- Specialized mental health services

SSI Enrollees

Must join a plan

Managed Care Benefits

- Physical Health
- Detox

Carved out FFS Benefits

- Mental Health (inpatient & outpatient)
- CD Inpatient Rehab
- Outpatient CD
- Specialized mental health services

For OMH, the current MMC plans include inpatient and clinic for TANF enrollees. For OASAS, the current MMC plans include Inpatient Rehabilitation services for non-SSI enrollees and Detoxification services for all Medicaid enrollees.

For Chemical Dependence, the Behavioral Health Organization (BHO) will manage Inpatient Rehabilitation services for SSI enrollees and Outpatient Clinic and Methadone services for all Medicaid enrollees.

Currently SSI enrollees do receive any mental health services through health plans. For all MMC enrollees specialty mental health services are "not covered" by MMC.

For mental health services, the BHOs (the recommendation is for 5-6 regional entities) will manage all SSI mental health care and will manage all "carved out" behavioral health services for all MMC populations and for individuals simultaneously enrolled in Medicare and Medicaid ("dual enrollees"), who are not eligible for MMC enrollment.

To achieve the goal to have an accountable entity managing behavioral health services and promoting the integration of medical and behavioral health services, the State would:

--Build on current plan arrangements. All individuals eligible for enrollment in Medicaid Managed Care will receive their physical health services through the plans. All specialty ambulatory behavioral health services apart from mental health clinic would be managed by a BHO. For OMH inpatient and mental health clinic would continue in the plan for TANF enrollees. For OMH inpatient and clinic would be managed by a BHO for the SSI enrollees and for the dual enrollees.
--Rapidly establish regional behavioral health organizations (BHO), accountable to State government, to provide a managed fee-for-service (FFS) model to infuse accountability, engagement, comprehensive care coordination and utilization management (UM) for the existing FFS system. This will provide savings and improve access using appropriate UM approaches and care management expectations. One BHO will cover a region of the State to avoid cost shifting and further fragmentation of the mental health system. After this interim period of managed fee-for-service, establish "special needs plans" (SNPs) that would manage both the physical and behavioral health benefits for New Yorkers with significant behavioral health problems. Key attributes would include establishing only a small number of plans on a regional basis; establishing eligibility criteria that combine clinical diagnosis with measures of significant disability or service need (e.g., receiving SSI/SSDI; meeting statewide definitions of "serious mental illness" for adults or "serious emotional disturbance" for children; past use of specialty services such as inpatient chemical dependency or detoxification services or residential treatment); mandating enrollment; and joint oversight by local and state health and behavioral health agencies. Fully capitated arrangements directly with integrated provider systems with demonstrated capacity to serve the behavioral and physical health needs of enrollees could also be established.
--DOH and OMH have begun to use Medicaid claims data to demonstrate the value of care management and

improved prescribing approaches, which will help inform the work of BHOs.
--OMH/OASAS as regulators of regional BHOs will mandate BHOs convene medical plans, integrated service delivery systems, and local government regularly to coordinate activities and plan for medical, behavioral and social services for high need patients. The actual coordination activities will be accomplished through "health" and "behavioral health" homes.
--OMH/OASAS will make current data platforms available, such as PSYCKES, which will allow managed care organizations and providers to access medical records of Medicaid patients.
--The BHO with the MMC plans will be accountable for care coordination for the most expensive Medicaid users (health and behavioral health costs) and underserved individuals.

OMH expects that a BHO will save psychiatric and physical health inpatient expenditures but not ambulatory mental health expenditures. The anticipated reductions in ambulatory volume by current users will be offset by additional severely mentally ill (SMI) individuals currently disconnected from physical and mental health care who the BHO, "health/behavioral health" and "medical homes" will engage in ambulatory care.

The anticipated savings from transitioning a substantial percentage of OMH's targeted case management (TCM) resources to "health/behavioral health home" providers or adjuncts to these providers, and changing from 50/50 Federal/State cost sharing to 90/10 sharing for two years will be substantially offset by the cost of establishing and operating the BHO before the savings are appreciated.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-5.00	$-15.00	$-30.00	$-30.00
Total Savings	$-10.00	$-30.00	$-60.00	$-60.00

Benefits of Proposal:
--Impose a management structure on fragmented mental health services;
--Reduce unnecessary and ineffective care and associated expenditures through effective care management provided by trained care managers experienced in managing mental health populations;
--Improved coordination of care between services and across service systems (physical health, housing, social services);
--Improved care management will reduce unnecessary psychiatric and physical health inpatient care.

Concerns with Proposal:
--System monitoring requires the development and implementation of outcome measures and reporting systems.

Impacted Stakeholders:
--Recipients of mental health services would need to be automatically enrolled in a BHO.
--Utilization management and responsibility for care planning would be placed in the BHO, "medical homes" and "health/behavioral health homes" and removed from providers.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
DOH's current service providers' claiming standards and reporting requirements for MCOs should, if the same MCO reporting requirements will apply to the BHO, be adequate to track service provision and savings, irrespective of any "shift" in service volume from or to FFS and per person per month (PMPM).

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 101

Proposal (Short Title):
Develop Initiatives to Integrate and Manage Care for Dual Eligibles

Theme: Ensure That Every Medicaid Member is Enrolled in Managed Care

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes
State Plan Amend: Yes **Federal Waiver:** Yes

Proposal Description:
The State will develop care models and reimbursement mechanisms for people who are dually eligible for Medicare and Medicaid to address people residing in the community and in nursing homes. Possible initiatives to be examined include, but are not limited to New York State assuming risk for all Medicare services for duals, and developing a gain sharing demonstration that would allow New York to share in the savings from reduced hospitalizations and emergency room use resulting from care management of nursing home residents and people residing in the community.

If funded, the initial contract would provide money for planning activities to enable the Department to evaluate options for program for people who are dually eligible for Medicare and Medicaid. A second round of applications would potentially lead to a demonstration initiative that would identify programmatic and reimbursement models.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$	$
Total Savings	$0.00	$0.00	$	$

Benefits of Proposal:
Health care and long term care for dual eligibles is currently split between Medicare and Medicaid. Initiatives such as Medicaid Advantage, Medicaid Advantage Plus have sought to bridge between the two programs to develop a model that is as seamless as possible for the consumer. However, there are still gaps and inconsistencies between the two payer sources. The Department will evaluate potential models for providing comprehensive health care services to duals and propose a demonstration program.

Concerns with Proposal:
Will require federal waivers.

Impacted Stakeholders:
Dual eligible consumers and advocates
Health care providers

The funds for activities during the planning year will include significant work with stakeholders to develop the full demonstration model for duals.

Additional Technical Detail: (if needed, to evaluate proposal)
Year 1 and Year 2 are planning years. Year 3 savings are to be determined based on the demonstration model.

System Implications:

Metrics to Track Savings:

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Viability: S

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 102

Proposal Author:
NYAHSA/CCLC, NYSAC, Senate Medicaid Reform Task Force, Senior Alliance of Greater Rochester, Jewish Home Lifecare

Proposal (Short Title):
Centralize Responsibility for Medicaid Estate Recovery Process

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Low

Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
The proposal would give statewide responsibility for making Medicaid recoveries from the estates of deceased recipients, in personal injury actions and in legally responsible relative refusal cases.

Federal law requires all states to have programs in place to recover funds from the probate estates of deceased Medicaid recipients. New York's local SSDs (i.e., counties and New York City) have little, if any, financial incentive to pursue estate recoveries, and thus have not done so aggressively. As a result, New York ranked 32nd nationally in estate collections as a percentage of total NH Medicaid spending, according to a 2008 report by the Congressional Research Service. New York's recovery rate was only 0.5% of all NH Medicaid spending, or approximately $30 million in 2004 (latest available).

Chapter 58 of the Laws of 2008 modified SSL §369(7) to give the Commissioner of Health the authority to assume responsibility for making Medicaid recoveries from estates, in personal injury actions and in legally responsible relative refusal cases from any SSD. The OMIG is authorized to assume this function from one or more SSDs. SSL §369(7) also permits DOH (OMIG) to contract with one or more entities to undertake this function.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-39.00	$-52.00	$-52.00	$-52.00
Total Savings	$-78.00	$-104.00	$-104.00	$-104.00

Benefits of Proposal:

The stated mission of the OMIG is to "enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care." OMIG has a sizeable staff of attorneys, auditors and other personnel dedicated to this purpose, and as a statewide entity, has significant official standing and the capability to execute broad-based recovery activities utilizing effective approaches. Contrast this with local social services districts which are poorly staffed, get to keep little if any of the funds they recover, and are less insulated from local dynamics that can make these activities difficult to undertake. This would also send a powerful message to New Yorkers that personal responsibility is needed to ensure that Medicaid can continue to fulfill its mission.

Concerns with Proposal:
LDSS personnel that undertake this function will be eliminated

Impacted Stakeholders:
Local social services districts would be positively impacted by being relieved of the authority/responsibility for pursuing recoveries. OMIG would assume a new responsibility, although it is conceivable that some of the administrative cost funding currently paid to local districts could be appropriated to OMIG for this purpose. Family members of deceased recipients may receive smaller inheritances as a result of the change.

Additional Technical Detail: (if needed, to evaluate proposal)
New York's baseline and comparative state information taken from the report, "Medicaid Coverage for LTC: Eligibility, Asset Transfers and Estate Recovery" by the Congressional Research Service, 2008.

System Implications:
Communications and information sharing may be needed between local social services districts and OMIG.

Metrics to Track Savings:
OMIG would track and periodically report recovery totals and work in process.

Contact Information:

Organization: OMIG

Staff Person: Jim Sheehan

Phone:

Email:

Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 103

Proposal Author:
DOH

Proposal (Short Title):
Reduce Inappropriate Use of Services, e.g., Cesarean Delivery, Coronary Artery Bypass Graft

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
This proposal would institute financial disincentives to reduce inappropriate use of cesarean deliveries.

In a recent analysis done by the Centers for Disease Control and Prevention (CDC), it was found that nearly one-third of all births were cesarean deliveries. Cesarean delivery involves major abdominal surgery which is associated with higher rates of surgical complications and maternal re-hospitalization, as well as with complications requiring neonatal intensive care unit admission. In addition to health and safety risks for mothers and newborns, hospital charges for a cesarean delivery are almost double those for a vaginal delivery, imposing significant costs. This proposal would limit Medicaid payments for c-sections to the average Medicaid payment for a vaginal delivery. All c-section claims would be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

Other services mentioned in discussion for inappropriate use were Coronary Artery Bypass Grafts (CABG) and Percutaneous Coronary Intervention (PCI). Approximately 19% of PCI patients and 14% of cardiac surgery patients have Medicaid as a payer; however, the advent of medical advancements (such as drug eluting stents) has caused declining trends in utilization that limit the potential for cost savings. Based on SFY 2009 Medicaid data, there were only 861 Medicaid (FFS and MMC) cases of Coronary Artery Bypass Grafts provided at a total Medicaid payment of $24M. The American Heart Association has indicated that on average 14% of CABG procedures are not necessary (which equates to just over $3M).

In an effort to improve quality in this area and to reduce costs to the healthcare system, the Department will share inappropriateness rates (based on industry standards) with hospitals, including specific types of patients and physician rates of inappropriateness and will identify and promote best practices employed by hopsitals with low rates.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-12.10	$-12.10	$-12.10	$-12.10
Total Savings	$-24.20	$-24.20	$-24.20	$-24.20

Benefits of Proposal:
This proposal generates immediate financial plan savings as well as improve quality and reduce overall healthcare system costs.

Concerns with Proposal:
There is debate in the medical community as to the appropriate level for the rate of cesarean deliveries.

Impacted Stakeholders:
Hospital Organizations and Care Management plans.

Additional Technical Detail: (if needed, to evaluate proposal)
On average, Medicaid payments made during SFY 2010 for c-sections were 25% greater than vaginal deliveries, $3,587 compared to $2,710 respectively.

A review of current published literature does not set a standard for an appropriate percentage of c-sections that are determined to be medically necessary. For the purpose of this fiscal, the Department has assumed that 15% of c-sections are deemed medically necessary.

System Implications:
None

Metrics to Track Savings:
The number of c-sections determined to be medically unnecessary through the appeal process.

Contact Information:

Organization: Division of Health Care Financing
Staff Person: John E Ulberg, Jr.
Phone: (518) 474-6350
Email: jeu01@health.state.ny.us

Viability: S False

Modified Delphi

Scoreable:

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 104

Date Submitted:01/28/2011

Proposal Author:
MRT Member (Senator Tom Duane); Dr. Anandavalli Menon, Ruth Kelleher, HHS

Proposal (Short Title):
Increase Enrollee Copayment Amounts for Medicaid Fee-for-Service and Family Health Plus; Require Copayments for Child Health Plus

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Ambulatory Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
For Medicaid fee-for-service and Family Health Plus: increase co-pays, add new co-pays, increase annual cap; implement co-pay for CHPlus. Exemptions include: pregnancy; under age 21; nh residents.

Enrollees who are in Medicaid fee-for-service or Family Health Plus are required to pay a co-payment for certain medical services. These services include clinic, pharmacy, radiology, inpatient, laboratory, and non-emergency services received in the emergency department. The co-payments presently range from $0.50 to $3.00 for Medicaid fee-for-service, and $0.50 to $6.00 for Family Health Plus. Both programs have a $25.00 co-payment for each hospital inpatient stay. The co-pay limits for Medicaid fee-for-service are based on caps specified in federal regulation 42 CFR 447.54. There is no federally mandated co-pay cap for Family Health Plus. To protect recipients from incurring extensive co-pays, there is a $200.00 annual cap on the amount of co-pays that a recipient is responsible for paying.

Under this proposal, four major changes will be made to the Medicaid, Family Health Plus, and Child Health Plus B programs:
1. co-payments will be increased to higher levels as permitted under federal regulation. The new co-pay amounts will range from $0.60 to $3.40 for Medicaid fee-for service, and from $0.60 to $6.00 for Family Health Plus.
2. the services where a co-pay applies will be expanded to include additional services offered by Medicaid and Family Health Plus, including physician, nurse practitioner, eye care, dental, audiology, and rehabilitative services.
3. the annual co-pay cap will be increased from $200.00 to $300.00.
4. enrollees in Child Health Plus B will now have co-pays applied to the medical services they receive (Child

Health Plus presently has no co-pays).

Patient populations specifically exempt under federal or state statute/regulation will continue to have no co-pays. Exempt enrollees include individuals under age 21 (except for those in Child Health Plus B), pregnant women, nursing home residents, and the developmentally disabled population (e.g., recipients receiving targeted case management services). Services exempt by federal/state regulation from co-pays include emergency care, family planning services, psychotropic drugs, and tuberculosis related services. Pursuant to federal regulation, although enrollees are fiscally responsible for all co-pays, enrollees cannot be denied services based on their inability to pay co-pay amounts. This provision will be maintained under the new co-pay program.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-7.50	$-15.10	$-15.10	$-15.10
Total Savings	$-15.90	$-31.80	$-31.80	$-31.80

Benefits of Proposal:
Expanding the Medicaid co-payment program will help to defray the cost of the overall Medicaid program while promoting enrollee accountability.

Concerns with Proposal:
Even a modest increase in co-pay amounts, increasing the annual co-pay cap, or expanding the list of services to which co-pays apply may cause some enrollees to forgo medically necessary care and services. Providers will be at risk of providing services and not being able to collect the co-payment from enrollees who do not have the available funds.

Enrollees in Child Health Plus B are not presently charged co-pays. Federal regulations do permit states to assign co-pays for these enrollees, but the annual co-pay amount that can be incurred is limited to 5% of the individual's annual income. It will be administratively difficult for the State to monitor when an Child Health Plus B individual has reached the annual cap, especially since all services received by Child Health Plus B enrollees is paid through managed care plans. Since the plans directly pay the providers, the state has no mechanism to track how much out-of-pocket co-pay expense may have been incurred by a Child Health Plus B enrollee. Other states have circumvented this barrier by instructing enrollees to track the amount of co-pays they have incurred. When the individual has reached the 5% annual income cap, the enrollee is instructed to contact their managed care plan, who will then reimburse providers full fees with no co-pays deducted from their payments.

Impacted Stakeholders:
Providers presently subject to co-pays will now have higher co-pay amounts deducted from their Medicaid and Family Health Plus payments. Providers of services for which new co-pays are being applied for the first time will see a reduction in their Medicaid and Family Health Plus payments. These providers will need to bill their Medicaid and Family Health Plus patients for the co-pays. Enrollees will have greater out-of-pocket expense due to the higher co-pay amounts, the additional services that co-pays will now be applied to, and the increased annual cap (from $200 to $300).

Additional Technical Detail: (if needed, to evaluate proposal)

Federal law prohibits providers from denying services based on a patient's inability to pay co-payment amounts.

The following table identifies new co-payment amounts:

	Fee-for-Service		Family Health Plus	
Service	**Current**	**Proposed**	**Current**	**Proposed**
Clinic Visits	$3.00	$3.40	$5.00	$5.00
Brand Name Drug	$3.00	$3.40	$6.00	$6.00
Generic	$1.00	$1.15	$3.00	$3.00
OTC	$0.50	$0.60	$0.50	$0.60
Lab Tests	$0.50	$0.60	$0.50	$0.60
X-Rays	$1.00	$1.15	$1.00	$1.15
Medical Supplies	$1.00	$1.15	$1.00	$1.15
Inpatient	$25.00	$30.00	$25.00	$30.00
ER (non-emergent)	$3.00	$6.40	$3.00	$6.40
Additional Co-Pay				
Eye Glasses	$0.00	$1.15	$0.00	$1.15
Eye Exams	$0.00	$1.15	$0.00	$1.15
Dental Services	$0.00	$3.40	$5.00	$5.00
Audiologist	$0.00	$2.30	$0.00	$2.30
Physician Serv	$0.00	$3.40	$5.00	$5.00
Nurse Practitioner	$0.00	$2.30	$5.00	$5.00
Occup Therapist	$0.00	$2.30	$0.00	$2.30
Physical Therapist	$0.00	$3.40	$0.00	$3.40
Speech Pathologist	$0.00	$3.40	$0.00	$3.40
Annual Max	$200	$300		

System Implications:
Significant eMedNY and WMS system changes will be required. Child Health Plus B managed care plans will need to develop system mechanisms to terminate co-pays when an individual reaches the 5% annual income cap.

Metrics to Track Savings:

Contact Information:

Organization: DFPP
Staff Person: Greg Allen
Phone: 473-2160
Email: gsa01@health.state.ny.us

Viability: S

Comments:
Was included in DOB's scorecard for 11/12 Budget

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 109

Reform?: Yes

Date Submitted: 01/28/2011

Proposal Author:
MRT Member (Eli Feldman, Metropolitan Jewish Health System); HANYs; GNYHA; Nassau-Suffolk Hosp. Council, HealthCare Chaplaincy

Proposal (Short Title):
Require Hospitals and Nursing Homes to provide Patient Centered Palliative Care

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Long Term Care

Effective Date: 01/01/2011

Implementation Complexity: N/A
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Require hospitals and nursing homes to provide access to palliative care and pain management services for people with advanced, life-limiting illnesses and conditions.

Several organizations have recommended expanding access to palliative care through outreach and education of providers and consumers. The NYS Health Foundation has proposed requiring palliative care services as a condition of hospital licensure and requiring palliative care consults for every inpatient with a chronic condition. See also MRT #634 proposing: palliative care as a condition of Medicaid participation for hospitals, using state GME dollars to support palliative medicine fellowships, and requiring palliative care services for Medicaid beneficiaries with complex, life-limiting conditions.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:

Expanded access to palliative care would improve the quality of care and quality of life for people with advanced, life-limiting illnesses or conditions. It might result in fewer inpatient admissions and ED visits for these patients, as a result of better symptom management. It might also result in less aggressive, unwanted and futile care at the end of life.

Concerns with Proposal:
There are an insufficient number of physicians trained in palliative care in NYS. Palliative care services (other than hospice or medications) are often not reimbursed, or are reimbursed only under very limited circumstances. Palliative care is appropriate not just for patients at the end of life, but also for any patient with an advanced, life-limiting illness or condition (including those who are expected to live for years or decades). Expanded access to palliative care may lead (appropriately) to increased utilization of certain community-based health care services, which will generate additional costs.

Impacted Stakeholders:
Patients with advanced life-limiting illnesses or conditions, physicians, nurses, hospitals, nursing homes, hospice programs, home care agencies, families.

Additional Technical Detail: (if needed, to evaluate proposal)
Effective Feb. 9, 2011, PHL section 2997-c requires physicians and nurse practitioners to offer information and counseling to every patient with a terminal illness concerning palliative care and end-of-life options. This law should expand the conversations between clinicians and patients concerning palliative care and empower patients to make informed decisions concerning end-of-life options.

System Implications:
Palliative care is inter-disciplinary and requires coordination among providers.

Metrics to Track Savings:
Reduced inpatient and ED spending associated with Medicaid beneficiaries with advanced, life-limiting illnesses or conditions off-set by spending on institutional and community-based palliative care services.

Contact Information:

Organization: DOH
Staff Person: Karen Lipson
Phone: 518-474-3920
Email: kxl10@health.state.ny.us

Viability: S

Comments:
- Require robust palliative care programs in hospitals. The New York State Health Foundation's Bending the Health Care Cost Curve in New York State report estimates 10-year savings of $11.9 billion from this.

Diane Meier, Mt. Sinai Medical School recommends using state GME dollars to support NY's 9 ACGME-accredited palliative medicine fellowships in order to expand the number of physicians trained in palliative care.

She also recommends making the establishment of a palliative care program a condition of Medicaid participation for hospitals. And, she recommends requiring palliative care for Medicaid beneficiaries with complex, life-limiting conditions. MRT #634.

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 116

Proposal Author: OASAS

Proposal (Short Title):
Accelerate IPRO Review of Medically Managed Detox (Hosp)

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Hospital

Effective Date: 10/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:**
	State Plan Amend:	**Federal Waiver:**

Proposal Description:
Refocus Island Peer Review Organization (IPRO) reviews of medically managed withdrawal cases from those based on DRG rates to those using the new per diem billing.

We suggest that IPRO refocus its review of Medically Managed Withdrawal from past DRG cases to the current detox medical and billing procedures effective December 2008. At present, the Island Peer Review Organization (IPRO) has a contract with the NYS Department of Health to review hospital based medically managed withdrawal cases, looking at quality of care and utilization. The withdrawal services underwent a change in care billing and process last year. The DRG rate has been changed to a rate dependent on the first and third day of withdrawal services. In addition, emphasis was placed on the linkage of the patient with the next level of care. IPRO usually has a lag of about 1 ½ years on chart reviews. Refocusing will facilitate the adoption of the new processes by the providers and the accompanying savings.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-1.14	$-2.28	$-2.28	$-2.28
Total Savings	$-2.28	$-4.56	$-4.56	$-4.56

Benefits of Proposal:
There should be significant improvement in quality of care delivered with emphasis on shorter stays and linkage to the next level of care. In addition, the shorter stay should amount to cost savings.

Concerns with Proposal:
None noted.

Impacted Stakeholders:
Hospital based medically managed withdrawal service units could have billing reduced if the unit does not follow the medical procedure changes.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
Requires a change in contract/focus between the Department of Health and IPRO

Metrics to Track Savings:
1. Cost of hospital based detox prior to the change and quarterly thereafter.
2. Percentage of patients linked to the next level of care of service

Contact Information:

Organization: OASAS
Staff Person: Steven Kipnis, MD
Phone: 845-680-7633
Email: stevenkipnis@oasas.state.ny.us

Viability: S

Comments:

Modified Delphi Scoreable:
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 121

Proposal Author:
MRT Member (Steve Acquario NYSAC)

Proposal (Short Title):
Better utilize County Nursing Homes

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
This proposal will create a state authority that county nursing homes can join at their option.

The future of County Nursing homes has been the subject of much debate at the local level. This proposal would establich a State authority/public benefit corporation that counties with nursing homes could opt into to benefit from group purchasing, workforce flexibility and other administrative changes. The State's four nursing homes would also be added to this new structure.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Would allow the counties with nursing homes and the state's nursing homes to avoid civil services rules and maximizes administration efficiencies. Gor example, this new structure will allow for group purchasing and centralized personnel functions.

Concerns with Proposal:
A new authority or public benefit corporation is inconsistent with the SAGE commission effort.

Impacted Stakeholders:
Counties with nursing homes and their employees as well as state employees at the 4 state operatored facilities

Additional Technical Detail: (if needed, to evaluate proposal)
Detailed Legal research and analysis of cost

System Implications:
TBD

Metrics to Track Savings:
FTE to resident ratios
Administration costs per resident

Contact Information:

Organization: Office of Long Term Care
Staff Person: Mark Kissinger
Phone: 402-5673
Email: mlk15@health.state.ny.us

Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 129

Proposal Author:
OHSM DOH

Proposal (Short Title):
Use State's Authority to Supervise Integration of Health Services and Providers to Minimize Anti-Trust Exposure

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Health system reform strategies, such as medical homes and accountable care organizations, that seek to improve quality, efficiency, and outcomes through increased coordination and integration are also likely to raise anti-trust concerns.

The U.S. Supreme Court has held that legitimate state decisions to supplant competition should also override federal antitrust law. This is known as the State Action Immunity doctrine. The doctrine applies when the state has clearly articulated and affirmatively expressed as state policy its intent to displace competition; and when it commits to supervising actively the anti-competitive conduct and its results with ongoing oversight. In order to satisfy the active supervision test, the State must review the proposed actions of private parties, control the process, and exercise independent judgment in approving or disapproving rates or other actions that might otherwise be considered anti-competitive.
In appropriate cases, the State should explicitly articulate a policy to displace competition and should actively supervise proposed mergers and joint ventures among health care providers and payors.

Also included in Proposal #67: Assisting safety-net hospitals.

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:

Assist in system reconfiguration

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: DoH
Staff Person: Karen Lipson
Phone: 518 474 7028
Email:

Viability: s

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 131

Proposal Author:
DOH, GNYHA, HANY; Nassau-Suffolk Hosp. Council; NY Hospital Queens, Anne Weeks; New York Presbyterian Hospital; ACOG and others that testified at the MRT hearings

Proposal (Short Title):
Reform Medical Malpractice and Patient Safety

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Create a neurologically impaired infant medical indemnity fund and establish a cap on non-economic damages in medical malpractice cases in addition to exploring alternatives such as disclosure and early settlement and judge-directed negotiations.

In 2009, NYS hospitals spent $1.6 billion to cover medical malpractice expenses. This represents an estimated 3% of their revenue. In addition, it has been estimated that 30-50% of the premium dollar is directed toward obstetrical cases ($500m-$800m). Of these obstetrical cases, Medicaid is the insurer for an estimated 50% of the deliveries and covers the medical costs of a significant number of children affected by neurological impairment both before and after settlement or award. The variation in both malpractice payouts and premiums differs significantly between upstate and downstate. There are some downstate providers that cite that they pay up to $9,400 a delivery in Medical malpractice expense . This can significantly undermine patient access to critical services in many communities and provider financial health.

This proposal would:

â€¢ Cap non-economic damages for medical malpractice awards. In 2004, Milliman estimated that a $250,000 cap would reduce hospital and physician premiums Statewide by 24%, which translates to a $384m savings for hospitals.

â€¢ Establish a Neurologically Impaired Infant Medical Indemnity Fund that will provide payment for medical expenses of eligible children as well as repayment of the State's Medicaid lien where applicable. Participation would be mandatory. The Fund could be capitalized by an assessment on all insurers' gross premiums (except annuities) or other sources including HCRA funds or some combination of sources. GNYHA estimates that a Fund of this nature would reduce costs to hospitals by 20% or $320m. It also estimates that the Fund would

result in additional savings to the State Medicaid program in terms of Medicaid lien repayment from the Fund (estimated to be $75m per year) and from reduced expenditures for future medical expenses of children covered by the Fund (ranging from $5m in year one to $37.5m by year 8).

OB providers would be required to demonstrate participation in meaningful obstetrical safety and quality initiatives.

â€¢ Monitor the impact of the $3 million/ 3year AHRQ demonstration project that DOH is conducting along with the Unified Court System and Maimonides, Montefiore, Beth Israel, Mount Sinai and NY Presbyterian hospitals. The project will assess and measure patient safety culture and outcomes of malpractice adjudication as the hospitals implement increased emphasis on patient safety culture, specific patient safety interventions in the surgical departments, a disclosure and early settlement program and judge-directed negotiations for cases that do end up in Court.

These projects do not require statute but do require significant investment in provider resources to try these relatively new approaches in disclosure and settlement, along with new Court based procedures for judges.

â€¢ To support the foregoing proposals, a few modest tort reforms are also recommended:

o Allow peer review privileges to be extended to defendants;
o Early pre-trial showing of each defendants' involvement in case;
o Some protection of statements of remorse and acceptance of responsibility;
o Require a 182 Day Pre-Suit Notice Period.

Additionally, Proposal # 103 seeks to eliminate financial incentives for cesarean deliveries. This will also assist in reducing medical malpractice premium costs.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-208.50	$-208.50	$-208.50	$-208.50
Total Savings	$-417.00	$-417.00	$-417.00	$-417.00

Benefits of Proposal:
The proposal has the potential of reducing medical malpractice premiums for both physicians and hospitals.

Concerns with Proposal:
There will concerns from plaintiffs/consumer groups that medical care maybe limited.

A medical indemnity fund and capping of non economic damage does not address or change the tort system's approach to these cases

Impacted Stakeholders:
Trial lawyers, medical malpractice insurers, consumer groups, hospitals, physicians.

Additional Technical Detail: (if needed, to evaluate proposal)
ACOG has recommended a no-fault neurological impaired infant fund that is farther reaching than a medical indeminity fund for these children. The no-fault fund provides lifetime care for children based on condition opposed to an award or settlement of a legal claim.

System Implications:

Metrics to Track Savings:
Longitudinal studies on the number and amount of medical malpractice claims and settlements. Also, on the level of medical malpractice premiums adjusted for medical inflation and number of providers participating.

Contact Information:

Organization: DoH
Staff Person: Lora Lefebvre
Phone: 518-408-1828
Email:

Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 132

Proposal Author:
MRT Member Eli Feldman, OPWDD; Jamaica Hosp. NH; Onondaga County, Senior Alliance of Greater Rochester

Proposal (Short Title):
Expand the Definition of Estate

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Eligibility

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
Expand definition of "estate" to include assets that bypass probate in order to recover more assets from a deceased Medicaid recipient over age 55.

When a Medicaid recipient who received assistance after age 55 dies, the assets in the recipients probate estate must be subject to Medicaid recovery before being distributed to the recipient's adult, non-dependent heirs. The proposal would expand the Mediciad definition of "estate" to include assets that normally bypass probate (e.g., assets that pass directly to a survivor, heir or assignee through joint tenancym rights of survivorship, life estates, or living trust).

The proposal would (1) prohibit a Medicaid estate recovery at a time when the recipient has a surviving spouse, minor child, or blind or disabled child of any age; and (2) allow the Medicaid program to waive an estate recovery in undue hardship situations.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-1.10	$-2.60	$-2.70	$-2.80
Total Savings	$-2.50	$-5.20	$-5.30	$-5.40

Benefits of Proposal:
Under this proposal, the State would recover more revenue from estates due to the expanded definition. It would also limit the ability of Medicaid recipients to avoid estate recoveries by shifting assets out of the future probate estate. The proposal would continue to contain an undue hardship provision that allows the Medicaid program to waiv an estate recovery in compelling circumstances. Contractors are currently performing estate

recovery activities for this Department. This alleviates any additional burden this proposal may have on the local departments of social services.

Concerns with Proposal:
Certain legal groups have argued that if this proposal is enacted, and non-probate assets are subject to Medicaid recoveries, seniors will have to transfer full title to assets to an adult child or other relative during their lifetimes, in order to avoid having Medicaid make a recovery after death. However, seniors may be unwilling to use this method of Medicaid planning because they fear they will be placing themselves at the mercy of the relative to whom the assets are transferred. Therefore, outright transfers may be unattractive, and thus, discourage recipients from shielding their assets from estate recoveries. An espanded definition of estate requires closer monitoring and scrutiny of assets.

Impacted Stakeholders:
Local departments of social services
Consumers
Elder Bar Attorneys

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
None

Metrics to Track Savings:
Increase in amount recovered from estates
If specific detail is required on the savings from broadening the definition, the reporting form will need to be modified to capture this information.

Contact Information:

Organization:	OHIP/Division of Coverage and Enrollment
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Viability: S

Modified Delphi Scoreable:	False
Modified Delphi Score:	

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 133

Proposal Author:
Buffalo Regional Forum;

Proposal (Short Title):
Administrative Renewal for Aged and Permanently Disabled

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Eligibility

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Allow aged and permanently disabled with fixed incomes to be automatically renewed based on cost of living increases.

Currently, Medicaid recipients must complete and mail-in a renewal form once a year in order to continue to receive health care coverage. This is true even if the only income is fixed income (e.g., social security benefits) with known cost of living increases and when resources are well below the Medicaid resource level ($13,800 for an individual, $20,100 for a couple). This proposal would allow the State to calculate income annually based on any cost of living increase and renew the case for Medicaid coverage. This would be applied to single individual and couple households with fixed incomes and where resources are $2,000 below the Medicaid resource limit at application or last renewal whichever is later.

An annual sample of cases would be reviewed to ensure program integrity is maintained.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.20	$-0.20	$-0.30	$-0.30
Total Savings	$-0.40	$-0.40	$-0.60	$-0.60

Benefits of Proposal:
Otherwise eligible Medicaid recipients with fixed incomes would no longer be required to mail-in a renewal form in order to maintain their health care coverage. Some administrative savings may be realized by automating the renewal process.

Concerns with Proposal:
Individuals who are no longer required to renew once a year may be less likely to report other changes such as address, household composition or the receipt of lump sum payments.

Impacted Stakeholders:
Local social services districts
Elderly and disabled enrollees on fixed incomes

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
WMS Systems support is required to identify potential cases and automate an administrative renewal.

Metrics to Track Savings:
Change in renewal rates among elderly and disabled

Contact Information:

Organization: OHIP/Division of Coverage and Enrollment
Staff Person: Judy Arnold/Wendy Butz
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Email: wlb01@health.state.ny.us

Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 134

Proposal Author:
DOH

Proposal (Short Title):
Audit Cost Reports (rather than certification)

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
The Department of Health (DOH)seeks to contract with independent certified public accounting (CPA) firms licensed in NYS to conduct annual field and desk audits of the Institutional Cost Reports (ICRs). Beginning in the SFY 2011-2012 these audits would replace currently required certifications by CPAs.

Under current DOH regulations, (Part 86-1.6), the financial and statistical reports submitted by hospitals are required to be certified by a CPA. Hospitals complete the ICR and then must have it reviewed and certified by a CPA by the due date established by DOH.

The purpose of the audits is to review, analyze, test, and verify the hospitals' financial and statistical books and records and to determine that only proper items of cost applicable to provider services have been included in reimbursable costs. This type of audit would be similar to that of Medicare, where desk reviews and on site field audits are performed.

Based on a small survey, DOH estimates that hospitals pay CPA firms on average $13,000 per year for the ICR certification. Across all 200+ hospitals, this equated to an annual system cost of $2.6M. DOH also estimates (based on the cost of the Disproportionate Share Audit) that the annual cost to have the cost report audited (both desk and field studies) to be slightly higher, or $2.8M annually. However, since this would be considered an administrative expense, the Centers for Medicare and Medicaid Services (CMS) will share roughly 50% of the costs, bringing the State share to $1.4M.

DOH is proposing a modest processing fee to be levied on hospitals with each cost report submission. The fee schedule would be scaled such that smaller hospitals with fewer costs would pay less of a fee. The proposed fee schedule would range from $5,000 ($1.5B costs). Implementing this fee would generate $2.15M thereby resulting in a State Savings of $.75M.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.75	$0.75	$0.75	$0.75
Total Savings	$0.75	$0.75	$0.75	$0.75

Benefits of Proposal:
The Department has been engaged in a Data Integrity Program with the hospitals and their associations over the past two years. The Department has found that despite data being certified, it is often inaccurate and unusable. This has hindered the Department in producing reliable information for rate setting and providing data to CMS for timely completion of Upper Payment Limits (UPLs). The audit process will give the State more control of this process and will provide a vehicle to work with hospitals to ensure their data is accurate.

Eliminating the certification process creates a financial savings situation for both the hospital industry ($455,000 annual savings) and the State ($750,000 annual savings).

Hospitals will have additional time to assemble their cost report data since they will no longer need to submit the documents in advance to their auditors to accommodate their review.

Concerns with Proposal:
Hospitals may object to a fee. However, the aggregate cost of the fees industry wide is estimated to be more than offset by the savings hospitals will reap from eliminating the current requirement to secure and pay for CPA certification of costs. It should be mentioned that some hospitals may not realize savings, particularly those that may not be equipped to complete their cost reports without CPA assistance.

Impacted Stakeholders:
NYS Hospitals
Certified Public Accountants

Additional Technical Detail: (if needed, to evaluate proposal)
An RFP would be posted on the Contract Report on or about July 1, 2011 with the award of the contract made by September 1, 2011. Auditing is expected to commence no later than November 1, 2011.

System Implications:
There would be no impact on the EMEDNY system. However, an administrative fee system would need to be established and maintained for the hospitals to pay into. The establishment of such a system is deemed to be insignificant as it would be set up similar to the SPARCS fee system that is already in place.

Metrics to Track Savings:
Analysis of cost of fees vs. cost of certification and effect on state budget as well as hospitals financials.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 137

Proposal Author:
OPWDD

Proposal (Short Title):
Disregard retirement assets such as 401K plans for MBI-WPD

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Eligibility

Effective Date: 10/03/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
As an incentive to participate in the MBI-WPD program raise the resource standard and disregard retirement accounts.

Raise the resource standard for the MBI-WPD program from the current Medicaid resource standard of $13,800 for a household of one and $20,100 for a household of two to $20,000 and $30,000, respectively. In addition, this proposal seeks to disregard Individual Retirement Accounts (IRAs) as a resource in determining eligibility for MBI-WPD. Individual Retirement Accounts include IRAs, Keogh Plans and other individually owned retirement plans. Currently, retirement accounts are counted as a resource if the funds are available to an applicant and the individual is not receiving periodic payments from the fund.

The MBI-WPD program is a work incentive program established under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). Federal legislation provides states with the option for setting higher resource standards for this program as a work incentive for individuals with disabilities. It also allows states the option of establishing more liberal resource methodologies than are used by SSI (Section 1902(r)(2) of the Act).

Increase Resource Standard
When the MBI-WPD program was implemented in July 2003, the resource standard for the program was $10,000, making the resource standard for this program higher than the resource level for the SSI-related category of Medicaid, which was $3,850 for an individual and $5,600 for a household of 2. In April 2008, the Medicaid resource standard was increased to $13,050 for a household of one and $19,200 for a household of two and the MBI-WPD resource standard was increased to the same level. The current resource standard is $13,800 and $20,100 respectively. The resource test has been eliminated for all non SSI-related individuals.

In an effort to reinstate the previous work incentive resource standard, it is proposed that the MBI-WPD

resource standard be increased to $20,000 for a household of one and $30,000 for a household of two. In order to maintain the future work incentive aspect of the MBI-WPD resource standard, the higher resource standard will increase by the same amount as any increase to the Medicaid resource standard, rounded up to the nearest thousand.

Disregard Individual Retirement Accounts from Resources
In a 2005 survey of New York State MBI-WPD recipients, survey participants were asked to choose from a list of seven options regarding what they would save money for, if they were allowed to have more savings on the MBI-WPD program. Retirement purposes was chosen most frequently from the list, which included housing, medical emergencies, education and future employment. However, saving in a retirement account currently jeopardizes eligibility for the MBI-WPD program and may result in discontinuance or denial for the program. Based on the data collected by George Washington University Medical Center in 2006, 21 of 36 states with an MBI-WPD program allow the disregard of Individual Retirement Accounts.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.50	$1.50	$1.50	$1.50
Total Savings	$1.10	$3.10	$3.10	$3.10

Benefits of Proposal:
Allows working disabled individuals to accumulate modest savings for retirement without losing eligibility.

Concerns with Proposal:
The proposal has a cost of $1.1 million gross in 2011-12 and $3.1 million gross in 2012-13.

Impacted Stakeholders:
Working disabled

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
System support needed to change resource levels and implement disregard. WMS, CNS, MABL

Metrics to Track Savings:

Contact Information:

Organization: OHIP/DCE
Staff Person: Judy Arnold/Wendy Butz
Phone:
Email:

Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 139

Date Submitted: 02/04/2011

Proposal Author:
HCA

Proposal (Short Title):
Implement the new waiver for LTHHCP

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
This proposal will implement the new enhancements of the LTHHCP waiver, initiating the opportunities for increased Medicaid cost-savings and performance. The Department is in the process of implementing these enhancements.

The State Department of Health received Federal approval for the renewal of the home and community based services waiver for the Long Term Home Health Care Program (LTHHCP) in September 2010.

The renewed waiver contains a series of service enhancements (including assistive technology, community transition, community support services) designed to create efficiencies, reduce Medicaid costs, and further enable the LTHHCP to provide an alternative to institutionalization, including the enhanced ability to return institutionalized individuals to the community.

HCA recommends that the state immediately proceed to implement the enhancements of the new waiver, initiating the opportunities for increased Medicaid cost-savings and performance.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Enhanced opportunities for care in the community

Concerns with Proposal:
This initiative is already underway.

Impacted Stakeholders:
LTHHCPs
Consumers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
MMIS accommodations will be required for the service enhancements

Metrics to Track Savings:
Medicaid claim detail reports

Contact Information:

Organization: DOH/OLTC
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Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 141

Proposal Author:
HANYs, CBC, OPWDD, Empire Justice, Constituent Correspondance; CNYHSA, Island Nursing and Rehab Center; NYS Health Plan Association; Coalition of NYS Public Health Plans

Proposal (Short Title):
Accelerate State Assumption of Medicaid Program Authorization

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Benefits and Coverage

Effective Date: 04/01/2011

Implementation Complexity: High

Implementation Timeline: Long Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
Accelerate State assumption of Medicaid program authorization for Managed Long Term Care.

In June 2010, the Legislature enacted statute requiring the Commissioner of Health to develop a plan to assume the administration of Medicaid from the counties within 5 years. In November 2010, the Department issued the report required by the statute. The report was the first step in developing a plan for state assumption of Medicaid administration.

The report made some short-term recommendations, such as consolidating health plan contracts for Medicaid Managed Care and Family Health Plus, centralizing review of requests for private duty nursing, and regionalizing transportation services. It also provided longer-term recommendations, such as centralizing eligibility determinations as the State implements the requirements of federal health care reform and State assumption of long-term care.

As a first step in State administration, the local districts will no longer be involved in enrolling recipients in the Managed Long Term Care Program (MLTC). A companion proposal expands enrollment in MLTC in areas of the state with adequate capacity and includes plans to expand capacity.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Centralizing the Medicaid administrative functions will improve the uniformity of the program and create greater efficiencies.

Concerns with Proposal:
Local districts are concerned about losing staff.

Impacted Stakeholders:
Local Department of Social Services
Consumers
Providers
Managed Long Term Care Plans

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
Growth in MLTC enrollment
Timeliness of MLTC enrollment

Contact Information:

Organization: OHIP and OLC

Staff Person: Mark Kissinger/Vallencia Lloyd/Judy Arnold

Phone:

Email:

Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 144

Proposal Author:
HANYs; Nassau-Suffolk Hosp. Council; NY Hospital Queens

Proposal (Short Title):
Eliminate Duplicative Surveillance Activities (Labs/psychiatry)

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Hospital

Effective Date: 08/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Consolidate duplicative laboratory and hospital psychiatric surveillance currently conducted by DoH. This proposal will be referred to the SAGE Commission process.

(HANYS) The state must cease conducting facility surveillance activities that are duplicative of national oversight or that are not funded through federal contractual obligation, and must develop broader collaborations with recognized accrediting bodies.

For example:

a. Duplicative laboratory and proficiency testing requirements should be eliminated.
b. Duplicative hospital psychiatric service inspection activities should be eliminated.

The state has the option of accepting accreditation by national accrediting bodies as evidence of compliance with standards or entering contractual relationships like the one in place with The Joint Commission (TJC) for hospitals, where TJC effectively functions as the state's agent.

The NYS Department of Health (DOH) has regulatory authority in place for the contractual relationship with TJC. The Office of Mental Health (OMH) is seeking similar authority through statute. The Wadsworth Laboratories Division within DOH should review existing mandates and authority to determine how to provide authority for reduction of survey duplication.

Since the mid-1990s the state has delegated routine hospital inspection activities to TJC through a collaborative contractual relationship. The DOH continues, pursuant to contract with the federal government, to check the effectiveness of this arrangement. DOH and TJC have in place a detailed information-sharing relationship. This is a proven and effective model that fulfills an activity that the state can no longer afford. This same model must

be extended to hospital-operated laboratoriesâ€”where DOH and TJC (and for some hospitals, the College of American Pathologists) conduct duplicative and costly inspections at similar time intervals. Similarly, OMH conducts inspection activities duplicative of TJC inspections in hospitals that offer psychiatric services.

This survey duplication is costly to the state and disruptive to hospital operations. Hospital staff are taken away from their patient care responsibilities to respond to surveyor inquiries and to provide access to documentation, in order to respond to multiple and, ultimately, unnecessary and duplicative surveys.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

Benefits of Proposal:

Concerns with Proposal:
The proposed change would impair the Department's ability to protect the health of New Yorkers and to safeguard hospital patients.The level of review performed by the Joint Commission and CAP does not rise to the Department's standards in many areas.
The Department is responsible for assuring health care consumers that laboratory tests are performed correctly but, contrary to HANYS' claim that "DOH and the TJC have in place a detailed information-sharing relationship," the Joint Commission shares none of its findings with the Wadsworth clinical laboratory program. Were the Wadsworth program to discontinue its surveys, it would have no information on hospital laboratories unless the Joint Commission, discovers something it deems sufficiently serious to report. The Joint Commission and CAP have no enforcement authority and the laboratories they survey know this. If the goal is to avoid duplicative efforts, the responsibility for inspecting laboratory facilities should reside solely with DOH. review of new methods, technical advice, proficiency testing, referral for difficult to perform tests and ongoing oversight. Currently the Joint Commission surveys 100 of the state's 265 hospital laboratories. If the Department no longer inspects these labs the Joint Commission will further outsource this critical function, to entities over which the Department has no regulatory authority or oversight.
HANYS contends that duplicative surveys inconvenience hospital staff and take them from more patient-centered duties. The Department is more than willing to conduct its surveys in alternate years or otherwise accommodate the Joint Commission's schedule.Finally, the Department's comprehensive role makes it a much more effective inspector of hospital laboratories. Additionally, Wadsworth would still oversee the private clinical laboratories even if they were relieved of responsibility for hospital-based clinical laboratories. That would set up a dual system of laboratory oversight in the state.

Impacted Stakeholders:

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: DoH

Staff Person: Lora Lefebvre/Ellen Anderson

Phone:

Email:

Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 147

Proposal Author:
MRT Members (Eli Feldman, Metropolitan Jewish Health System; Dan Sisto, HANYS Steve Berger, Partnership for NYC Senator Kemp Hannon); Housing Works, Cerebral Palsy Association of NYS; Glens Falls Hospital, Wm Smith/Michael Irwin of Aging in America, Rochester Regional Healthcare Advocates;Therapeutic Communities Association of NY; Horizon Health

Proposal (Short Title):
Eliminate or modify unnecessary regulations and improvements for capital access

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: All

Effective Date: 01/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
There are a number of suggested initiatives that require both statutory and regulatory actions to reduce burdens on hospitals and other health care facilities and expand access to capital.

These proposals will be referred to the SAGE Commission process. There are also proposals that will be addressed by the MRT workgroups to be established by Proposal # 1451.

The legislative initiatives are:

1) Temporary suspension of the Nursing Care Quality Protection Act, Chapter 422 of 2009, which requires hospitals, nursing homes, and D&TCs to disclose, upon request, specified information concerning nursing care staffing levels.
2) Authorize modification of NYPORTS adverse event reporting for hospitals and D&TCs to align with national consensus standards adopted by the National Quality Forum under a contract with AHRQ.
3) Capital Access: Reinstate Industrial Development Agency (IDA) financing for health care facility capital projects and explore alternatives that include other local financing authority and ownership by publically traded companies.
4) Death reporting requirement for adult care facilities to apply for suicide or questionable circumstances.

The regulatory initiatives are:

1) Authorize observation units as an adjunct to hospital emergency departments and create a Medicaid rate for the units.

2) Facilitate access to capital financing through obligated groups, including multi-state obligated groups.
3) Implement a uniform incident report system for nursing home providers.
4) Implement a policy to allow approved nurse aide training program sponsors to provide training at nursing home sites which currently do not sponsor their own training.
5) Modify the reporting deadlines of the home care worker registry.
6) Allow home health aide training programs to have a single qualified supervisor RN for multiple training programs.
7) Eliminate the requirement for a physician to be on the Quality Improvement (QI) Committee of Licensed Home Care Services Agencies (LHCSAs).
8) Review reporting requirements for community based services

GNYHA also finds that New York State requires separate licensure and imposes separate regulations in providers of psychiatric and addiction treatment services. Neither the Medicare program nor other states follow this practice. Many hospitals have reported that the ability to treat a patient for mental illness and substance abuse in the same setting would much improve quality and efficiency. This proposal is to combine OMH and OASAS into a single agency and to develop a single license and set of regulations for both services. In particular, the single set of regulations would streamline and standardize reporting for quality assurance. Nassau Co. DSS recommends that DOH, OMH and OASAS be merged.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Given the financial pressures on health care facilities, the Department is committed to reducing regulatory requirements that do not produce the intended effect or that do not contribute significantly to quality of care and patient safety (e.g., the burden imposed by the regulation outweighs its positive impact). Accordingly, the Department is proposing legislation to suspend implementation of the Nursing Quality Protection Act. The disclosure requirements required by this law, while well-intentioned, are unlikely to have a material effect on quality of care.

The Department is also seeking legislation to align its NYPORTS adverse event reporting requirements with national standards. This will clarify the definitions of reportable events, eliminate unnecessary reporting, and facilitate comparisons of reporting rates among New York hospitals and hospitals around the country. Ultimately, it will support efforts to identify system failures that compromise patient safety and best practices to promote patient safety.

The Department is also proposing amendments to its regulations creating operating standards for observation units and a Medicaid rate for such units. Observation units can improve patient flow in emergency departments and reduce unnecessary hospital admissions and repeated emergency room visits.

In addition, the Department recognizes that, in the wake of the financial crisis, health care facilities are experiencing difficulty securing financing for needed capital projects. To support their efforts, the Department will advance legislative and regulatory changes that will facilitate access to capital through IDAs and obligated groups.

The Department has reviewed regulations and policy in the long term care area. Several areas have been identified to provide relief to providers without putting vulnerable individuals at risk. These include modifications to training requirements and reporting requirements.

Being able to treat patients for mental illness and substance abuse in the same setting would also permit hospitals to bill Medicare for substance abuse services under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) rather than the acute inpatient PPS. GNYHA is conducting a study to determine whether this would increase funding to New York hospitals. If so, it would help sustain vital behavioral health services.

Concerns with Proposal:
NYSNA will argue that the disclosure requirements of the Nursing Care Quality Act are important to assuring appropriate levels of nursing staff needed to promote quality of care.

Impacted Stakeholders:
Hospitals and nursing homes and industry associations (HANYS, GNYHA, NYAHSA, NYSHFA).

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization:
Staff Person: OHSM: Karen Lipson and Tom Jung/OLTC: Jacqueline Pappalardi,Mary Ann Angl
Phone:
Email:

Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 150

Proposal Author:
OPWDD, Empire Justice; NYS Catholic Conference; CNYHSA; Planned Parenthood of the North Country, Housing Works, Children's Defense Fund,Urban Justice Center Mental Health Project, Hudson Health Plan; FEGS , Suffolk County Department of Social Services,

Proposal (Short Title):
Develop an Automated Exchange/Medicaid Eligibility System

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Eligibility

Effective Date: 03/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
The most important redesign with greatest potential for efficiency will come from creating an automated Exchange/Medicaid eligibility system.

The Medicaid eligibility determination process is largely manual. Paper applications are entered into a computer, verification of income, resources, citizenship/immigration status and other factors is principally paper-based, and the eligibility logic that translates the information provided on the application into a determination is done by workers and the end result is entered into a computer.

The most important redesign of eligibility to gain the greatest streamlining and efficiency would be to invest in technology to automate the eligibility process. This would involve having an online application, maximizing online verification of eligibility, and automating the eligibility determination. The Affordable Care Act requires this automation for Medicaid and the Exchange by mid-2013.

An electronic enrollment and verification system is also a necessary precursor to the State assuming the eligibility determination function from the local districts.

This proposal would develop a vertically integrated health insurance eligibility system for Medicaid/CHIP and Exchange coverage building upon the MMIS architecture and maximizing automation of both eligibility determinations and verifications.

New York was one of seven states awarded an Early Innovator Grant for federal funding to support a new eligibility system for Medicaid and the Exchange. The funding will provide $27 million for the Exchange

component of the new system. A condition of the Early Innovator grant is to develop the system in two years and serve as a model for other states in their Exchange/Medicaid system efforts. As such, the State will need to obtain a contract amendment to its current system vendor to begin development immediately.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$-25.00	$-100.00
Total Savings	$27.00	$27.00	$-50.00	$-200.00

Benefits of Proposal:

Automating the eligibility determination process will:

- Improve the customer experience by reducing the time from application to enrollment
- Reduce worker time, thereby producing savings in greater efficiency
- Decrease errors and improve program integrity

Concerns with Proposal:

Tight time frame to meet the technology requirements of the ACA
Local Districts, while supporting greater automation, are concerned about the impact on their workforce

Impacted Stakeholders:

Local Departments of Social Services
Consumers
Providers
Health Plans

Additional Technical Detail: (if needed, to evaluate proposal)

The cost of the system will largely be borne by the Federal government in 100% Exchange funding and 90% Medicaid funding as long as the system is built by 2015. The savings from greater automation will more than offset the less than 10% cost of building the system.

System Implications:

Timing - System resources are severely limited today. It will be a challenge to meet the 2013 timeframe without flexibility in hiring and contracting with the new federal dollars.

Managing two systems - It will be a challenge to maintain current system operations while moving toward a new system given current resource constraints.

Metrics to Track Savings:

Change in time from application to enrollment
Change in error rates
Change in the staff time needed to change the old system compared to the new system

Contact Information:

Organization: OHIP/DCE and DS
Staff Person: Judy Arnold/Tom Donovan
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 153

Reform?: Yes

Proposal Author:
HANYS, Blossom View Nursing Home, Home Care Association of New York State; American TeleCare

Proposal (Short Title):
Develop innovative telemedicine applications by reducing regulatory barriers and providing payment incentives

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Hospital

Effective Date: 02/02/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Medicaid will promote and enhance coverage of telemedicine by providing payment incentives and reduce coverage barriers.

New York's Medicaid program supports certain uses of telemedicine, such as the state's "tele-stroke" initiative, which provides specialty care via video linkages to patients in underserved areas who may be experiencing a stroke and whose treatment requires immediate consultation with a neurologist. It also encourages use of telemedicine to provide much-needed adolescent psychiatric care to patients in high need areas. However, payment limitations and regulatory barriers are hindering development or sustainability of these and other innovative telemedicine applications.

Lack of sufficient volume and/or physician resources limit the capacity of many health care providers to staff their facilities with a wide array of physicians and specialists, 24-hours-a-day seven days-a-week. Yet patients in underserved areas deserve the same level of care as counterparts in other regions of the state.

Physician coverage is increasingly being provided in a more cost-effective way through video linkages between patients and providers at tertiary hospitals or centrally located facilities. Patients, such as those suffering with Parkinson's Disease or other physically limiting conditions, can benefit by not having to travel, and specialists can serve more patients in a more efficient way if aided by telemedicine. For example Tele-radiology, where the radiologist reads images from a remote location, is standard practice across the country.

Currently, Medicaid supports billing for services only for specialty consultations in the inpatient, outpatient or emergency department setting. In addition, Medicaid supports payment for home care, but not for the cost of the remote monitoring devices necessary to eliminate unnecessary travel or doctors' visits.

New York should coordinate the various efforts under way to promote use of telemedicine, including the DOH tele-stroke initiative, Office of Mental Health adolescent tele-psychiatry program, use of remote monitoring to improve primary care within the concept of "health homes," as described in federal health reform, and other initiatives. The state should develop a consistent and supportive approach for reimbursement and regulation.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.23	$-0.23	$-0.23	$-0.23
Total Savings	$-0.45	$-0.45	$-0.45	$-0.45

Benefits of Proposal:

Concerns with Proposal:
Need to resolve issues of physician credentialing and out of state ebusiness licensure

Impacted Stakeholders:

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: s

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 154

Reform?: Yes

Date Submitted:01/28/2011

Proposal Author:
OMIG

Proposal (Short Title):
Enhance and improve the State's Medicaid program integrity efforts.

Theme: Eliminate Fraud and Abuse

Program Area: Fraud and Abuse

Effective Date: 04/01/2011

Implementation Complexity: Medium

Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Enhance and improve the State's Medicaid program integrity efforts through coordination of audit and other fraud, waste and abuse activities and collaboration with other State and Federal entities, and use of new technologies, including:

Require that all CHHAs and Personal Care providers statewide above a $15 million threshhold in annual Medicaid reimbursement utilize a vendor to provide conflict and exception reports. These reports will be reviewed and reconciled prior to claim submission. Additionally, each service in a claim will need to be verified prior to submission.

OMIG will lead an effort to coordinate State audits of the Medicaid Program.

Require that physicians who order services for dually eligible individuals be enrolled in both Medicare and Medicaid consistent with Medicare Provider Enrollment, Chain and Ownership System (PECOS) requirements.

Review claims approved and paid by Medicare for dual eligible recipients, which are also submitted to Medicaid for payment, and refine existing edit logic to prevent such duplication.

Require all pharmacies billing Medicaid to participate in the OMIG Cardswipe Program (landline).

Require the identification and signature for home delivery and receipt of prescriptions at pharmacies; require pharmacies to re-stock and re-dispense returned medications from nursing homes; maintain destruction records for drugs that cannot be re-dispensed; and allow the OMIG access to Department of Health (DOH) Bureau of Narcotics Enforcement (BNE) data.

Exand the Restricted Recipient Program by defining triggers that create mandatory restriction for recipients without full clinical reviews; automatically authorize recipient restriction for recipients who possess multiple Medicaid identification cards and use or attempt to use such cards as well as present a forged or altered prescription; authorize recipient restriction for managed care enrollees for pharmacy/dental/other restriction categories; extend the initial restriction period from 24 to 36 months; and extend the second and third and any additional restriction periods.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$- 80.30	$- 159.90	$- 159.80	$- 159.80
Total Savings	$- 160.60	$- 319.80	$- 319.80	$- 319.80

Benefits of Proposal:
Expanding the use of respective vendor data statewide and requiring the provision of exception and conflict reports by providers would further deter potential fraudulent Medicaid claims billings relative to these service categories.

Necessary to ensure appropriate Medicare billings, thereby avoiding future increased Medicaid costs. Fiscal savings associated with denial of Medicare claims for physicans who order services for dual eligibles who are not enrolled as a Medicare providers. In these cases, Medicaid would be required to pay the entire claim as the payor of last resort.

Potential duplicate claims would be reviewed and recoveries made when appropriate. Would improve OMIG's program integrity efforts and eliminate inappropriate payments to ineligible persons.

Would generate signficant State savings by eliminating unnecessary pharmacy orders. Requiring pharmacies to restock returned medications would conform State processes to Federal Deficit Reduction Act of 2005 requirements.

Would yield additional State savings by reducing the Restricted Recipient Program (RRP)administrative requirements and, thereby, expanding the number of participants in the RRP. OMIG's RRP targeting capbilities would also be improved.

Would yield State savings by verifying appropriate delivery and receipt of prescriptions. Access to DOH BNE data would provide information on cash purchases of controlled substances to improve OMIG's RRP targeting capabilities.

Concerns with Proposal:
Providers may object to additional administrative burden and costs associated with the purchase of cardswipe devices.

Impacted Stakeholders:
Providers and beneficiaries.

Additional Technical Detail: (if needed, to evaluate proposal)
Currently, such vendor data and reports are used by New York City to verify actual services provided, length of visits, provider credentials, location of services provided and scheduled visits.

Existing edit logic is not always adequate to identify duplication of payments by Medicaid and Medicare.

System Implications:

Requires various eMedNY edits and Evolution Projects to implement saving initiatives.

Metrics to Track Savings:
Amounts denied by eMedNY; savings per restriction (RRP); prescription costs and pharmacy FFS reimbursement to nursing homes; providing billing activity.

Savings will also be measured using a pre and post implementation methodology.

Contact Information:

Organization: Office of the Medicaid Inspector General
Staff Person: James Sheehan
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Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 164

Date Submitted:01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Align Medicare Part B clinic coinsurance with Medicaid coverage and rates

Theme: Better Align Medicaid with Medicare and ACA

Program Area: Ambulatory Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
The Medicare Part B coinsurance will not be paid for certain physician services not covered by Medicaid. If Medicare's payment to a clinic exceeds the Medicaid rate, Medicaid will not pay the Medicare Part B coinsurance.

Centers for Medicare and Medicaid Services (CMS) permits state Medicaid programs to limit the amount of cost sharing they contribute to patients who are dually covered by both Medicare and Medicaid. Under Medicare Part B, providers are reimbursed 80% of the amount approved by Medicare. The remaining 20% Part B co-insurance is the patient responsibility. State Medicaid programs may pay providers the full Part B coinsurance amount, a portion of the coinsurance amount, or may pay no cost sharing. Medicaid presently pays physicians the full Medicare Part B coinsurance amount for certain services that are not covered by Medicaid. Medicaid will no longer pay the Medicare Part B coinsurance for such services. Medicaid also presently reimburses clinics the full Medicare Part B coinsurance amount, even if the total Medicare/Medicaid payment to the clinic exceeds the Medicaid clinic rate. Medicaid will no longer pay the Medicare Part B coinsurance when the Medicare payment to the clinic exceeds the Medicaid clinic rate. Providers will be prohibited from billing the Medicaid patient for any Medicare Part B coinsurance amounts not reimbursed by Medicaid.

The fiscal has been adjusted for the FFS move to Medicaid Managed Care by year as follows - 5%, 15%, 20%, 25%

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15

State Savings	$-8.55	$-15.30	$-14.40	$-13.50
Total Savings	$-17.10	$-30.60	$-28.80	$-27.00

Benefits of Proposal:
Medicaid will only reimburse physicians for those specific procedures that have been approved/paid by Medicare for a Medicare/Medicaid dually eligible recipient if those services would have been covered for a Medicaid only patient. Additionally, Medicaid will limit reimbursement to clinics so that their total Medicare/Medicaid payment does not exceed the amount that Medicaid would have paid the clinic for a Medicaid-only patient. This will serve to align both Medicare and Medicaid coverage for NYS Medicaid enrollees, providing cost savings to the Medicaid program.

Concerns with Proposal:
Physicians will lose Medicaid revenue if this proposal is adopted, which may compromise practitioner participation as well as patient access to services.

Impacted Stakeholders:
Physicians and clinic providers.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
Significant eMedNY systems changes will be required.

Metrics to Track Savings:
eMedNY payment datea will be used to track savings.

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Comments:
Eliminate Medicaid payment to practitioners for Medicare Part B coinsurance amounts for services provided to Medicare/Medicaid dually eligible patients when the procedure (e.g., CPT-4 code) is not reimbursed for Medicaid-only recipients.

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 191

Date Submitted: 02/02/2011

Proposal Author:
HANYS, Department of Health

Proposal (Short Title):
Decrease the Incidence and Improve Treatment of Pressure Ulcers

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 02/02/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Decrease the Incidence and Improve Treatment of Pressure Ulcers.

Provide financial incentives to support demonstrations of cross-setting coalitions that engage regional collaborations with acute and post-acute providers in developing pressure ulcer improvement systems to provide continuity of care, prevent pressure ulcers, and promote healing of unavoidable pressure ulcers to NYS residents.

Medicaid recipients with multiple chronic illnesses are at high risk for developing pressure ulcers and slow to recover from this painful and potentially, life-threatening complication. Clinical research by members of the National Pressure Ulcer Advisory Panel (NPUAP) reveals that pressure ulcers are slow to heal due to a patient's co-morbid conditions, the care is complicated, the costs are high, and treatment involves coordination of care settings over a prolonged period of time.

Initiatives that bring coalitions of providers from different care settings together to coordinate care and to prevent and effectively treat pressure ulcers will lower Medicaid costs.

Potential Medicaid Savings: With nearly 70% of New York's nursing home residents covered by Medicaid and billions spent on hospital and home health care for Medicaid patients vulnerable to pressure ulcers, cross-setting collaborations to improve pressure ulcer prevention and treatment will result in significant Medicaid savings. While some of the treatment takes place in the hospital, 25% of patients with pressure ulcers discharged will require home care services and another 25% of patients with pressure ulcers require nursing home care. In addition to the care of post acute home care and/or nursing home care, pressure ulcer treatment

can add another $2,000 to $40,000 or more for pressure ulcer care.
(Bergstrom, 1992; Bergstrom, 1994; NPUAP, 1989).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
The reduction of pressure ulcers is a patient safety issue that affects quality of care and quality of life for all NYS residents. The cost of care for people with pressure ulcers is spread across settings. Initiatives that bring coalitions of cross-setting providers together to coordinate care and to prevent and effectively treat pressure ulcers will lower Medicaid costs. The use of care coordination to improve outcomes, control costs, and augment the prevention and management of pressure ulcers can result in significant Medicaid savings

Concerns with Proposal:
Financial support would be needed to sustain regional coalitions dedicated to the reduction of pressure ulcers.Cost savings will require an initial investment by nursing homes for additional staff, specialized training and equipment necessary for the prevention and treatment of pressure ulcers.

Impacted Stakeholders:
Hospitals, LTC agencies and facilities, consumers, NYS Medicaid, health care advocacy groups and health care provider associations

Additional Technical Detail: (if needed, to evaluate proposal)
Analysis of indirect and pharmeautical costs associated with the prevention and treatment of pressure ulcers.

System Implications:
IT resources and statistical analysis of available SNF data for incidence of SNF acquired pressure ulcers. Expansion of IT resources to capture data from all health care settings.

Metrics to Track Savings:
Collection of incidence rates of Pressure Ulcer across health care settings; Pressure Ulcer rates per 1000 hospital patients discharged.

Contact Information:

Organization: Division of Residential Services
Staff Person: Jacqueline Pappalardi
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Viability: L

Comments:
HANYS utilized the Quality Indicator methodology from AHRQ (Agency for Healthcare Research and Quality) to identify that there are approximately 35 pressure ulcers that occur in NYS for every 1000 hospital patients discharged.This proposal has no State Medicaid direct savings. Savings may be realized on the provider side.

OLTC will request an appropriation in the amount of $350,000 to support Regional Collaboratives dedicated to the reduction of pressure ulcers across health care settings.

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 196

Date Submitted: 01/28/2011

Proposal Author:
Finger Lakes Health Systems Agency, HANYS; MRT Member (LInda Gibbs); NYAHSA; CNYHSA; Ralph Fasano-Concern for Independent Living,Susan Sorrentino, Family Residences and Essential Enterprises; Katheryn P Bunce; Project Renewal, Center for Urban Community Services; Assoc for Community Living

Proposal (Short Title):
Supportive Housing Initiative

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 01/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Proposal would create a supportive housing interagency work group with a goal of formal proposal submitted to the MRT by July 1, 1011. The goal of the workgroup is create between 5000 and 10,000 housing opportunities for persons at risk of nursing home placements.

Lower costs by keeping patients out of institutional care (Nursing homes, etc) and establishing a supportive housing initiative.

There are many activities underway as alternatives to nursing homes such as assisted living, assisted living residences, special needs assisted living residences, and the OMH supportive housing initiative. The need to expand these alternatives is critical to reducing reliance on nursing homes and other institutional settings. A NY/NY 4 agreement with New York City would be pursued based on the findings of earlier agreements.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$75.00	$75.00	$75.00
Total Savings	$	$	$	$

Benefits of Proposal:

Provides housing resource to aged and disabled that avoids institutional placements
By providing housing stability, research has shown that health care costs including Medicaid can be reduced.

Concerns with Proposal:
In order to expand this type of resource additional funding is required for development.

Impacted Stakeholders:
Consumers, developers, housing providers

Additional Technical Detail: (if needed, to evaluate proposal)
There is a lack of detail on the nature of what "supportive housing" means and the role of the state Medicaid system.

System Implications:

Metrics to Track Savings:
Institutional placements pre and post agreement

Contact Information:

Organization: OLTC
Staff Person: Mark Kissinger
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Viability: S

Comments:
Workgroup would have to have buy in from the Executive chamber, DOB and all relevant agencies.

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 200

Reform?: Yes

Date Submitted:01/28/2011

Proposal Author:
MRT Members (Carol Raphael Visiting Nurse Service Karen Ballard, NYSNA); Louis Kaplan, PA-C; Long Island OCD Support Services;HCA, Blossom View Nursing Home, VNSNY

Proposal (Short Title):
Change in scope of practice for mid-level providers to promote efficiency and lower Medicaid costs.

Theme: Empower Patients and Rebalance Service Delivery

Program Area: All

Effective Date: 01/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Expand the scope of practice for RNs, LPNs and home health aides to improve access to services and decrease associated costs in delivering services.

HCA-Reforms the state's supervision and orientation regulations for home health aides and personal care workers. Permit nurses/patients (under their scope of practice/practice exemption) to orient/direct HHAs and PC workers to provide "nursing care" as is currently allowed in the consumer directed personal assistant program. Allow Nurse practitioners to sign Medical Evaluations for ACF/AL. Eliminate restrictions on nursing practices in ACFs

Blossom South-Allow LPNs to complete assessments in LTC settings.
SNYA and NYSHFA - Extension of medication aides into nursing homes.

Visiting Nurse Service of New York-Expand the scope of practice of home health aides to include the administration of pre-poured medications to both self-directing and non-self directing individuals.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00

Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Expanding the use of mid-level practitioners will help expand access to certain types of health care services and possibly help control costs.

Concerns with Proposal:
Scope of practice; patient safety concerns pertaining to assuring home health aides are properly trained to assess medication reactions and drug administration problems.

Impacted Stakeholders:
Providers of home health services personal care services, consumers and families

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: OHSM; OLTC
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Viability: S

Comments:
Also note Nurse Practitioner Association (NPA) Global Signature Legislation, MRT #934, Blossom View Nursing Home, MRT #321; SNYA and NYSHFA, MRT#414

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 209

Proposal Author:
MRT Member (Eli Feldman, Metropolitan Jewish Health System), Hospice of NY

Proposal (Short Title):
Expand Hospice

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Long Term Care

Effective Date: 01/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
This proposal will expand hospice:
Expand concurrent hospice and curative care to Medicaid adults.
Expand definition of terminal illness to 12 months
Integrate hospice into medical home and ACO projects.

Election of hospice care waives the patient's right to any Medicare or Medicaid services that are related to the treatment of the terminal illness and related conditions for which hospice care was elected. Implementation would require amendment of the Social Security Act.

Hospice is a program that provides care to terminally ill individuals that focuses on easing symptoms rather than treating disease. The Social Security Act 1861(dd) defines hospice care and a terminally ill individual who has to elect the benefit and acknowledge that the care they receive will be palliative and not curative. Election of hospice care waives the patient's right to any Medicare or Medicaid services that are related to the treatment of the terminal illness and related conditions for which hospice care was elected. Implementation would require amendment of the Social Security Act.

Adult individuals who wish to continue with active curative treatments can receive palliative (not hospice services) through physicians, home health agencies.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00

Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Potentially makes hospice services available to a broader population.

Concerns with Proposal:
Allowing individuals to receive hospice benefits through Medicaid is not consistent with the rules established by the CMS regarding participation and payment for these services could negatively impact FFP.

Impacted Stakeholders:
Hospice organizations, hospice associations, patients

Additional Technical Detail: (if needed, to evaluate proposal)
TBD

System Implications:
TBD

Metrics to Track Savings:
TBD

Contact Information:

Organization: Division of Home and Community Based Services
Staff Person: Mary Ann Anglin
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 217

Proposal Author:
MRT Member (Elizabeth Swain, CHCANYS/ PCC)

Proposal (Short Title):
Create an office for development of patient-centered primary care initiatives

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: N/A
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:**	**Statutory Change:**
	State Plan Amend:	**Federal Waiver:**

Proposal Description:
Create an office for development of patient-centered primary care initiatives.

A dedicated Office of Primary Care is necessary to assure that New York takes advantage of the opportunities available under the Affordable Care Act (ACA) to support primary care, gives the Department a single point of contact for providers and stakeholders to help facilitate expansion of primary care, and addresses workforce shortages and barriers, resulting in improved primary care access statewide.

Expanding primary care will be an important part of integrating patients' physical and behaviorial health services as well as assuring appropriate care coordination services are being provided to chronically ill patients under health homes.

Improving access to primary care will result in a reduction of avoidable hospital admissions and inappropriate emergency department use. The savings achieved through improving primary care access should be reinvested in this Office to support its continued work.

This proposal is also being referred to the Spending and Government Efficiency (SAGE) process.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
This Office will be responsible for ensuring that NY takes advantage of ACA funding opportunities, and will provide support for the development of health homes, provide a single point of contact on primary care, and serve to centralize all functions related to the expansion of primary care.

Concerns with Proposal:
Creating an Office at a time when the Government is looking at consolidating resources.

Impacted Stakeholders:
Consumers, providers, payors, including Medicaid and Medicare, business.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: Division of Financial Planning and Policy
Staff Person: Gregory Allen
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Email: gsa01@health.state.ny.us

Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 243

Proposal Author: MRT Member (Assemblyman Richard Gottfried); HANYs; GNYHA; HHS, Beacon Health Strategies

Proposal (Short Title): Explore Models to Implement Accountable Care Organizations (ACOs)

Theme: Ensure That Every Medicaid Member is Enrolled in Managed Care

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** Yes

Proposal Description:
Explore reimbursement models to implement Accountable Care Organizations (ACOs) for Medicaid beneficiaries. Need guidance from CMS.

Explore models through which to implement Accountable Care Organizations (ACOs) for Medicaid beneficiaries, including individuals eligible for both Medicare and Medicaid. ACOs are provider-led entities that monitor patient care across multiple care settings (e.g., Medicare, Medicaid and private insurers) for the overall cost and quality of care for a defined population. ACOs create incentives for providers to emphasize primary care, prevention and adherence to evidence-based guidelines. These practices reduce patient care costs, the surplus of which is shared among participating providers.

ACOs will need to satisfy the following Federal requirements: (1) become accountable for the quality, cost and overall care of the fee-for-service beneficiaries assigned to it; (2)enter into an agreement with the Secretary of Health and Human Services (Secretary) to participate in the program for not less than a 3-year period; (3) establish a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers; (4) include primary care ACO professionals that are sufficient for the number of beneficiaries assigned to the ACO; (5) provide the Secretary with such information as the Secretary deems necessary regarding professionals participating in the ACO; (6) establish a leadership and management structure that includes clinical and administrative systems; (7) define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care; and (8) meet patient-centeredness criteria specified by the Secretary.

There are several different ways to structure an ACO. In order to determine the potential savings created by implementing an ACO, a payment model and method of participation must be developed.

An ACO may be reimbursed under either a partial capitation or fee-for-service payment model. Under a partial

capitation payment model, an ACO would assume financial risk for some, but not all, of the services it provided. In contrast, under a fee-for-service payment model, an ACO would receive a shared savings incentive payment in addition to its regular fee-for-service reimbursement.

Participation in an ACO may be either voluntary or mandatory. Physicians may elect to participate in an ACO under a voluntary model whereas physicians would be assigned to an ACO that includes at least one hospital under a mandatory model. The potential for savings is greater under a mandatory model. Patients retain the choice of provider, including those providers not participating in the ACO, under both models.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD	TBD	TBD	TBD
Total Savings	TBD	TBD	TBD	TBD

Benefits of Proposal:
Implementation of the ACO model has the potential to create significant Medicare and Medicaid cost-savings through the coordination of care. The ACO model provides financial incentives to curb fee-for-service spending while simultaneously encouraging improvement in the quality and efficiency of health care services. Furthermore, the ACO model establishes the framework through which other cost saving measures (e.g., medical homes, bundled payments, partial capitation and HIT) can be implemented.

In addition, certain New York hospitals, such as Montefiore and NYC Health and Hospital Corporation (HHC), are well positioned to quickly and effectively implement the ACO model.

Concerns with Proposal:
The ACO model will need to be well defined before it can be implemented and may require amendments to state and/or federal laws and regulations. This is of particular concern with issues related to patient privacy and anti-trust laws. Full implementation may take a significant amount of time, hindering the realization of any meaningful short-term savings.

Impacted Stakeholders:
Providers of services to Medicare and Medicaid beneficiaries as well as industry associations (e.g., Healthcare Association of New York State, Greater New York Hospital Association and other trade organizations) will be impacted by the implementation of the ACO model.

Savings associated with the establishment of ACOs are reflected in the commitment to implement pay-for-performance, health homes and other such initiatives. ACOs may, however, create potential for additional provider savings in the long-term, especially as relating to the Medicare program.

Additional Technical Detail: (if needed, to evaluate proposal)
Implementation of the ACO model will require significant restructuring of the current health care delivery system in New York State. For example, health care providers will need to form new legal entities that will

satisfy objectives of the ACO model while maintaining compliance with state and federal laws. Furthermore, patient information will need to be accessible to a greater number of providers administering a broader range of services.

System Implications:
There are no immediate eMedNY implications.

Metrics to Track Savings:
A comparison of historical Fee-for-Service utilization and expenditures versus utilization and expenditures under the ACO.

Contact Information:

Organization:	Department of Health; Division of Health Care Financing
Staff Person:	John E. Ulberg, Jr.
Phone:	518-474-6350
Email:	jeu01@health.state.ny.us

Viability: S/L

	True
Modified Delphi Scoreable:	
Modified Delphi Score:	

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 264

Proposal Author: DOH

Proposal (Short Title): Apply HCRA Surcharges to Physician Office Based Surgery and Radiology Services

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Ambulatory Care

Effective Date: 07/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
Implement a broad based and uniform surcharge on surgery and radiology services provided by physicians in office based settings, including non-licensed urgent care centers, in accordance with Current Procedure Terminology (CPT)codes. Payment of the surcharge would be the responsibility of all third-party payors who have voluntarily agreed to make HCRA surcharge and assessment payments directly to the State. These surcharges would not apply to Medicaid, Medicare, and other federally sponsored insurance programs (e.g., CHAMPUS, FEHBA, and CHPLUS). Payments made directly by patients for such procedures (including co-pays, deductibles, and payments for uncovered services) would also be exempted.

Outside counsel advised that the State could implement this proposal as a broad based and uniform tax under the physician provider tax class of federal law, because it applies to any office based physician that wishes to engage in surgical or radiological services. Further 42 CFR 433.68(d)(iv) states that the uniformity requirement can be satisfied by the uniform application of the tax to particular "items or services" within the physician provider tax class. However, it should be noted that this provision requires that "the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services". Consequently, CMS's affirmative agreement is required.

It should also be noted that from a legal perspective the viability of this proposal in terms of federal provider tax rules is unrelated to the issue of requiring insurance carriers to pay facility fees to private physician OBS practices, as has been requested by some stakeholders.

Implementation will require approximately $100,000 in Department administrative expenses for SFY 11-12 and $1.5M in SFY 12-13 for support staff, pool administration and audit compliance (which has been netted from the fiscal impacts noted below).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-57.80	$-99.20	$-99.20	$-99.20
Total Savings	$-57.90	$-99.20	$-99.20	$-99.20

Benefits of Proposal:
Physicians have taken business away from hospitals, partially due to the competitive disadvantage hospitals are under as a result of added surcharge obligations (i.e., office-based surgical and radiology procedures). Application of HCRA surcharges to physicians provides some equity.

Provides a reasonable means for certain physician services to financially support programs funded through the HCRA Pools that directly, or indirectly, advantage NYS physicians (e.g., Excess Medical Malpractice Pool, CHPLUS, HealthyNY, etc.)

Funds raised by these surcharges could be used to support essential State health programs.

Can be practically implemented by linking surcharge obligations to specific CPT-4 locater billing codes.

There is no need to obtain payments and reports directly from physicians. All obligations would be placed on third-party payors, with whom we already have a reporting relationship.

Concerns with Proposal:
To the extent possible, affected third-party payors will likely pass this obligation onto physician providers by reducing payments, or onto subscribers through increased premiums/cost sharing arrangements.

It is difficult for the Department to determine an accurate fiscal impact, because data on physician revenue is not available.

NYOBS, Society of NY Office Based Surgery Facilities, is requesting that the NYS Health Department require commercial insurance carriers (including Medicaid) to reimburse physician office based surgery practices a "facility fee" to help defray costs including equipment, staff, supplies, and overhead. If such entities are paid a facility fee in addition to the physician professional component, their reimbursement would essentially mirror commercial/Medicaid payments for ambulatory surgery provided in Art 28 certified ambulatory surgery centers. However, physician office based surgery practices are not subject to the same strict Health Department oversight that applies to Art 28 facilities. This would result in an inequity of service delivery standards and associated facility fees. Art 28 ambulatory surgery centers could then seek de-certification, since they would be subject to the same oversight and payment structure whether or not they were Art 28 certified.

CMS must agree to the broad based and uniform nature of the proposed assessment.

Impacted Stakeholders:
Physician office based surgery and radiology practices. Art 28 certified ambulatory surgery centers. Insurers.

Additional Technical Detail: (if needed, to evaluate proposal)

The Department investigated other means of fashioning this proposal, but to no avail. Outside counsel indicated that this proposal could not be implemented under the federal ambulatory surgery center or licensing/certification fee provider tax classes. It also could not be implemented as a permissible tax under federal law if it was strictly a tax on office based surgery practices that have been accredited by national organizations.

System Implications:
Payors will need to revise their systems to recognize specific CPT codes, calculate payments, and make remittances. The Department will need to revise payor monthly reporting forms. The Department's contracted HCRA pool administrator will need to make systems modifications.

Metrics to Track Savings:
The Department will track these surcharge receipts separately.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 889

Date Submitted: 01/28/2011

Proposal Author:
DOH

Proposal (Short Title):
Redesign NYS bed hold policy for nursing homes.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 01/02/2012

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Redesign the NYS bed hold policy for nursing homes.

Federal policy allows, but does not require, a state to provide reimbursement to reserve the bed of a Medicaid recipient residing in a nursing home or residential treatment facility (RTF) during a period of temporary hospitalization or leave of absence. Currently, New York State does reimburse various medical institutions. The current regulation requires, unless medically contraindicated, a nursing home, as a condition of participation in the Medicaid program and under certain circumstances, to reserve a Medicaid recipient's bed during a period of temporary hospitalization or therapeutic leave. The facility must have a minimum occupancy rate of 95% in order to be eligible to receive this reimbursement.

Chapter 109 of the Laws of 2010 amended the reserved bed day reimbursement policy for Medicaid-eligible residents of nursing homes aged twenty-one and older. Specifically, Chapter 109 reduced the Medicaid reimbursement rate for reserved bed days from 100% of the per diem rate to 95%. Chapter 109 also limited the number of reserved bed days for which a facility will be reimbursed while a resident is temporarily hospitalized or on a non-hospitalization leave of absence.

This proposal would eliminate Nursing Home Medicaid reserved bed day reimbursement for all Medicaid recipients over 21. Additionally, Nursing homes could regain the ability to receive reserved bed payments if they enroll 50% of their eligible residents in a Medicare Managed Care Program. If the nursing homes successfully enroll 50% of those eligible, reserved bed day payments would be made consistent with the current statute.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$-20.00	$-17.50	$-17.50
Total Savings	$0.00	$-40.00	$-35.00	$-35.00

Benefits of Proposal:
The proposal would result in substantial Medicaid cost savings and discourage unnecessary hospitalizations.

Concerns with Proposal:
Residents and their families will be opposed to the elimination of Medicaid reserved bed days. After the enactment of Chapter 109 of the Laws of 2010, the Department received complaints from nursing home residents and their family members regarding the reduction in the number of reserved bed days, particularly for non-hospitalization leaves of absence.

Nursing home representatives can be expected to object to this proposal. However, a reduction in unnecessary resident transfers would maintain occupancy driven revenue.

Impacted Stakeholders:
All Medicaid eligible nursing home residents and consumers of LTC services, NYS nursing home operators, Article 28 general hospitals, nursing home provider associations and long term care advocacy agencies.

Additional Technical Detail: (if needed, to evaluate proposal)
System to collect information on Medicare Care Management enrollees in each nursing home.

System Implications:
The proposal will require edits to the eMedNY system. State Plan and state law amendments would be required.

Metrics to Track Savings:
Quarterly review and analysis of EMEDNY and Minimum Data Set (MDS) 3.0 information.

Contact Information:

Organization: DOH/Division of Residential Services
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Phone: 408- 1267
Email:

Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 990

Proposal Author:
Commission on the Public's Health System - Judy Wessler, Director, Mark Hannay, Director, Metro NY Health Care for All Campaign

Proposal (Short Title):
Explore the Establishment of Reimbursement Rates to Support Efforts to Address Health Disparities

Theme: Empower Patients and Rebalance Service Delivery

Program Area: Ambulatory Care

Effective Date: 02/10/2011

Implementation Complexity: N/A
Implementation Timeline: N/A

Required Approvals: **Administrative Action:** No **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
Explore the establishment of reimbursement rates to support providers efforts to offer culturally competence and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation, and gender expression.

Provide adequate reimbursement for interpretation and translation services to patients with limited English proficiency.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Better, more comprehensive culturally competent care could lead to a reduction in hospitalizations.

Concerns with Proposal:

Impacted Stakeholders:

Consumers, Providers, Payors

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: Division of Financial Planning and Policy
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Viability: S

Modified Delphi Scoreable:
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1021

Proposal Author:
Charles King

Proposal (Short Title):
Facilitating Co-Located physical health, behavioral health and developmental disability services

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Ambulatory Care

Effective Date: 02/11/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Allow approved DOH, OMH, OASAS and OMRDD facilities to add services licensed by another agency through a streamlined process to facilitate integration of physical, behavioral, and developmental disability services.

Commissioners would grant multiple service authorization at a single site for agencies/organizations which have demonstrated a track record of quality service provisions for all the services being authorized.

Collaboration among the agencies will remove barriers and determine a single set of rules that would apply to facilities seeking to co-locate services for the purpose of integrating physical, behavioral, and developmental disability services. Agencies would be expected to waive requirements that are duplicative of each other. For example, if the applicant certifies that the space licensed under the existing license generally met the requirements of the other licensing agencies, there would be no further review of space or physical plant. The applicant could meet the requirement of demonstrated need simply by showing that the provider is already serving persons in need of the additional services in its current program. Shared allocation of administrative and appropriately credentialled program staff would not be a barrier to co-locating services. Rate methodology and reimbursement would remain the same as the current structure.

Facilities would be still be expected to meet the federal and state health home requirements in addition to meeting the streamlined process requirements.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00

Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Would simplify process of adding services licensed by another agency to an existing licensed facility. Would support improved integration of physical health, behavioral health and developmental disability services.

Concerns with Proposal:
Identifying which rules should be waived may be difficult; determining the responsible agency for surveillance, oversite, and adherence to program requirements.

Impacted Stakeholders:
Licensed operator of health or behavioral/DD health services, consumers of behavioral health or developmental disability services.

Additional Technical Detail: (if needed, to evaluate proposal)
This type of proposal is under consideration by the SAGE Commission.

System Implications:
May improve integration of health and behavioral health and developmental disability services.

Metrics to Track Savings:
Reduced ED use and readmissions by persons with co-occurring disorders.

Contact Information:

Organization: DOH/OHIP/Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1029

Proposal Author:
Hudson Health Plan, GMHC, Empire Justice

Proposal (Short Title):
Enrollment and Retention Simplification

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Eligibility

Effective Date: 06/01/2012

Implementation Complexity: Medium

Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
Implement several enrollment and retention simplification initiatives.

The proposals include:

Pursue federal approval for two year renewal periods
Develop a short-term method for data transfer between health plans and counties for use while the state transitions to consolidation.
Allow for outreach to certain populations via phone or electronically, based on data matching and develop authorization protocols for individuals who may be eligible for Medicaid, CHP, or FHP, e.g., "Are you interested?" box on the tax return forms.
Eliminate the need to present original supporting documents as part of eligibility determination. This requirement currently undermines the State's goal of ending face-to-face meetings with applicants.

Empire Justice included a proposal to maximize MSP enrollment. One way to do that is to administratively renew MSP enrollees. There would be small administrative savings with this proposal. It affects 98,000 individuals.

Administrative renewal for MSP has a full annual state savings of $.15 million.

Two year administrative renewal has a full annual state cost of $25.3 million.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15

State Savings	$-0.10	$-0.15	$-0.15	$-0.20
Total Savings	$-0.20	$-0.30	$-0.30	$-0.40

Benefits of Proposal:
Reducing churning can reduce administrative costs by decreasing the number of new applications that need to be processed for eligible people who lose coverage.

Concerns with Proposal:
It is unclear whether HHS will grant a waiver for 2 year renewal. Federal rules require annual renewal. A two year renewal period may also increase PERM errors because the information reviewed must be no older than 12 months. It would require DOH to obtain current eligibility information from those whose eligibility was verified longer than 12 months. Errors will increase as people may not respond or may be ineligible at the point in time reviewed.
In other states, outreach using the tax form has proven to be costly with little yield in terms of new enrollments. DOH now matches identity and citizenship to the SSA data which has virtually eliminated the need for original documents. We no longer see this as an issue.

Impacted Stakeholders:
Health plans
Local departments of social services
Consumers
Tax Department

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
WMS modifications for 2 year renewals, CNS changes
Tax department changes

Metrics to Track Savings:
Increase in retention

Contact Information:

Organization: Division of Coverage and Enrollment

Staff Person: Judy Arnold

Phone:

Email:

Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1032

Proposal Author:
MRT Member (Jim Introne)

Proposal (Short Title):
Establish a Housing Disregard as Incentive to Join MLTC

Theme: Ensure That Every Medicaid Member is Enrolled in Managed Care

Program Area: Eligibility

Effective Date: 04/02/2012

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
Allow nursing home eligibile individuals to receive a disregard of a portion of housing expenses if they join a Managed Long Term Care Plan.

The State will seek a waiver from HHS to apply a disregard to a subset of an eligibility category. Federal rules requires that disregards apply to the entire category (e.g., SSI-related or Medically Needy). Such a disregard would result in an eligibility expansion for a large number of people that are targed in this initiative. To limit it, the State will see an 1115 waiver.

The fiscal assumes 1240 individuals are added to MLTC programs per year as a result of the disregard, 25 percent of whom are discharged back to the community from nursing homes.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$13.80	$13.80	$13.80
Total Savings	$0.00	$27.60	$27.60	$27.60

Benefits of Proposal:
Some nursing home residents could be discharged back to the community, but they do not have adequate income to afford housing in the community, even subsidized housing. A disregard would allow them to retain income to pay for housing. The State is interested in making this disregard available only to those who agree to join a managed long term care plan.

Concerns with Proposal:

Unclear if the State can obtain the waiver.
Some people who already have housing will benefit from the eligibility expansion provided by the disregard.

Impacted Stakeholders:
Consumers
Managed Long Term Care Plans
Nursing Homes
Local departments of social services

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
WMS and MBL will need to be changed to effectuate the disregard. The population will need to be separately identified to track.

Metrics to Track Savings:
Number of individuals diverted from nursing homes due to the disregard
Increase in the number of individuals enrolled in MLTC

Contact Information:

Organization: Division of Coverage and Enrollment
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1058

Proposal Author:
New York Association of Psychiatric Rehabilitation Services, Long Island Recovery Association, Long Island OCD Network, Buffalo Psychiatric Center

Proposal (Short Title):
Maximize Peer Services

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** No
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Explore Medicaid reimbursement for peer services such as support, care coaches and recovery coaches.

Peer support can be an effective means of providing community support to Medicaid enrollees with chronic illness and/or long term care needs. Peer supports draw on their knowledge and experience to help others coping with similar situations. Peer supports can offer emotional, social, and practical assistance that can help others toward a healthier and more stable lifestyle. Peer supports can be utilized in conjunction with Patient Centered Medical Homes (PCMH) and new health homes.

Washington state has peer support services which involve individuals who have experienced mental illness first-hand, parents of children who have experienced mental illness, or individuals who have experienced co-occurring disorders (a combination of mental health and substance use disorders) using their experience to support others facing similar issues. Peer support services are provided by a certified peer support counselor grounded in their recovery who has gone through specialized training and testing to earn their certification. Because of their life experience with mental illness and mental health services, peer counselors provide expertise that professional training cannot easily replicate. Peer counselors model recovery and resiliency in overcoming obstacles common to those who live with serious mental illness and help identify goals that promote recovery and resiliency.

Minnesota uses community health workers to bridge the gap between communities and the health and social service systems, navigate the health and human services system, and advocate for individual and community needs. CHWs work in a variety of settings: health clinics, mental health centers, public health departments, mutual assistance associations and other community organizations and agencies that provide counseling, advocacy and health education. In Minnesota, CHWs are now serving deaf, aged and disabled populations. Their work includes health education; information and referral to medical care and a range of social services;

outreach; cultural consultation to clinical and administrative staff; social support, such as visiting homebound clients; informal counseling, goal setting, encouragement, motivation; advocacy; and follow-up to ensure compliance with treatment recommendations.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Peer support services may be a useful adjunct service to support Medicaid enrollees in recovering from or managing their illness when provided under the direction of, and pursuant to a plan of care developed by a health care/mental health care practitioner in the mental hygiene or community long term care system.

Concerns with Proposal:
The role of the peer in improving patient outcomes and reducing health care costs will need to be clearly defined. Peer service provider qualifications and/or certifications will need to be developed. Service oversight responsibilities will need to be determined. Payment mechanisms will need to be developed.

Impacted Stakeholders:
OMH. OPWDD, consumer groups, LTC providers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:
TBD

Metrics to Track Savings:

Contact Information:

Organization: NYSDOH/OHIP/Division of Financial Planning and Policy
Staff Person: Greg Allen
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Viability: S

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1116

Proposal Author:
Senate Medicaid Reform Task Force

Proposal (Short Title):
Apply 60 Month Look Back Period to Non-Institutional LTC

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Eligibility

Effective Date: 04/02/2012

Implementation Complexity: Medium

Implementation Timeline: Long Term

Required Approvals:

Administrative Action: No

Statutory Change: Yes

State Plan Amend: Yes

Federal Waiver: No

Proposal Description:
Apply the 60 month look back period for transfer of assets to non-institutional long-term care applicants with spousal impoverishment protections.

Per CMS, the transfer penalty for community based long-term care service can not begin until the person is institutionalized, otherwise eligible for Medicaid payment of nursing home care, and discharged back to the community. Any transfer penalty started in the nursing home would continue to run when discharged and would affect payment for community based long term care services.

This proposal would explore with CMS whether the state could broaden the transfer penalty for home care to all Medicaid eligible home care recipients instead of limiting it to those discharged from nursing homes. The broadened proposal would include spousal impoverishment protections.

Any income placed in a pooled trust that is used appropriately for allowable services will not be affected.

The proposal does not violate the ACA MOE because it does not affect the eligibility determination. If someone has made a transfer, it would affect the services they can receive not their eligibility for Medicaid.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
More private dollars to fund nursing home care.

Concerns with Proposal:
The limit placed on when the penalty can begin reduces the potential benefit of the look back period for non-institutional long-term care.

Impacted Stakeholders:
Consumers
Nursing homes
Local departments of social services

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
Increase in recoveries for non-institutional care

Contact Information:

Organization: Division of Coverage and Enrollment
Staff Person: Judy Arnold
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1172

Proposal:
Nursing Home Sprinkler Loan Pool

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** No
State Plan Amend: No **Federal Waiver:** No

Proposal Description:
The Federal Centers for Medicare and Medicaid Services (CMS) had mandated that by August 13, 2013 all nursing homes/long term care facilities be equipped with a supervised automatic sprinkler system. This proposal would assist nursing homes in obtaining financing (which would be reimbursed through the nursing home Medicaid capital rate) by combining the individual debt financings into one pooled financing.

Based on information collected by the Department, it is estimated that more than one-half of the 600+ nursing homes are now compliant with the sprinkler mandate. For the facilities that are not yet compliant, the sprinkler requirement will be a major capital expense, ranging from a few hundred thousand dollars to millions of dollars per facility, depending upon the scope of the upgrade need and other factors (e.g., potential asbestos abatement). In addition, for many nursing homes (some of which are facing fiscal challenges) it is proving to be extremely difficult if not impossible to obtain financing. In cases where financing is accessible, the interest rate reflects a "premium" to compensate the lender for doing business with a nursing home it may consider to be a high risk borrower.

The Dormitory Authority of the State of New York (or other local finance authorities, if authorized) could provide either bonded or leased financing for these projects. Bonded financing would likely be accompanied by HUD insurance. The degree to which savings can be achieved will depend upon the market at the time of the borrowing, the issuer of the borrowing, and the structure of the financing. However, it is not likely to generate material savings in the current or out years. In addition, DASNY does not have the authority to provide financing for for-profit entities (i.e., proprietary facilities).

CMS has consistently stated there will be no waivers granted for non-compliant NHs. The Department has been proactive in assessing the impact of the requirement on nursing homes by setting up three dates for submission of materials to assist nursing homes in attaining the August 2013 benchmark. The Department requested information on status of current compliance, expected need and most recently (January 1, 2011), plans for CON requests. The Department continues to track nursing homes progress towards compliance.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

Benefits of Proposal:

- This proposal may provide access to financing for some borrows that cannot independently secure financing in the traditional commercial lending market.
- This proposal may result in savings to the Financial Plan by structuring a pooled financing that may result in a more favorable interest rate.

Concerns with Proposal:

- To ensure funds are available to pay for the debt service on the financing between the time the debt is issued and the projects are completed and Medicaid rates can be revised to provide reimbursement, the financing will include capitalized interest. This will add to the costs of the borrowing and mitigate potential savings.
- The proposal does not provide an avenue for proprietary facilities to access capital for sprinkler systems.

Impacted Stakeholders:
Nursing Homes and nursing home patients.

Additional Technical Detail:
None

System Implications:
None

Metrics to Track Savings:
Comparison of interest rate and cost of issuance of financing pool to non-pool financing.

Contact Information:

Organization: Division of Health Care Financing
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1427

Proposal Author:
DOH , Ms. Perrin

Proposal (Short Title):
Allow consumer direction in MLTC; provide regulatory framework for CDPAP

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** Yes

Proposal Description:
Adds Consumer Directed Personal Assistance Program (CDPAP) services to managed long term care plan packages.

Promulgates regulations for CDPAP. Currently, CDPAP is guided by the personal care services program regulations. This proposal promulgates regulations specific to CDPAP. It should be noted that the Department has drafted regulations that are currently going through the regulatory review process.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

Benefits of Proposal:
Eliminate barrier for recipients of CDPAP to enroll in managed care.

Provides program specific guidance through regulation.

Concerns with Proposal:
none

Impacted Stakeholders:
Consumers, MLTC plans

Additional Technical Detail: (if needed, to evaluate proposal)
none

System Implications:
none

Metrics to Track Savings:
none

Contact Information:

Organization: DOH
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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1434

Reform?: Yes

Date Submitted:02/17/2011

Proposal Author:
DOH

Proposal (Short Title):
Convert a portion of Family Planning grants to Medicaid rate reimbursement

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Convert a portion of Family Planning grants from 80% state funds to Medicaid reimbursement that would be 90% federally funded.

There is an immediate $10 million reduction from the 04/01/11 DOH local assistance budget when the Family Planning grant dollars are converted to Medicaid reimbursment.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-7.00	$-7.00	$-7.00	$-7.00
Total Savings	$-7.00	$-7.00	$-7.00	$-7.00

Benefits of Proposal:
Reduces state expense withought reducing reimbursement of services.
Fee-for Service Medicaid providers benefit the most.

Concerns with Proposal:

Proposal will adversely impact providers who serve a low percent of Medicaid recipients but a high volume of uninsured or a high percent of Medicaid Managed Care and low FFS Medicaid; this is a permanant reduction to this grant while Title X is also being reduced; the grant currently pays for services which are not eligible for a 90% match.

Impacted Stakeholders:
Family Planning providers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:
Medicaid claim data

Contact Information:

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Staff Person: Greg Allen
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Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1451

Date Submitted: 02/17/2011

Proposal Author:
DOH

Proposal (Short Title):
Establish various MRT workgroups

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 03/02/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No

State Plan Amend: No **Federal Waiver:** No

Proposal Description:
The MRT will establish various workgroups to focus discussion on major reform issues. The workgroups will include:
Payment Reform , Basic Benefit review, Program streamlining, Supportive housing, Assisted Living Program redesign, Workforce flexibility, Long Term Care waiver redesign, Managed Long Term Care implementation; these workgroups will continue the work on these issues with a reporting deadline of November 1, 2011.

Preliminary Financial Impact (Dollars in Millions):

2011-12	Minimum	Average	Maximum
State Savings	$	$	$
Total Savings	$	$	$

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

Benefits of Proposal:
These workgroups will continue the work of the MRT in the same transparent, inclusive manner.

Concerns with Proposal:
Staffing

Impacted Stakeholders:
Medicaid enrollees, providers, family members and taxpayers

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: MRT/DOH

Staff Person: Jason Helgerson and DOH staff

Phone:

Email:

Viability: S

Comments:
Need work plans and staffing resources

Modified Delphi Scoreable: False

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1458

Proposal (Short Title):
Care Management Population and Benefit Expansion, Access to Services, and Consumer Rights

Theme: Ensure That Every Medicaid Member is Enrolled in Care Management

Program Area: All

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: N/A

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** Yes

Proposal Description:
Omnibus Care Management initiatives, which eliminates many excluded/exempt populations, expands the benefit package, promotes access to services, and ensures consumer rights.

Several proposals are included in this package which are attached:
Expand Medicaid managed care non dual enrollment and modifies the benefit package which will eliminate many exclusions and exemptions. Additional services are added to the mainstream benefit package (proposal#96/MRT#55) Attachment 1.

An important component of expanding enrollment is ensuring that the populations continue to have access to benefits and that they are aware of consumer rights and protections(proposal#1123/MRT#606) Attachment 2.

Streamline managed care enrollment will allow the State to enroll individuals at the time their eligibility is determined and will shorten the choice period for selecting a plan.(proposal#98/MRT#69) Attachment 3.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-10.10	$-45.40	$-55.97	$-58.04
Total Savings	$-20.20	$-90.80	$-111.94	$-116.07

Benefits of Proposal:
Expand care management enrollment over three years to include high need populations, modify the current benefit package to ensure continuity and coordination of inpatient, outpatient and long term care services, streamline enrollment processes and ensure services re provided based on coverage, issue appropriate notices, and preserve member rights.

Concerns with Proposal:
Please review each proposal identified

Impacted Stakeholders:
Consumers, advocates, MCOs, counties, providers, and enrollment broker.

Additional Technical Detail: (if needed, to evaluate proposal)
Please review each proposal identified

System Implications:

Metrics to Track Savings:

Contact Information:

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Staff Person: Vallencia Lloyd
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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

Attachment 1

Expand Managed Care Enrollment for Non-Duals and Modify Mainstream Benefit Package

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: No **Federal Waiver:** Yes

Proposal Description:
This proposal would authorize the Department of Health (DOH) to enroll additional non-dually eligible Medicaid recipients into mainstream Medicaid managed care programs.
Under current New York State Law and included in the state's federally approved 1115 demonstration waivers, there are categories of Medicaid eligibles who are either excluded from enrolling into mainstream Medicaid managed care, or exempt from mandatory enrollment. Approximately 229,000 of non-dually eligibles fall into one of these excluded or exempt categories.

This change would allow for the enrollment of additional categories of persons into a managed care environment where complex medical needs may be better managed over a three year period. Prior to mandating additional populations to enroll, the State will work with the managed care industry and other stakeholders to ensure appropriate networks are in place to support the needs of the population. An evaluation of operational components will also be conducted for the complex and high need populations. As a result, the complex populations are scheduled for year three to provide sufficient time to plan and establish appropriate mechanisms for added populations.

Patient cash incentives or vouchers for healthful products could be considered to induce patients into plans with higher HEDIS and customer service scores.

The phase in schedule for enrolling the exempt/excluded population would be as follows:

Year 1

Exclusion categories to be enrolled:
• Persons in the Recipient Restriction Program

Exemption categories to be enrolled:
• Persons with a relationship w/primary Care provider not participating in any managed care plans
• Persons living with HIV (upstate)
• Persons without a choice of primary care provider within 30 miles-30 minutes
• Non-SSI SPMI adults and non-SSI SED children
• Individuals temporarily living outside of their home district
• Pregnant woman w/prenatal provider not participating in any managed care plans
• Persons with chronic medical issues with specialist provider not participating in any managed care plans (exemption would be limited to 6 month duration)

Year 2

Exclusion categories to be enrolled:
• Infants born weighing under 1200 grams or disabled under 6 months of age
• Individuals enrolled in the Long Term Home Health Care Program where capacity exists (LTHHCP)**
• Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY) *
• Residents of residential health care facilities - Nursing Homes

Exemption categories to be enrolled:
• Individuals with characteristics and needs similar to those in the LTHHCP
• Persons with end stage renal disease
• Individuals receiving services through the Chronic Illness Demonstration Program
• Homeless persons

Year 3

Exclusion categories to be enrolled:
• Persons eligible through the Medicaid Buy-In for the Working Disabled (no premium and premium pay)
• Residents of State-operated psychiatric centers *
• Blind or disabled children living separate and apart from their parents for 30 days or more
• Institutional foster care children *

Exemption categories to be enrolled:
• Residents of an ICF/MR or ICF/DD(Working with OPWDD)
• Individuals with characteristics and needs similar to residents of an ICF/MR
• Individuals receiving services through the Nursing Home Diversion and transition waiver
• Residents of Long Term Chemical Dependence programs *
• Children enrolled in the Bridges to Health (B2H) foster care waiver program *
• Non-institutionalized foster care children living in the community
• Individuals with characteristics and needs similar to those receiving services through a Medicaid Home and Community-based Services Waiver
• Individuals receiving services through a Medicaid Home and Community-based Services Waiver (allowed to enroll while remaining in the waiver program)
• Individuals with characteristics and needs similar to those receiving services through a Medicaid Model Waiver (Care at Home) Programs
• Individuals receiving services through a Medicaid Model Waiver (Care at Home) Programs (allowed to enroll while remaining in the waiver program)

* These populations enrolling are contingent upon decisions made regarding the benefit package.

** LTHHCP populations will have the opportunity to opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program

Benefit Changes

In conjunction with the enrollment of the above exempt/excluded populations, the following benefits have been proposed to be added to the current Medicaid Managed Care benefit package:

Year 1
Personal Care Services (including consumer directed personal care)

Year 2
Skilled Nursing Facility Services

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-9.63	$-44.47	$-55.04	$-57.10
Total Savings	$-19.26	$-88.93	$-110.07	$-114.20

Benefits of Proposal:
This proposal would allow the Department to enroll additional persons into Medicaid managed care, many in categories that are high utilizers of medical services. Enrollment of additional persons in Medicaid managed care will result in higher quality of care through management of medical services as well as cost savings both on the medical services side (better management of medical services for high cost recipients) and administrative side for printing, mailing and processing exemption/exclusion forms. The Department will ensure through program enhancements that the provider network infrastructure will be adequate to add these persons with more complex medical needs.

Concerns with Proposal:
Advocates and consumers will be impacted by this proposal as these are recipients currently not enrolled in managed care and may feel this will have a negative impact on their Medicaid.

The managed care plans will be impacted by this proposal as many of the additional recipients to be enrolled may have chronic illnesses that some plans have little experience in managing, including persons presently living in a residential or institutional setting.

Impacted Stakeholders:
Managed care plans
Consumer Advocates

Additional Technical Detail: (if needed, to evaluate proposal)
Exempt/Excluded population totals will be enrolled with the following phase in:

Year 1(begin Oct 11) – 13,406
Year 2 – 29,788
Year 3 – 54,834

Assume populations will be "ramped up" over the given fiscal year targeted for enrollment.

For all years, savings is calculated from current Managed Care benefit FFS expenditures only. For some categories, a large portion of their costs is not part of the current managed care benefit and therefore is not build into these estimates. Additional savings will be realized through "carving in" additional benefits to Managed Care including Pharmacy and Mental Health/Substance Abuse services. Carving in these benefits is part of a separate redesign proposal.

Savings estimates do not include the impact of fee-for-service claim lag payments.

Estimated savings are subject to review by the State's actuary.

Additional staff are needed in order to implement and the additional cost is reflected in savings.

System Implications:
WMS systems changes will be necessary to include additional categories in the enrollment process, changed edits, etc. There will also be programming changes necessary with enrollment broker transactions

Metrics to Track Savings:
No metric needed, as the rates established by the Department will build in the savings.

Contact Information:

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Viability: Merge with Proposal # 1458

Modified Delphi Scoreable: True

Attachment 2

Access to Benefits and Consumer Protections

Effective Date: 07/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** No
State Plan Amend: No **Federal Waiver:** No

Proposal Description:
With the expansion of managed care to additional populations, it is important that consumers, especially those with more chronic health issues ,such as the HIV and developmentally disabled populations, are fully engaged in understanding managed care, the benefits, and how to navigate the system. Fully informed consumers are less confused, and more apt to navigate the managed care system in a healthy way. It is crucial that materials be culturally and linguistically competent, and plan information promoted in a way that ensures consumers are able to make an informed choice of the health plan that will best meet their needs.

In addition, it is important to ensure that plans, providers, and all other stakeholders are fully informed and trained regarding benefits covered in the Medicaid program and how consumers are able to

access all benefits, whether in the health plan benefit package or available fee-for-service (for example DME, EPSDT services, etc). Full understanding of the benefits, the level of coverage, and the grievance and appeal rights of consumers when benefits are denied - to include the fair hearing process, is integral to successful program implementation.

This proposal also requires that managed care enrollees receive clear information pertaining to coverage denials and how to access carved out services. This proposal would build on current efforts by the SDOH, LDSS, health plans, and consumer groups statewide to provide adequate education to consumers regarding managed care.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
Medicaid consumers will be better able to navigate the managed care delivery system, ensuring healthier outcomes.
Managed care plans and medical providers will be better informed of covered benefits, how to assist consumers in accessing care, and the appeals process for benefits that are denied.

Concerns with Proposal:
Health plans may feel that this additional education process is duplicative of current policies and procedures in the program and could result in additional administrative costs.

Impacted Stakeholders:
Consumers and advocacy groups
Health plans

Additional Technical Detail: (if needed, to evaluate proposal)
Additional training, either regionally or locally would need to be provided to plans, providers, enrollment broker staff and advocacy groups. In addition, all materials currently in use in the program by plans, providers, LDSS, the enrollment broker, and the SDOH will need to be reviewed for full disclosure of necessary information as well as cultural competence, etc.

System Implications:

Metrics to Track Savings:

Contact Information:

Organization: OHIP Division of Managed Care
Staff Person: Vallencia Lloyd
Phone:
Email:

Viability: Merge with Proposal # 1458

Modified Delphi Scoreable: False
Modified Delphi Score:

Attachment 3

Streamline Managed Care Enrollment Eligibility Process

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** No	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** Yes

Proposal Description:
Mandate selection of a Medicaid Managed Care plan as a condition of eligibility for Medicaid recipients in counties with mandatory enrollment.

Similar to enrollment rules for the Family Health Plus program, Medicaid recipients who are newly eligible will be required to select a managed care plan at the time of application for Medicaid. Recipients who currently have eligibility, or are ending their period of exemption/exclusion, would be informed at renewal that they would have 30 days to select a managed care plan before the State would auto assign them into a health care plan. In addition, pregnant women will be required to pick a managed care plan at the point of application for presumptive eligibility. This would allow for immediate enrollment into a managed care plan once eligibility is determined. In 2009 a letter was sent to all presumptive eligibility providers requesting that they comply with this directive.

The state's 1115 demonstration waivers and SSL 364-J must be amended to implement this proposal.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.47	$-0.94	$-0.94	$-0.94
Total Savings	$-0.94	$-1.87	$-1.87	$-1.87

Benefits of Proposal:
Streamlining the Medicaid eligibility process and managed care enrollment process will accomplish goals in three priority areas.
1. Employing an earlier plan selection would reduce the administrative resources that currently exist in the enrollment process, including confusion on the applicant with differing program rules as well as multiple mailings to remind potential enrollees to chose a plan or be assigned. As additional categories of recipients are enrolled into managed care, the pool of potential enrollees would increase, necessitating a streamlined enrollment process that would reduce local district efforts to monitor enrollment cycle and cut back the need for costly enrollment reminder mailings.

2. Deliver recipients into the managed healthcare system more expediently. As has been seen, managed care enrollees tend to utilize services more appropriately with a primary care doctor managing their health care.

3. Pregnant women would be enrolled in a managed care plan sooner to promote early entry into prenatal care. This would improve outcomes for high risk women.

Concerns with Proposal:
Education of local district staff directing the program would need to be done in a timely fashion so that enrollment procedures can be modified. Training (via teleconference) would be made a priority.
Client advocacy groups may voice concerns that persons with more complex medical needs will need time to choose a health plan.

Impacted Stakeholders:
The 1115 Waiver and SSL 364-J need to be amended to allow this proposal. Advocates and other interested parties would need to be informed.
Health plans will likely support this proposal.

Additional Technical Detail: (if needed, to evaluate proposal)

Potential savings were calculated for this proposal based on information from the state's contracted enrollment broker and administrative costs for the mailing of mandatory enrollment materials to persons newly eligible for Medicaid that will be required to chose their health plan at the time of application, thus, avoiding the mailing costs. Currently, the enrollment broker (contracted to assist with managed care education and enrollment in NYC and upstate counties representing approximately 83% of the eligible population enrolled into Medicaid managed care) is paid an amount per mailing that considers both the cost of the postage as well as the printing and processing of the mailing.

Approximately 34,500 initial mandatory mailings are mailed each month from the broker at a cost of $22.79 each. This accounts for approximately $783,000 per month in mandatory mailings to newly eligible as well as persons being renewed or have a change in their Medicaid coverage. If roughly 20% of the mailings are for persons newly applying for assistance who will have picked a plan at application and avoided the mailing, the savings could be calculated at a monthly savings of approximately $156,000 monthly.

In addition, the shortening of the choice period for current eligibles who will have 30 days to now choose a plan will negate the need for reminder mailings, which will generate an additional administrative savings.

Additional staff is needed in order to implement.

System Implications:
The enrollment broker enrollment systems, which currently functions in counties that make up approximately 75% of all recipients, would have to be reprogrammed with new selection rules.
The State's Welfare Management System for auto assignment would have to be updated to reflect the rule changes. The enrollment broker call center and renewal center would need training and both the State and broker would need time to program system changes.

Metrics to Track Savings:
Reduction in administrative costs.

Contact Information:

Organization: Department of Health, Division of Managed Care

Staff Person: Vallencia Lloyd / DMC

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Viability: Merge with Proposal # 1458

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1462

Proposal Author:
MRT Member (Steve Acquario NYSAC; Eli Feldman, Metropolitan Jewish Health System); HANYs; NY Hospital Queens; DOH;

Proposal (Short Title):
LTC insurance proposals

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 01/01/2012

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: No	**Federal Waiver:** No

Proposal Description:
Various proposals to expand use of the Partnership for Long Term Care Insurance Program and other LTC insurance products.
Part A
Currently there is a 20% NYS Income tax credit for the purchase of tax qualified LTC insurance policies. By increasing the benefit to 40% of the policy premium for Partnership policy holders an additional incentive is created for these policies which have benefit amounts designed to result in Medicaid savings. Surveys indicate that the existing tax deduction is an incentive to purchase LTC policies. This proposal would increase that incentive, increase the number of policies sold and the level of protection of Medicaid. Assuming an increase of 10% in the number of Partnership policies purchased; and a consistent use of the tax credit by 75% of policyholders; the estimated negative impact to income tax revenue of this proposal is $1.9 million.

The Partnership for LTC provides that with the purchase of LTC insurance with appropriate minimum standards and protections, individuals receive Medicaid extended coverage when their private insurance benefits lapse. With 92,819 policies purchased to date and 3674 policies accessed to date, only 255 people have accessed Medicaid. The alternative for most of these people would be to transfer assets for quicker access to Medicaid. The Partnership has resulted in projected Medicaid savings to date of over $68 million.
Part B
This proposal will create additional plan options for the Partnership for LTC insurance program (PLTC).

Program data show that plan participants utilize less than two years of insurance benefit. Current plan options have minimum benefits of 3-6 or 4-4 (years of nursing home coverage and years of home care coverage). Adding a 2-4-100 plan that would cover two years of nursing home care; four years of home care; and protect 100% of family assets. A lower premium will result in increased sales and result in fewer people accessing Medicaid for LTC.

Part C
Part C contains several options for innovations in individual financing of LTC services and supports. These can be considered individually or in combination.

1. Permit access without penalty to IRA/401k/and other pension savings for the purchase of LTC insurance (preferably a Partnership Plan) or for the cost of LTC services and supports.
2. Expand new 2010 law (S.7196-A/A.10876-A) that allows life insurance accelerated death benefit to cover costs of LTC services for nursing home residents to all individuals needing LTC services.
3. Allow for reverse mortgage proceeds to be used for purchase of Partnership for LTC (PLTC) insurance plans.
4. Allow a demonstration project for 500 people to set aside LTC savings accounts with (state) pre-tax dollars, with a restriction that these funds be utilized for LTC services and supports.

Each of these components has the potential to increase personal responsibility for the costs of LTC services and supports thus reducing future Medicaid exposure for these services. In the case of options that include the Partnership for LTC Insurance Program individuals would also gain the benefit of asset protection should they survive the duration of their PLTC insurance plan and need to access Medicaid.

Part D

This proposal creates a fund to support marketing of Partnership for LTC Insurance by utilizing voluntary contributions to increase consumer awareness and participation to reduce dependence on Medicaid for LTC costs. Currently individuals are not incentivized to purchase LTC insurance; rather, many use Medicaid as a payer while attempting to preserve assets in other ways. The Partnership for LTC allows individuals to both cover their LTC costs AND preserve assets for themselves and future generations, but many are not aware of this program.
Insurers selling long-term care insurance products would voluntarily contribute a recommended percentage of every individual policy premium to an outreach fund managed by Partnership for LTC Program. The funds would be allocated to an annual educational, advertising and outreach campaign that, rather than being Insurer specific, would carry the name and endorsement of the New York State Partnership. This would alleviate some of the suspicions of large corporations that can inhibit consumers; foster a sense of public trust in this long term care insurance by presenting a consistent, clear message; and relieve insurers of supporting individual campaigns.
The campaign would be planned, designed and launched by NYS Partnership for LTC. Materials would be reviewed by participating insurers prior to distribution, but NYS would retain final decision making on all expenditures.
Private partners (i.e. the Ad Council; NYS Assoc. of Broadcasters) would be contacted to potentially expand reach of the project.
Savings estimates are dependent on the amount of marketing that is carried out; the number of policies purchased; and when those policies are utilized for benefits. Most savings for newly purchased policies will be realized in future years.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

Benefits of Proposal:

Part A
Additional tax deduction of LTC insurance premiums creates a greater incentive to purchase insurance.

Part B
This proposal affords individuals the opportunity to take personal responsibility for their LTC costs while protecting family assets for surviving family members. The result is significant Medicaid savings by avoiding spenddown eligibility to the Medicaid program.
Part C
1. Eliminates or reduces current penalties that discourage or preclude access to pension savings for purchasing LTC services.
2. For individuals who have life insurance products with guaranteed death benefits, expanding the accelerated death benefit to allow for costs of LTC services would help families avoid a Medicaid "look back" (to protect family assets) and still allow for covering the costs of LTC. Currently people with certain life insurance policies can only access an accelerated death benefit when they are terminal; in the last year of life; and for medical care costs.
3. Utilizing home equity for the purchase of a PLTC Insurance Plan provides a reasonable means of payment for this valuable insurance; insulates Medicaid from front end LTC costs; and protects other family assets.
4. Encourages individuals to take personal responsibility for costs of LTC through shielding income from NYS income tax.

Part D
Has potential for Medicaid savings in out years; Increased use of private insurance for LTC; and personal asset protection for individuals and heirs.

Concerns with Proposal:
Part A - Initially results in tax revenues reduction; Medicaid savings not likely to occur for several years.

Impacted Stakeholders:
Seniors approaching the need for LTC; AARP; Other senior advocacy groups; Insurers; Mortgage lenders; Investment companies

Additional Technical Detail: (if needed, to evaluate proposal)
Part C - Each of these components will require coordination between DOH and other agencies to conform necessary statute and regulation.

System Implications:
none

Metrics to Track Savings:
Part A â€“ Unknown; coordination with Tax and Finance will be required
Part B - Upgrade partnership for LTC Program data systems can identify purchases and benefit use.
Part C & D - Existing Partnership data systems can be utilized to assess impact; some new metrics will need to be designed for Part C

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 4647

Reform?: Yes

Date Submitted:02/21/2011

Proposal Author:
Linda Gibbs (NYC Government)

Proposal (Short Title):
Expand Managed Addiction Treatment Program (MATS)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Long Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** No
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Expand the New York City Managed Addiction Treatment Program to three times its current size.

MATS is a case management program created to assure effective and appropriate access to needed treatment services for voluntary participating, high cost, chemically dependent (CD) Medicaid eligible recipients while providing savings through the reduction of unnecessary or excessive utilization of Medicaid services. The program is provided at the county/New York City level through a partnership with the local mental hygiene agency and the Local Department of Social Services (LDSS).

The City proposes expansion of the MATS program to approximately 3 times its current size, for an additional cost of $7,524,000. Initially, procurement will be managed by amending the existing contracts HRA holds with the 3 MATS providers, enabling rapid implementation and scale-up for an additional active caseload of 1,500 individuals.
Expanded methods of program recruitment will be implemented, including through in-patient detoxification and rehabilitation services, to maximize program reach and scale up enrollment as quickly as possible.

The City also proposes that the MATS program be considered a "Health Home" as part of a State Plan Amendment and thereby be eligible for 90% FMAP reimbursement for two years.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15

State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
High-end users account for a large percentage of the expenditures for Medicaid-funded substance abuse services, often cycling in and out of substance abuse treatment programs, including expensive detoxification and in-patient services.
This pattern is not only costly to the City and State, and but also often results in diminished recovery outcomes. In 2007, NYS OASAS funded New York City to develop and implement a care coordination program for high-end users of substance abuse services -- Managed Addiction Treatment Services (MATS) -- to promote recovery and self-sufficiency while reducing Medicaid-funded substance abuse expenditures.

SFY2005 Medicaid expenditure data shows 7,137 individuals used more than $20,000 in Medicaid-reimbursed substance abuse services, including 4,927 individuals who used more than $25,000. (Although this group represented only 8% of all New Yorkers accessing substance abuse services during that year, they were responsible for 38% of Medicaid-reimbursed costs for such services.)

The MATS effort will be synchronized with other Health Home programs as the proposal rolls out to ensure appropriate mental health and physical care management.
Savings are in Health Home proposal #89.

Concerns with Proposal:
Current regulations do not allow the City to analyze Medicaid data to identify MATS eligible clients in order to provide them with case management, treatment, and access to social services. To achieve rapid expansion and effectively identify and enroll potential participants, the City must obtain or have access to patient- and encounter-level Medicaid claiming data.

Impacted Stakeholders:
Chemical dependent Medicaid recipients and behavioral health providers in NYC, and the NYC Department of Health and Mental Hygiene, Human Resources Administration would be impacted.

Additional Technical Detail: (if needed, to evaluate proposal)
â€¢Three community-based agencies deliver MATS via contracts with NYC HRA.
â€¢Recruitment: HRA cash assistance clients who used at least $25,000 of Medicaid- reimbursed substance abuse treatment over the past year (does not include other Medicaid service costs).
â€¢Cumulative enrollment (April 2007 â€" June 2010): 2,599 individuals
â€¢Active cases across the 3 agencies: 700-750 (max overall caseload = 750)
â€¢Outcomes: 78% of enrolled individuals remained in substance abuse treatment for at least 30 days, 64% for at least 90 days, and 64% for 180 days. More than 280 individuals have been placed in jobs despite severity of addiction and multiple other barriers, and more than 210 individuals have been awarded federal disability.

System Implications:
There would be no immediate systems implications.

Metrics to Track Savings:
eMedNY Medicaid payment data would be used to track savings on the expanded MATS enrollee cohort.

Contact Information:

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Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 4648

Reform?: Yes

Proposal Author:
Linda Gibbs

Proposal (Short Title):
Family Planning Benefit Program as a State Plan Service

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:	**Administrative Action:** Yes	**Statutory Change:** Yes
	State Plan Amend: Yes	**Federal Waiver:** No

Proposal Description:
Move Family Planning Benefit Program (FPBP) to a State Plan service and auto-enroll post-partum pregnant women into the program, including undocumented immigrants.

FPBP is a Medicaid § 1115 waiver program in New York State that provides free and confidential family planning and related services to men and women ages 10-64 with income of 200% FPL or less. It has the same immigration and residency requirements as Medicaid. An individual enrolled in Medicaid or Family Health Plus is not eligible for FPBP. Individuals with private health insurance through another person (dependents) or Child Health Plus concerned about confidentiality may enroll in FPBP.

FPBP coverage includes the provision of screening for sexually transmitted infections, including HIV, and cervical cancer; related clinical exam and laboratory tests; and the provision of FDA-approved birth control methods, devices and supplies.

The proposal would move FPBP to a State Plan service and auto-enroll post-partum pregnant women into the program, including undocumented immigrants. The City can implement a demonstration project to increase access to FPBP for youths and young adults by providing (1) training and technical assistance for SBHCs and community family planning providers on how to enroll teens and young adults in FPBP and (2) leveraging City programs and technologies to ease the application process for patients. Eventually, develop a sustainable and replicable facilitated enrollment process for FPBP and Medicaid to be expanded.

Currently, NY State utilizes an easement process to estimate the percentage of undocumented women getting

prenatal care services through Medicaid, and must pay the full prenatal health care costs for these women, as undocumented persons are ineligible for any Medicaid services. As undocumented immigrants are also ineligible for family planning benefits provided by Medicaid (i.e. FPBP), it may be possible to use the same easement process these women into family planning services with the State also covering the equivalent costs of undocumented enrollees. Cost savings would be realized by reducing unintended pregnancies and abortions and the resulting health care savings, as well as savings from other public sector costs (education, social services, etc.).

While studies have demonstrated significant savings from this program, this proposal assumes program costs will be offset by savings resulting from reductions of unintended pregnancies.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$0.00	$0.00
Total Savings	$0.00	$0.00	$0.00	$0.00

Benefits of Proposal:
In 2007, alone, the California Family PACT program enabled an estimated 296,200 women, including 81,000 teenagers, to avoid an unintended pregnancy and as a result also averted 122,000 abortions. The California program was shown to be cost effective as the $437.3 million spent in 2007 generated a net savings of $1.88 billion from conception to age two, which includes public sector costs for health, education, social and other services, and the savings for health care alone was $838 million. In other words, every dollar spent under the program saved $4.30 from conception until age two and $9.25 within five years. The savings in health care alone were almost 2 to 1, with $1.92 savings for every dollar spent.
A 2007 national study of State family planning programs found that Medicaid family planning expansions resulted in lower birthrates, and the cost offset of maternal and child health expenditures of the expansions exceeded program costs in all but one State.
Changing the method of determining the income cut-off based on FPL to be the same as that used for pregnant women, i.e., the individual counts as two people in the household, would increase participation by 3,400 individuals. This increase in participation would potentially avoid 480 unintended pregnancies, 160 abortions, and 250 Medicaid-funded births.

Concerns with Proposal:
No federal funds are available for FPBP services provided to undocumented immigrants.

Impacted Stakeholders:
Family planning providers, Medicaid enrollees of child bearing age would be stakeholders.

Additional Technical Detail: (if needed, to evaluate proposal)
Currently, there are 81,000 mothers in New York City and an estimated 125,000 in New York State, receiving prenatal coverage through Medicaid (i.e. PCAP). Only 45% of these mothers submit an application for Medicaid coverage when 60 day postpartum period lapses, but it is unclear how many are approved. As a conservative estimate, if only 25% of all auto-enrollees would be eligible for and utilize FPBP, it will result in projected

savings of $16 million annually if implemented only in New York City or $24.5 million if implemented Statewide "if 10% enroll and utilize the benefit, that savings will equal $6.4 million in NYC and $9.8 million statewide.

System Implications:
Considerable systems changes will be necessary for eMedNY and WMS.

Metrics to Track Savings:

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

Proposal Number: 4651

Proposal (Short Title): Global Spending Cap on Medicaid Expenditures

Theme:

Program Area: All

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** No **Statutory Change:** Yes
State Plan Amend: Yes **Federal Waiver:** No

Proposal Description:
The Governor's Budget commits to limiting total Medicaid spending to no greater than four percent annual growth, in essence, a global spending cap. With this limit in place, total State funds spending would grow from $15.1B in 2011-12 to $15.7B in 2012-13. In addition, the Medicaid Redesign Team (MRT) reform package includes a number of measures that will decrease spending in 2011-12 by $1.1 billion in State share. An essential element of these reform measures is a commitment on the part of key members of the health care community to voluntarily reduce spending if Medicaid State funds (including enrollment growth) exceed the spending limits set by the Governor (Voluntary Health Care Industry Cost Containment Initiative).

In order to achieve balance with the global budget, a two percent across-the-board reduction is necessary, although certain sectors may be exempted in order not to violate federal limits and requirements or to preserve access to critical services. In addition, each sector will have the flexibility to substitute a new initiative (not on the current MRT list) for all or a portion of the across-the-board reduction (see Attachment 1 for Sector Impact Analysis).

Below is a chart that illustrates the effect of these limits in terms of State share funding and the 2-year impact of the MRT measures to limit spending growth:

Proposal to Impose a Medicaid Global Spending Cap

(State Fund Dollars in Millions)

	2011-12	2012-13
Medicaid Spending Target (assumes 4% trend)	$15,109	$15,713
Annual Growth	--	$604
MRT Savings	($1,138)	($1,516)
Trend Elimination	($186)	($306)
2% Across the Board Reduction	($345)	($345)
Total Reduction Actions	**($1,669)**	**($2,167)**

Key features of a global spending cap and the Voluntary Health Care Industry Cost Containment Initiative include the following:

- To maintain transparency, DOH and DOB will report quarterly on spending against target and corrective actions (if any) to be taken. In addition, spending will be analyzed on both a statewide basis and a regional basis. This reporting will coincide with quarterly updates to the Financial Plan made by the Division of Budget.

- The Medicaid spending plan will shift to a biennial budget with two-year appropriations, which will provide DOH and health care stakeholders a longer planning horizon and greater flexibility to ensure spending stays within limits. Monitoring of spending will occur on a regular basis, and if total State share spending exceeds the cap, DOH will have the statutory flexibility to take action to bring spending back in line with the target. However, proper notification to industry stakeholders will occur prior to corrective action being taken by the State.
    - Such flexibility would include utilization controls, and if necessary rate reductions to prevent costs exceeding the cap (the only flexibility that DOH will not have will be related to eligibility changes).

- DOH will work with the health care community to monitor spending, identify sectors that drive spending above the target, and make programmatically sound reductions as needed.

- Current eligibility levels will be preserved.

Important work of the MRT will continue beyond the 3/1/11 session in order to find additional measures to reduce costs while improving quality. One such important measure is the Pay for Performance (P4P)/Accountable Community Care initiative which was aimed at reducing nearly $1.5B in preventable admissions/readmissions while providing industry stakeholders gain sharing opportunities. It's imperative that providers work together to control utilization and ensure that spending does not exceed the cap. To truly bend the cost curve and control unnecessary spending in the upcoming state fiscal years, these discussions are necessary.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$	$	$	$
Total Savings	$	$	$	$

*Note – the financial impact on providers is subject to expenditures meeting the global spending cap.

Benefits of Proposal:

- Global budget caps will ensure that the Medicaid program remains sustainable and affordable to taxpayers. It also allows the State to have a viable program which avoids scaling back essential benefits to needy patients to address fiscal short-falls. Furthermore, limiting an entitlement program to a specific rate of growth will strengthen the State's position with rating agencies and other fiscal watchdog groups.

- A two-year budget will provide a longer planning horizon for DOH, the MRT and other stakeholders to implement additional measures to control Medicaid spending. For this construct to be successful, however, it is imperative that DOH have the flexibility to move quickly in implementing control measures in order to provide a longer time period over which to apply any reductions, thus mitigating the impact of any such reductions.

- Industry stakeholders will have the opportunity to develop and propose new ideas in lieu of across-the-board reductions.

Concerns with Proposal:

If enrollment drives spending above the cap, the Medicaid system, and providers in particular, will be under pressure to reduce spending; however, this creates incentives for communities to work together across sectors to limit spending growth. Transparency in the process and reporting of progress toward spending goals will assist stakeholders in making informed reductions.

Impacted Stakeholders: All Medicaid providers.

Additional Technical Detail: (if needed, to evaluate proposal)

System Implications:

Metrics to Track Savings: Tracking overall Medicaid spending compared to the target. This analysis will also be provided regionally in order to inform healthcare communities.

Contact Information:

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Viability: S

Modified Delphi Scoreable: False
Modified Delphi Score:

Global Spending Cap/Voluntary Health Care Cost Containment Initiative

- Mechanism for controlling spending within the Global Sending Cap framework:
    - Rate reductions either through targeted actions or across the board reductions;
    - Implement new prior authorization controls;
    - Additional systemic measures (P4P/Accountable Community Care).

- All cost controls measures will be considered in transparent manner either through a consumer advisory committee or an MRT sub-group.

- All measures will also be brought back to the MRT for consideration and a vote.

Proposal # 4651 - Global Spending Caps
Attachment 1

Sector Impact of Across the Board Reduction
(Dollars in Millions)

Sector	Across the Board Cuts
FS Clinic & Practitioner	$ (22)
Hospital	$ (61)
Managed Care	$ (51)
Non-Inst. LTC	$ (97)
Nursing Homes	$ (69)
Pharmacy	$ (41)
Transportation	$ (4)
Sector Total	$ (345)

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 4652

MRT Number: 4151

Reform?: Yes

Date Submitted:02/23/2011

Proposal Author:
DOH

Proposal (Short Title):
Reform Personal Care Services Program in NYC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

Required Approvals: **Administrative Action:** Yes **Statutory Change:** Yes

State Plan Amend: Yes **Federal Waiver:** Yes

Proposal Description:
Reform personal care services program in New York City. There are three major elements of this comprehensive package:
Implement improved management and utilization for split shift and other high intensity users;
Cap housekeeping cases at 8 hours a week; and
Increase technology and improve assessment for all personal care recipients.

Preliminary Financial Impact (Dollars in Millions):

2011-12	Minimum	Average	Maximum
State Savings	$	$	$
Total Savings	$	$	$

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-57.00	$-57.00	$-57.00	$-57.00

Total Savings	$-114.00	$-114.00	$-114.00	$-114.00

Benefits of Proposal:
In NYC, this proposal provides care coordination of high need personal care cases. It also rationalizes the housekeeping benefit while maintaining supports to keep people in their homes. A pilot program for certain personal care cases will be developed as part of the overall transition to MLTC. This proposal addresses the historical issue with NYC related to the size and scope of the personal care program.

Concerns with Proposal:
Implementation issues may delay the fiscal impact in SFY 11-12. Some recipients will see a reduction in the number of hours currently given

Impacted Stakeholders:
Personal Care recipients in NYC, NYC, personal care providers and workers

Additional Technical Detail: (if needed, to evaluate proposal)
Assessment Tool development is underway however a web based system between HRA and the state needs to be created.

System Implications:
TBD

Metrics to Track Savings:
Recipients served and hours authorized in NYC

Contact Information:

Organization: DOH
Staff Person: Mark Kissinger/Vallencia LLoyd
Phone:
Email:

Viability: S

Comments:

Modified Delphi Scoreable: False
Modified Delphi Score:
