

# A Plan to Transform the Empire State's Medicaid Program

*Better Care, Better Health, Lower Costs*

**COMPANION DOCUMENT:**  
Final Reports of the MRT Work Groups





## WORK GROUP REPORTS

Program Streamlining and State/Local Responsibilities Work Group

Behavioral Health Reform Work Group

Managed Long Term Care Implementation and Waiver Redesign Work Group

Health Disparities Work Group

Basic Benefit Review Work Group

Workforce Flexibility and Change of Scope of Practice Work Group

Payment Reform and Quality Measurement Work Group

Affordable Housing Work Group

Health Systems Redesign: Brooklyn Work Group

Medical Malpractice Reform Work Group

Additional Recommendation Approved December 13

**Redesigning**  
THE MEDICAID PROGRAM

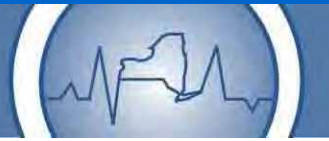


NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Program Streamlining and State/Local  
Responsibilities Work Group

**FINAL RECOMMENDATIONS**



**Medicaid Redesign Team**  
**Program Streamlining and State/Local**  
**Responsibilities Work Group**  
**Final Recommendations – October 17, 2011**

**WORK GROUP CHARGE:**

- Identify the administrative impediments that prevent New York residents from accessing the health care coverage they need.
- Explore ways to make enrollment easier by reducing paperwork and other administrative requirements that do not add value or improve program integrity, while ensuring these streamlining activities are in concert with implementation of federal health care reform and operation of the health benefits exchange.
- Consider consolidating programs to reduce confusion and administrative costs, with a priority focus on streamlining and centralizing long term care administration and services.

**WORK GROUP MEMBERSHIP:**

**Co-chair: Steve Acquario**, Executive Director, New York State Association of Counties

**Co-chair: Ann Monroe**, President, Community Health Foundation of Western & Central New York

- **Joe Baker**, President, Medicare Rights Center
- **Kate Breslin**, President & CEO, Schuyler Center for Analysis and Advocacy
- **Maggie Brooks**, Monroe County Executive
- **Wendy Darwell**, Vice President & COO, Nassau-Suffolk Hospital Council
- **Trilby de Jung**, Senior Staff Attorney, Empire Justice Center, Rochester
- **Robert Doar**, Commissioner, New York City Human Resources Administration
- **Melinda Dutton**, Partner, Manatt Health Solutions
- **Denise A. Figueroa**, Executive Director, Independent Living Center of the Hudson Valley, Troy
- **David Jolly**, Commissioner, Orange County Department of Social Services
- **Deborah Mabry**, Executive Vice President & Chief Operating Officer, Morris Heights Health Center
- **Michelle Mazzacco**, Vice President/Director, Eddy Visiting Nurse Association
- **Loren Ranaletta**, President & CEO, Episcopal Church Home
- **Martha Robertson**, Chair, Tompkins County Legislature
- **Hon. William J. Ryan**, President, New York State Association of Counties
- **Thomas Santulli**, Chemung County Executive
- **Robert H. Thompson**, Vice President, Safety Net Programs, Excellus BlueCross BlueShield
- **Francine Turner**, Political Action Director, CSEA



## MEETING DATES AND FOCUS:

- **July 7, 2011** – The first meeting of the Work Group reviewed the group’s charge and set priorities for ongoing work. The Department of Health provided background information to ensure that the group started its work from a common knowledge base. This included a review of efforts over the past three years to simplify the program, new requirements under the Affordable Care Act (ACA) that will further streamline program rules and change state and local responsibilities, and the DOH and NYSAC reports on State Administration of the Medicaid program. Most of the meeting centered on a discussion of the ACA and what the Health Benefit Exchange will mean for Medicaid and the state and local roles in administering the program. The group agreed to focus their work on three priority areas: **1)** determining state/local responsibilities for eligibility and enrollment in the context of the Exchange; **2)** exploring realignment of state/local responsibilities for Medicaid financing; and **3)** streamlining eligibility rules for long-term care.
- **August 11, 2011** – The second meeting of the Work Group focused on Medicaid financing and State/Local responsibilities for eligibility and enrollment in the context of an Exchange. The group agreed that funding Medicaid through local taxes was not sustainable and recommended the state reduce its reliance on local financing over time. In terms of state and local responsibilities in eligibility and enrollment, the group agreed to centralize populations whose eligibility determination can be automated and to provide in-person assistance at the local level for more vulnerable applicants or those desiring “hands on” help completing the application. The group agreed to complete a survey of eligibility and enrollment functions and to assign a preference for whether the function should be conducted at a central or local level. Finally, the group agreed to form a long-term care subcommittee to focus on enrollment and eligibility simplification.
- **September 8, 2011** – The majority of the meeting focused on reaching consensus on a model of State and Local responsibilities for eligibility and enrollment in the context of the Exchange. Consensus development was facilitated by a review of the results of a pre-meeting survey of members on their views about which eligibility and enrollment functions should be centralized and which should remain local. The major theme that arose from the survey results was that if automation has been achieved, the function should be centralized. Where automation is not yet available, the functions should remain local. The group also agreed to a Medicaid financing recommendation and a recommendation urging New York to adopt legislation to establish its own Exchange. The group also received an update from the long-term care subcommittee.
- **September 27, 2011** - The first part of the meeting focused on the role of local districts with the non-MAGI populations and the linkages between Medicaid and other social services programs (e.g., public assistance, food stamps). Several new recommendations were advanced as a result of this discussion. The remainder of the meeting focused on completing and voting on a package of recommendations to forward to the full MRT.



## OUTSIDE EXPERTS CONSULTED WITH:

No outside experts apart from members of the group. The group was aided by a summary of the Medicaid and Exchange Eligibility regulations prepared by Manatt Health Solutions. In addition, Trilby de Jung and Melinda Dutton prepared a summary of local assistor functions from a project for the New York Health Foundation on Navigators under the ACA.

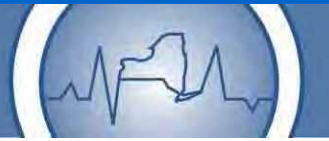
## BRIEF SUMMARY OF DISCUSSIONS THAT LED TO FOCUS ON RECOMMENDATION INCLUDED WITHIN THIS REPORT:

The Work Group was guided by the State law requiring the development of a plan for the state to assume the administrative responsibilities of the Medicaid program (Section 47-b of Chapter 58 of the Laws of 2010) and the federal health care reform law (Affordable Care Act). The MRT Work Group viewed its charge as taking some important concrete steps toward planning for an increased state role in Medicaid administration in the context of federal health reform.

The Work Group devoted a considerable amount of time to reviewing and understanding the provisions of the Affordable Care Act. Specifically, the group focused on the requirements of the Exchange and the new Medicaid eligibility rules that will be in place in 2014. It conducted its work under the assumption that the State will establish an Exchange or be part of the Federal Exchange. The populations the Exchange is required to determine eligibility for include: Children, Non-Medicare adults under age 65, and Employees of qualified employers. The Exchange is not required to, but may, determine eligibility for the elderly and individuals with disabilities who are eligible for Medicare.

The Medicaid, Exchange and IRS Proposed Eligibility Rules issued on September 9 align to create a coverage continuum and simplify eligibility determinations. The rules:

- *Simplified eligibility pathways.*
- *Collapsed 16 separate Medicaid eligibility categories into three, simplifying eligibility determinations for families, children, and many childless adults.*
- *Base income eligibility for Medicaid, CHIP, and Exchange Advance Payment Premium Tax Credits and Cost Sharing Reductions on Modified Adjusted Gross Income (MAGI) with no deductions.*
- *Base household composition on tax household rather than Medicaid households with some exceptions.*
- *Require the Exchange to screen and determine MAGI eligibility for all Insurance Affordability programs (i.e., MAGI Medicaid, CHIP, Advance Payment Premium Tax Credits, Cost Sharing Reductions, and any Basic Health Program the State may decide to offer).*
- *Require the Exchange to enroll individuals identified as eligible for Medicaid or CHIP, without any further determination by the State.*
- *Place new obligations on the Medicaid Agency to screen all applicants for all Insurance Affordability Programs. The Medicaid agency must determine eligibility and enroll all Medicaid eligible consumers applying or renewing through the agency, including MAGI consumers. For those determined ineligible, the Medicaid agency must assess individuals for potential eligibility for other Insurance Affordability, and seamlessly transfer the individual's electronic account to the other programs/Exchange.*
- *Allow the Exchange to contract with the Medicaid Agency to make determinations for Advance Payment Premium Tax Credits and Cost Sharing Reductions.*



The ACA requires that by the fall of 2013, the Exchange begin open enrollment for applications for Insurance Affordability programs online, by mail, by phone, and in -person using an automated eligibility system that determines eligibility in near real time using trusted third party verification sources and self-attestation. The Work Group strongly supported this vision for a modernized eligibility system. The state, as an Early Innovator Grantee, is on a path to automate the eligibility determination for Insurance Affordability Programs through the Exchange. The Work Group also urged that the automation opportunity be broadened to include the non-MAGI Medicaid populations (elderly, dual eligibles, and special populations) over time. To the extent automation is achieved, the group supported greater centralization of the eligibility and enrollment functions.

## SUMMARY LISTING OF RECOMMENDATIONS:

- 1) **Exchange:** New York should establish its own Exchange to best meet the needs of its residents and small businesses. We urge the State to enact authorizing legislation establishing a New York Health Benefits Exchange to allow the State to be deemed “operationally ready” by January 1, 2013.
- 2) **Medicaid Financing:** The State should develop and implement a plan for more sustainable Medicaid financing that phases out reliance on local taxes (e.g., property taxes) and includes the examination of financing structures in other states.<sup>1</sup>
- 3) **Eligibility System Modernization:** New York must have one eligibility determination and enrollment system for its Medicaid program and all Medicaid-eligible sub-populations. The eligibility system should be developed to be interoperable with human service programs.
- 4) **State/Local Roles in Eligibility and Enrollment:** The Work Group agreed to a set of principles to guide the State as it modernizes eligibility and enrollment in the context of the implementation of the ACA. The principles are:
  - ✓ *Recognize that implementation of the ACA and Medicaid is a state responsibility.*
  - ✓ *Maximize gains in coverage and reduce the number of uninsured.*
  - ✓ *Demand robust performance accountability for customer service.*
  - ✓ *Maximize automation so more time can be spent with vulnerable populations.*
  - ✓ *Create a cost-effective administrative approach that improves the consumer experience.*
  - ✓ *Promote uniformity and consistency in eligibility and enrollment.*
  - ✓ *Ensure program integrity.*
  - ✓ *Involve stakeholders.*
  - ✓ *Develop a plan for phased implementation that includes timely education for consumers and local district staff that minimizes disruptions during the transition.*

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<sup>1</sup> The intent of the recommendation is for the plan to explore a wide array of financing options and that the added costs to the state of assuming local Medicaid costs shall be considered outside the global spending cap.



Under the rubric of the guiding principles, the group recommended that eligibility determinations and enrollment be centralized for MAGI applications (on-line, phone, mail, in-person), wherever initiated. Local in-person assistance must be available to help consumers apply for all Insurance Affordability programs with eligibility determinations centralized through a common eligibility system. Provide local specialized "hands on" help for non-MAGI individuals and centralized supports for assistors for non-MAGI populations tailored to local needs. De-link Medicaid MAGI eligibility determinations from human service determinations by requiring MAGI Medicaid applications to be entered into the central eligibility system while the eligibility determination for the other human service program is being determined (e.g., public assistance). If however, individuals found eligible for public assistance do not already have Medicaid, they will be automatically enrolled in Medicaid to the extent permitted by state law. The state, working in collaboration with counties, should develop an appropriate transition plan for state/local administration of non-MAGI Medicaid populations within a reasonable time after 2014, taking into account the ongoing development and phasing of the statewide, automated eligibility and enrollment system.

- 5) **Long-Term Care Recommendations:** The Long-term Care Subcommittee was guided by one overarching principle: Medicaid recipients who need long-term care should share in all the eligibility and enrollment simplification, streamlining and automation, to the extent allowed by federal law that will be developed and implemented for Medicaid recipients who need health care services. The subcommittee recommended five specific recommendations that were endorsed by the full Work Group:
- ✓ *Centralize and automate eligibility processes for the Medicare Savings Programs by January 2014.*
  - ✓ *The State should invest in an Asset Verification System (AVS) to permit the electronic verification of assets (including assets in the 5 year look back period) for determining eligibility for aged, blind, and disabled Medicaid applicants and recipients.*
  - ✓ *Automate Spend Down by linking eMedNY to WMS and using provider billing to track spend down similarly to an insurance deductible.*
  - ✓ *Disabled and elderly New Yorkers in need of long term care services should have the same access to enrollment and eligibility assistance as other applicants for Medicaid. New York's plan for meeting consumer assistance needs must include a focus on this vulnerable population, whether it is through the use of Navigators, Consumer Assistance Programs, Facilitated Enrollers or some other funded initiative.*
  - ✓ *Create a Work Group of consumer representatives (including who benefit from specific programs, like the consumer-directed program), providers, plans, workers and local and state officials to assist the state in:*
    - *evaluating eligibility and enrolment processes for long term care and identifying further reforms and tracking implementation of those agreed upon;*
    - *evaluating the implementation of managed long term care and identifying further reforms and tracking implementation of those agreed upon;*
    - *ensuring appropriate training and support of long term care stakeholders, including consumers, providers, workers and local officials as new systems and new programs are implemented.*





**Medicaid Redesign Team  
Program Streamlining and State/Local  
Responsibilities Work Group  
Final Recommendations – October 17, 2011**

**Recommendation Number:**

**Recommendation Short Name:** HEALTH BENEFITS EXCHANGE AUTHORIZATION

**Program Area:** ACA IMPLEMENTATION

**Implementation Complexity:** MEDIUM

**Implementation Timeline:** SHORT-TERM

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

**PROPOSAL DESCRIPTION:**

- ▶ New York should establish its own Exchange to best meet the needs of its residents and small businesses.
- ▶ We urge the State to enact authorizing legislation establishing a New York Health Benefits Exchange to allow the State to be deemed “operationally ready” by January 1, 2013.

**FINANCIAL IMPACT:**

None

**HEALTH DISPARITIES IMPACT:**

The Exchange is expected to expand coverage which would have a positive impact on health disparities.

**BENEFITS OF RECOMMENDATION:**

A New York Exchange will allow the state to shape the implementation of the Affordable Care Act to best meet the needs of its residents, to align the insurance markets inside and outside the Exchange and to modernize its Medicaid program. Failure to enact Exchange legislation in a timely manner jeopardizes significant federal funding for the establishment of New York’s Exchange, increases the likelihood of a federally run Exchange in New York, impedes Medicaid modernization, and enhances the potential for adverse impacts on the state insurance market.

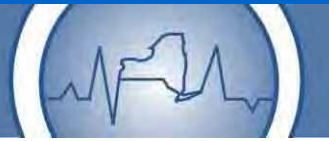


## CONCERNS WITH RECOMMENDATION:

Some opponents do not want to implement the Affordable Care Act (ACA), but they fail to recognize that the ACA is the law and doing nothing means that New York will be in the Federal Exchange, not that the state can avoid having an Exchange. Most stakeholders agree that the state should craft its own Exchange rather than be in the federal Exchange.

## IMPACTED STAKEHOLDERS:

Insurers, Consumers, Counties, Brokers, and Providers.



**Medicaid Redesign Team**  
**Program Streamlining and State/Local**  
**Responsibilities Work Group**  
**Final Recommendations – October 17, 2011**

**Recommendation Number:**

**Recommendation Short Name:** MEDICAID FINANCING

**Program Area:**

**Implementation Complexity:** HIGH

**Implementation Timeline:** LONG-TERM

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

**PROPOSAL DESCRIPTION:**

- ▶ In most of the 50 states, Medicaid is financed almost exclusively with state and federal tax dollars. In New York State, approximately 30 percent of the non-federal cost of Medicaid is paid through local taxes (\$5 billion in New York City and \$2 billion in Rest of State).
- ▶ The fiscal structure is unsustainable for several reasons:
  - *Reliance on local property taxes to fund Medicaid has contributed to making New York's local tax burden the highest in the nation.*
  - *Use of a narrowly defined and regressive tax for such a large State program contributes to both negative perceptions of the program and inconsistent eligibility policies across counties.*
  - *The new property tax cap imposes annual growth limits on revenue that are far below the expected growth rate in Medicaid costs.*
  - *This fiscal structure creates challenges as the State implements the requirements of the Affordable Care Act. It will be difficult to accomplish the goals of the ACA – to greatly expand access to health coverage for all New Yorkers – if the funding continues to be derived from local property taxes.*
- ▶ The State should develop and implement a plan for more sustainable Medicaid financing that phases out reliance on local taxes (e.g., property taxes) and includes the examination of financing structures in other states.<sup>2</sup>

<sup>2</sup> The intent of the recommendation is for the plan to explore a wide array of financing options and that the added costs to the state of assuming local Medicaid costs shall be considered outside the global spending cap.



#### **FINANCIAL IMPACT:**

None to develop a plan; specific proposals will have a fiscal impact to be determined.

#### **HEALTH DISPARITIES IMPACT:**

Neutral impact on health disparities; could be negative if program savings fund the reduction in local revenues.

#### **BENEFITS OF RECOMMENDATION:**

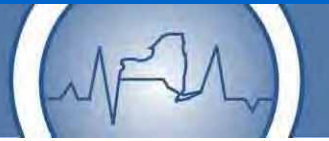
Reduce the local tax burden, ease the negativity directed toward Medicaid by counties, reduce inconsistent application of policy in an attempt to reduce tax burden.

#### **CONCERNS WITH RECOMMENDATION:**

The impact on consumers and providers from a reduction in local revenues if no new source of state revenue is identified and the reduction is funded solely from program savings.

#### **IMPACTED STAKEHOLDERS:**

Counties, Consumers, Taxpayers, State, Providers, and Unions.



**Medicaid Redesign Team  
Program Streamlining and State/Local  
Responsibilities Work Group  
Final Recommendations – October 17, 2011**

**Recommendation Number:**

**Recommendation Short Name:** MODERNIZE AND AUTOMATE ELIGIBILITY SYSTEM

**Program Area:** ACA IMPLEMENTATION

**Implementation Complexity:** HIGH

**Implementation Timeline:** LONG-TERM

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

**PROPOSAL DESCRIPTION:**

New York must have one eligibility determination and enrollment system for its Medicaid program and all Medicaid-eligible sub-populations (i.e., over 65, non-MAGI, under 65, MAGI, those who need health care services, those who need long term care services). While the State may implement this system incrementally for these populations, there must be a plan that sets certain implementation dates for each Medicaid sub-population. These dates should fall within the period during which the federal government will fund the development and implementation of this system at 90% FMAP.

New York should invest in one eligibility and enrollment system, initially supporting Exchange, Medicaid, and CHIP determinations. The system should undergo continued development to achieve interoperability with human service programs/systems, including the capacity for appropriate electronic communications and transactions to maximize possible benefits and maintain benefits across programs. Ultimately, the new system should support eligibility determinations and enrollment for all health and human service programs.

**FINANCIAL IMPACT:**

TBD, but small. Over 90% of the cost of the system development for Insurance Affordability programs will be financed by federal sources (100% Exchange funding and 90% Medicaid funding).

**HEALTH DISPARITIES IMPACT:**

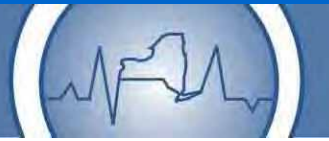
To the extent automation increases coverage, the recommendation has a positive impact on health disparities.

**BENEFITS OF RECOMMENDATION:**

A modern, fully automated eligibility system will allow the State to meet the IT requirements of the ACA. It will also improve the efficiency and accuracy of eligibility determinations.

**CONCERNS WITH RECOMMENDATION:** None

**IMPACTED STAKEHOLDERS:** State, Counties, Consumers, Providers, and Health Plans.



**Medicaid Redesign Team  
Program Streamlining and State/Local  
Responsibilities Work Group  
Final Recommendations – October 17, 2011**

**Recommendation Number:**

**Recommendation Short Name:** CENTRALIZE MAGI ELIGIBILITY DETERMINATIONS

**Program Area:** ACA IMPLEMENTATION

**Implementation Complexity:** HIGH

**Implementation Timeline:** LONG-TERM

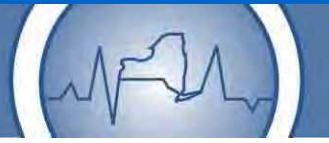
**Required Approvals:**  Administrative Action       Statutory Change  
 State Plan Amendment       Federal Waiver

**PROPOSAL DESCRIPTION:**

Centralize eligibility determinations for MAGI applications, wherever initiated and whether online, mail, phone, or in-person. Provide local in-person assistance (i.e., government, plans, community organizations) to help consumers apply for all Insurance Affordability programs with eligibility determinations centralized through a common eligibility system. Provide local specialized “hands on” help for non-MAGI individuals and centralized supports for assistors with non-MAGI applications tailored to local needs.

De-link Medicaid MAGI eligibility determinations from human service program determinations by local districts, and in accordance with the prior recommendations, require all Medicaid MAGI applicants be entered in the new automated eligibility system, with MAGI determination and any follow up by the central processing unit. Local districts would be required to enter MAGI Medicaid applications into the central eligibility system while the eligibility determination for the other human service program is being determined (e.g., public assistance). If however, individuals found eligible for public assistance do not already have Medicaid, they will be automatically enrolled in Medicaid to the extent permitted by state law.

The state, working in collaboration with counties, should develop an appropriate transition plan for state/local administration of non-MAGI Medicaid populations within a reasonable time after 2014, taking into account the ongoing development and phasing of the statewide, automated eligibility and enrollment system. Counties should have the option, in consultation with and subject to the approval of the state, to continue responsibility for non-MAGI Medicaid eligibility and enrollment, consistent with standards determined by the state.



The continued development of a statewide health insurance eligibility system should be interoperable with human service programs/systems at the county level, including the capacity for appropriate electronic communications and transactions to maximize possible benefits and maintain benefits coverage across programs.

#### **FINANCIAL IMPACT:**

TBD. Funding to establish a central processing unit at the state for Insurance Affordability program applications is almost entirely from federal sources through 2014.

#### **HEALTH DISPARITIES IMPACT:**

To the extent enrollment is simplified, timely and coverage increases, the recommendation should have a positive impact on health disparities.

#### **BENEFITS OF RECOMMENDATION:**

This will allow for a more efficient processing unit for all MAGI applications on a health insurance continuum from Medicaid to Advance Payment Premium Tax Credits. Will provide greater consistency in the application of eligibility rules and increased accuracy through automation.

#### **CONCERNS WITH RECOMMENDATION:**

The state's ability to fully automate eligibility determinations by 2014.

#### **IMPACTED STAKEHOLDERS:**

State, Counties, Consumers, Providers, Health Plans, and Unions.



**Medicaid Redesign Team  
Program Streamlining and State/Local  
Responsibilities Work Group  
Final Recommendations – October 17, 2011**

**Recommendation Number:**

**Recommendation Short Name:** LONG-TERM CARE RECOMMENDATIONS

**Program Area:** ELIGIBILITY

**Implementation Complexity:** MEDIUM

**Implementation Timeline:** SHORT-TERM

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

**PROPOSAL DESCRIPTION:**

Centralize and automate eligibility and enrollment processes for the Medicare Savings Programs by January 2014.

The State should invest in an Asset Verification System (AVS) to permit the electronic verification of assets (including assets in the 5 year look back period) for determining eligibility for aged, blind, and disabled Medicaid applicants and recipients. AVS should be deployed as soon as possible in existing systems and this functionality should also exist in any new eligibility system.

Automate spend down by linking eMedNY to WMS and using provider billing to track spend down similarly to an insurance deductible. In addition to streamlining spend down eligibility, the automation ensures that Medicaid is correctly paid. This spend down automation function should be deployed as soon as possible in existing systems and this functionality should also exist in any new eligibility system.

Disabled and elderly New Yorkers in need of long term care services should have the same access to enrollment and eligibility assistance as other applicants for Medicaid. New York's plan for meeting consumer assistance needs must include a focus on this vulnerable population, whether it is through the use of Navigators, Consumer Assistance Programs, Facilitated Enrollers or some other funded initiative.





Create a Work Group of consumer representatives (including those who benefit from specific programs, like the consumer-directed program), providers, plans, workers and local and state officials to assist the state in:

- *evaluating eligibility and enrolment processes for long term care and identifying further reforms and tracking implementation of those agreed upon;*
- *evaluating the implementation of managed long term care and identifying further reforms and tracking implementation of those agreed upon;*
- *ensuring appropriate training and support of long term care stakeholders, including consumers, providers, workers and local officials as new systems and new programs are implemented.*

#### **FINANCIAL IMPACT:**

MSP Automation and centralization \$5 million state share; AVS \$2 million state share; Enrollment Assistance for Disabled and Elderly Individuals \$3 million state share.

#### **HEALTH DISPARITIES IMPACT:**

Streamlining enrollment in Medicaid for elderly and disabled individuals should have a positive impact on health disparities.

#### **BENEFITS OF RECOMMENDATION:**

Will enhance automation for the elderly and disabled populations in MSP, through AVS, and spend down to reduce processing delays in determining eligibility. Will provide the elderly and disabled population some of the simplification and enrollment assistance that has been available to the community Medicaid population.

#### **CONCERNS WITH RECOMMENDATION:**

None

#### **IMPACTED STAKEHOLDERS:**

Consumers and Providers.

**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Behavioral Health Reform Work Group

**FINAL RECOMMENDATIONS**



## **Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011**

### **Work Group Charge:**

As part of Governor Andrew Cuomo's efforts to "conduct a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure," the Governor appointed a Medicaid Redesign Team (MRT). The MRT is composed of representatives from the legislature, health care industry, patient/consumer advocacy groups, New York City and State executive staff including the Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), and the New York State Medicaid Director. The MRT adopted 73 recommendations for Medicaid reform, many of which were enacted into New York State law.

The MRT also created several work groups to review and provide additional follow up recommendations in key areas, including behavioral health. The Behavioral Health Reform Work Group (the Work Group) was charged by the MRT with helping to establish the parameters of the transformation to care management for New Yorkers with mental illnesses and substance use disorders. It was specifically asked to:

- Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services.

The Work Group chose to address its mission in the context of MRT 93, the implementation of BHOs (see appendix A). Specifically, the Work Group identified a set of managed care principles and recommendations that should apply to behavioral health care management regardless of whether BHOs are implemented through full-benefit Special Needs Plans (SNPs), provider-based Integrated Delivery Systems (IDSs), or benefit carve-out BHOs.



## The Fragmentation of Behavioral Health Care in NYS

New York's behavioral health system (which provides specialty care and treatment for mental health and substance use) is large and fragmented. The publicly funded mental health system alone serves over 600,000 people and accounts for about \$7 billion in annual expenditures. Approximately 50 percent of this spending goes to inpatient care. The publicly funded substance use disorder treatment system serves over 250,000 individuals and accounts for about \$1.7 billion in expenditures annually. Despite the significant spending on behavioral health care, the system offers little comprehensive care coordination even to the highest-need individuals, and there is little accountability for the provision of quality care and for improved outcomes for patients/consumers. This fragmentation problem is compounded since mental health and substance use care and treatment systems are separated, with discrete regulations and funding streams, though there are substantial rates of people with co-occurring serious mental illness and substance use disorders.

Behavioral health also is not well integrated or effectively coordinated with physical health care at the clinical level or at the regulatory and financing levels. The behavioral health system is currently funded primarily through fee-for-service Medicaid, while a substantial portion of physical health care for people with mental illness or substance use disorders is financed and arranged through Medicaid managed care plans. This also contributes to fragmentation and lack of accountability.

This lack of coordination extends well beyond physical health care into the education, child welfare, and juvenile justice systems for those under the age of twenty-one.

The fragmented and uncoordinated payment and delivery systems have contributed to poor outcomes, including:

- People with serious mental illness die 15 - 25 years earlier on average than the rest of the population. The leading contributors to this disparity are chronic, co-occurring physical illnesses, which are not prevented and are treated inadequately. (Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States [http://www.cdc.gov/pcd/issues/2006/apr/05\\_0180.htm](http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm))
- The majority of preventable admissions paid for by fee-for-service Medicaid to Article 28 inpatient beds are for people with behavioral health conditions, yet the majority of expenditures for these people are for chronic physical health conditions. (New York Medicaid Redesign Team, Building a more affordable, cost-effective Medicaid program, January 13, 2011 Albany, New York)
- There is an over-reliance on State psychiatric hospitals, adult homes and nursing homes, partly due to the system's inability to assign responsibility for integrated community care.
- In NYS, under the current Medicaid fee-for-service system, 20% of patients discharged from psychiatric inpatient units are readmitted within 30 days. ([http://www.omh.state.ny.us/omhweb/rfp/2011/bho/databook\\_tables.xlsx](http://www.omh.state.ny.us/omhweb/rfp/2011/bho/databook_tables.xlsx))



- The unemployment rate for people with serious mental illness is extremely high, approximately 85% based on national surveys.
- Only 30% of youth age 14 and older with a serious emotional disturbance graduate with a standard high school diploma.  
([http://www.omh.state.ny.us/omhweb/News/leadership\\_conf/index.htm](http://www.omh.state.ny.us/omhweb/News/leadership_conf/index.htm))
- Serious mental illness and substance use disorders confer significant risks of homelessness.
- The overuse of inpatient detoxification and SUD inpatient rehabilitation services by a small number of individuals results in poor outcomes and high Medicaid costs.
- The average time between onset and treatment of mental illness in children and treatment of mental illness is approximately nine years.
- Collaborative care is not widely implemented in New York, though it is recognized as a best practice.
- Early intervention for psychiatric disorders (usual onset in early twenties) is infrequent and not promoted under the current regulatory and financing approach, despite wide recognition as a best practice.

It is with these challenges in mind that the Work Group commenced its work. The recommendations in this report are intended to address the problems and poor outcomes referenced above, while contributing to Medicaid budget solutions.



## Work Group Process

The Work Group began meeting on June 30, 2011 in New York City and held four additional meetings – July 12 in Albany, August 1 in New York City, August 23 in Albany, and September 12 in New York City. The Work Group recognized the need to involve experts with knowledge and experience specific to children with serious emotional disturbances and substance use disorders in a subgroup of the Work Group, and its recommendations are addressed in the child-specific section later in this document.

Meetings included expert presentations on relevant topics and discussions examining issues related to the Work Group's charge and potential recommendations to the MRT. Presentation topics included:

- Components of effective treatment and services for Serious Mental Illness (SMI), and Serious Emotional Disturbance (SED) - Mike Hogan, Ph.D. Commissioner, NYS OMH.
- Physical Health of Individuals with SMI and SUD and the Integration of Physical and Behavioral Health Care – Adam Karpati, M.D., Executive Deputy Commissioner for Mental Hygiene, NYC DOHMH and Andrea Cohen, Director of Health Services, New York City.
- Services and Medicaid in the OASAS Treatment System – Arlene Gonzalez-Sanchez, Commissioner, NYS OASAS, and Robert Kent, Chief Counsel, NYS OASAS.
- Managed care principles and practices – Ilene Margolin, Senior Vice President, Public Affairs & Communications, Emblem Health & Health Plan Association.
- The DOH health homes initiative – Gregory Allen, Director, Division of Financial Planning and Policy, NYS DOH.
- Management of SUD - Arlene Gonzalez-Sanchez, Commissioner, NYS OASAS, and Robert Kent, Chief Counsel, NYS OASAS.
- Lessons learned from the Care Monitoring Initiative (information about this initiative is available at <http://www.omh.state.ny.us/omhweb/cmi/faq.html>) - Robert Myers, Ph.D., Senior Deputy Commissioner, Division Director, NYS OMH, and Adam Karpati, M.D., Executive Deputy Commissioner for Mental Hygiene, NYC DOHMH.
- Performance standards to promote good care at reasonable cost – Susan Essock, Ph.D., Director, Division of Mental Health Services and Policy Research, Columbia University.
- Presentation of recommendations from the Children's sub-group – Gail Nayowith, Executive Director, SCO Family of Services and Kristin Riley, Deputy Commissioner, Division Director, NYS OMH.

Given the challenges outlined above, the Work Group proposed several key principles for behavioral health that should apply to the new financial and programmatic mechanisms being implemented in New York (BHO, IDS, SNPs, and Health Homes).



## Work Group Membership:

- **Co-Chair, Michael F. Hogan, Ph.D.** *Commissioner, New York State Office of Mental Health*
- **Co-Chair, Linda I. Gibbs**, *New York City Deputy Mayor for Health and Human Services*
- **Wendy Brennan**, *Executive Director, National Alliance on Mental Illness – NYC Metro*
- **Pamela Brier**, *President & CEO, Maimonides Medical Center*
- **Alison Burke**, *Vice President, Regulatory & Professional Affairs, Greater New York Hospital Association*
- **Lauri Cole**, *Executive Director, NYS Council for Community Behavioral Healthcare*
- **Donna Colonna**, *Executive Director, Services for the Underserved*
- **John Coppola**, *Executive Director, New York State Association of Alcoholism and Substance Abuse Providers*
- **Betty Currier**, *Board Member, Friends of Recovery – New York*
- **Philip Endress**, *Commissioner, Erie County Department of Mental Health*
- **Arlene Gonzalez-Sanchez**, *Commissioner, NYS Office of Alcoholism and Substance Abuse Services*
- **Kelly Hansen**, *Executive Director, New York State Conference of Local Mental Hygiene Directors*
- **Ellen Healion**, *Executive Director, Hands Across Long Island*
- **Tino Hernandez**, *President & CEO, Samaritan Village*
- **Cindy Levernois**, *Senior Director, Behavioral Health and Workforce, HANYS*
- **Ilene Margolin**, *Senior Vice President, Public Affairs & Communications, Emblem Health & Health Plan Association*
- **Gail Nayowith**, *Executive Director, SCO Family of Services*
- **Kathy Riddle**, *President and CEO, Outreach Development Corp.*
- **Harvey Rosenthal**, *Executive Director, New York Association of Psychiatric Rehabilitation Services, Inc.*
- **Paul Samuels**, *Director & President, The Legal Action Center*
- **Phillip Saperia**, *Executive Director, The Coalition of Behavioral Health Agencies, Inc.*
- **Sanjiv Shah, M.D.**, *Chief Medical Officer, Fidelis Care NY*
- **Richard Sheola**, *Executive Vice President, Value Options*
- **Ann Sullivan, M.D.**, *Network Senior Vice President, Queens Hospital Network; NYCHHC*

## Meeting Dates:

- *Thursday, June 30, 2011*
- *Tuesday, July 12, 2011*
- *Monday August 1, 2011*
- *Tuesday, August 23, 2011*
- *Monday, September 12, 2011*
- Meeting Agendas, Presentations and Minutes can be found at:  
[http://www.health.state.ny.us/health\\_care/medicaid/redesign/behavioral\\_health\\_reform.htm](http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm)



## Principles for Behavioral Health Services in a Managed Care Environment

As charged by the MRT, the Work Group identified a number of key elements of design and practice needed for a managed and coordinated behavioral health care system in New York State relevant across the age span. Beginning with the first meeting, the Work Group engaged in a goal-setting and prioritization process to reach group consensus on these key principles. The Work Group also identified critical types of metrics and indicators that should be measured to determine the extent to which these principles are met. The following are the principles established by the Work Group:

- 1. There should be mechanisms at multiple levels for connecting and coordinating all of the different participants, including healthcare providers, payers, and care managers. The delivery of clinical care should be coordinated and efficient.**
  - Mental health, physical health, and substance use should be addressed in an integrated manner.
  - APG caps on physical health services provided in behavioral health settings and behavioral health services in physical health settings must be revisited.
  - Patient/Consumer screening for mental illness and substance use disorders should be done across specialty and primary care settings and should use state-of-the-art techniques and technology.
  - Providers should use electronic medical records and available mechanisms for health information exchange. They should have access to, and use, their patient/consumers' Medicaid data.
  - There should be a "no wrong door" approach so that no matter where patients/consumers enter the system, they are guided to the right provider. Standardized screening tools should be used.
  - A system of empowered care coordination should be established, and be stratified by risk/need of patient/consumer. Payment models should incentivize coordination among physical and behavioral health providers.
  - Duplication of services should be avoided.
  - Co-location of services should be one available model to promote integrated care.
  - There should be clarity around roles and accountability across service providers.
  - Linkages to other systems, such as the criminal justice, juvenile justice, homeless, and child welfare systems, also should be developed.





**2. Payment for services should be tied to patient/consumer outcomes.**

- Incentives should guide providers to the appropriate type and amount of care.
- The reimbursement rate structure should recognize the varying levels and capabilities of providers.
- There should be flexibility to finance wrap-around services.
- The fee-for-service “mentality” should be eliminated, although that does not preclude using fee-for-service payment mechanisms within a managed care arrangement.

**3. Patient/Consumer input and choice is critical.**

- Whenever possible, consumer choice should be preserved.
- There should be in-person care coordination activities for high-need users.
- Peer programs should be used to help engage patient/consumers.
- Families should be integrated into care whenever possible.
- Treatment should be based on condition, and not on insurance status.
- There should be a person-directed focus on wellness and recovery.
- Consumer access should be considered as part of any data-sharing initiative.

**4. Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.**

- Available social services outside of health care should be utilized maximally.

**5. Housing resources need to be available directly for timely use to avoid lengthy or repeat admissions, and to provide stability for patient/consumers in the community.**

**6. Money saved should be reinvested smartly to improve services for behavioral health populations.**

- Savings from better managed behavioral and physical health care should be reinvested to the extent possible for improved outcomes and reduced health costs.
- Reinvestment should prioritize non-clinical support services, such as housing, peer, employment, and family services.
- Investment in preventive services that avoid the need for tertiary care should be incentivized.
- Savings might be shared with consumers to incentivize engagement.



- 7. Distinction in design and operation must be made to address the unique needs of children and their families.**
- 8. The needs of older adults are unique and require special attention.**
  - For older adults, care coordination will require interface with home health services, adult day care, and a heightened sensitivity to physical health needs.
- 9. Regulatory burden should be minimized.**
  - Unfunded mandates should be avoided.
  - The paperwork required of providers by government and managed care organizations should be reduced, or, at the very least, not increased.
- 10. The diversity of New York State's communities should be taken into account.**
  - Varying levels of patient/consumer needs and provider capacities may dictate different approaches in different parts of the State, especially those which are predominately rural or urban.
- 11. Key outcomes at the individual, provider, and system levels include:**
  - Sustainable medical-loss ratios and reasonable levels of reinvestment
  - Elimination of inappropriate financial barriers to care
  - Adequate and promptly paid reimbursement rates to ensure appropriate capacity
  - Appropriate risk-adjustment to incentivize treatment of the harder to serve
  - Payments that promote the delivery and use of the appropriate level of care
  - Good clinical outcomes for key chronic medical conditions
  - Cultural and linguistic competency and use of peer services
  - Reduced hospital admissions inpatient detoxification and SUD inpatient rehabilitation services
  - Reduced mortality and health disparities associated with mental illness and substance use
  - Reduced gap between prevalence of service engagement and prevalence of conditions in the population
  - Reduced criminal and juvenile justice involvement
  - Reduction in use of court-ordered outpatient treatment for mental health (excluding mental health courts)
  - Improved care transitions (e.g., appointments after hospitalizations)
  - Meaningful and useful communication across providers



## Summary Listing of Recommendations:

In addition to principles for managed care, the Work Group identified a number of recommendations in the area of finance and contracting with plans; eligibility; performance metrics/evaluation; children, youth, and family; peer services; and Health Homes, as well as some issues that were considered important but outside the scope of the Work Group's mission. These are provided below:

### A. Overarching recommendations include:

- Managed care approaches using risk-bearing Special Needs Plans (SNPs), Integrated Delivery Systems (IDS), and/or Behavioral Health Organizations (BHOs) should be developed, consistent with MRT recommendation #93 (See Appendix A) and State statutes. In New York City, based on its population and its delivery system infrastructure, full-benefit IDSs or SNPs should be developed to include mental health, substance use, and physical health.
- Meeting the MRT's key goals of improving the outcomes for individuals with serious mental illness and/or substance use disorders and reducing the growth in costs through a reduction in unnecessary institutional care will require a strong and well-functioning community-based system of care and supports. Building this system will require investments in care coordination; in access to affordable housing; in health information exchange; and in other non-clinical services and supports.
- SNPs/BHOs should be given responsibilities to pay for inpatient care at State psychiatric hospitals and to coordinate discharge planning. This will help reduce incentives for BHOs/SNPs to institutionalize people in State psychiatric hospitals. It is expected that facility downsizing would occur on a phased basis. As State psychiatric hospital resources are freed, these funds will be reinvested to fund community-based services (housing, employment, peer support, family and children's support), with a modest amount taken as savings. OASAS State-operated Addiction Treatment Centers (ATC's) already participate in Managed Care Plans and services provided there will continue to be paid for by the SNP/BHO.
- Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare, consideration should be given to integrating Medicaid and Medicare benefits for dual eligibles through the SNP, IDS or BHO using an 1115 waiver or other mechanism. Medicare savings should be reinvested in SNP, IDS or BHO at least in part.
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.
- Use the 1115 waiver that is being developed to advance the recommendations outlined in this report.



- The Work Group should continue to deliberate and provide guidance and recommendations as budget projections, 1115 waivers, and regulatory efforts are developed to implement these recommendations.
- The recommendations below are to be accomplished largely through the redistribution of existing resources; as inpatient and emergency room services decrease resources will be reinvested into community supports and rehabilitation services. Therefore, individual recommendations cannot be costed out separately because they are part of an overall system restructuring.

Through deliberation, the Work Group reached consensus to advance the following more specific recommendations consistent with its principles and mission as part of the MRT.

## **B. Financing and Payment**

- Initial premium levels for managed care entities should be based on prior service spending, including Health Home and targeted case management spending, and should be designed to encourage plan investment in prevention and development of capacity for cost-effective, evidence-based services. State share savings should not be targeted for the first year of risk-based behavioral health managed care.
- There should be transparency with respect to the portion of premium attributable to behavioral health actuarial assumptions and actual behavioral health service spending by plans.
- Formal mechanisms should be established for reinvestment of resources into clinical and non-clinical services that can improve the quality and cost-effectiveness of care for people with serious mental illnesses and substance use disorders. Savings on behavioral and physical health care attributable to improved care coordination of behavioral health populations should be tracked. Reinvestment should be focused on high priority areas, including housing, employment services, peer services, and family support. Reinvestments should be based on county/City planning processes and include input from managed care entities, providers, consumers and other stakeholders, and should be approved by the State.
- Non-Medicaid savings in State and local systems serving patients/consumers with behavioral health needs also should be tracked and accounted for as savings generated by Behavioral Health reform. These systems with potential savings include criminal and juvenile justice, homeless services, cash assistance/benefits, Special Education, and child welfare, among others.
- Compliance with existing New York State Medicaid managed care legal requirements and principles are assumed unless otherwise noted.



**C. Contracting with Behavioral Health Plans (BHOs, SNPs, IDSs) and Benefit Package**

- The operations of behavioral health managed care entities should be tailored to local health delivery infrastructure and populations.
- Contracting responsibility for BHO/SNP/IDS should rest with OMH/OASAS coordinated with NYS DOH in consultation with the counties/City. Managed care entities in NYC, whether full-benefit SNPs, IDSs or carve-out BHOs, should be overseen jointly by the State and NYC behavioral health agencies with close NYS DOH collaboration.
- Managed care entities should offer comprehensive behavioral health benefits, and full-benefit SNPs also should offer comprehensive physical health benefits. Care coordination, care management, and health home services should be fully integrated into SNPs, and also integrated into BHOs for management and coordination of behavioral health services. Non-clinical services, including peer services that contribute to continuity of care, wellness, and recovery, should be included in the behavioral health service array. The SNP benefit should include pharmacy.
- SNPs and BHOs should be required to participate in coordination activities with the relevant social and human services system, including the criminal and juvenile justice system and children’s service system.
- SNPs and BHOs should be required to coordinate with the local planning process as provided for in Article 41 of the Mental Hygiene Law and in the county/City behavioral health agencies’ ongoing oversight and monitoring activities around access to mental health, substance use services, and social supports in the region.
- Protocols should be developed to ensure:
  - Coordination of services covered by BHOs with physical health payers and providers and/or social service benefits/services that are not covered by Medicaid managed care.
  - Coordination of services covered by SNPs with social service benefits/services that are not covered by Medicaid managed care. These protocols should ensure that resources are targeted to highest need populations.
- Managed care entities should develop robust care coordination activities that include intensive data-driven strategies to identify high-need consumers (e.g., those disengaged from care; those at high risk of suicide; those with history of violence); policies and procedures to exchange information with and hold accountable clinical providers, including exchange of information between psychiatrist and primary care doctor, between social worker and doctor, etc.; and programs of direct, community-based engagement with consumers. Special attention should be placed on points of transition: discharge from hospital or emergency department, from jail or prison, from shelter, and outreach to people disengaged from care, especially people potentially at high risk.



- Special attention should be given to individuals with co-occurring behavioral health and developmental disability challenges.
- Managed care entities should be required to have networks of providers that are appropriate to enrollee needs and existing provider relationships and that foster strong and collaborative plan/provider network partnerships focused on highest quality and performance. Continuity of care, access to an appropriate array of providers, and opportunities for consumer choice in providers should be prioritized. The number of managed care entities in a region should be limited, in order to ensure accountability and access. OMH and OASAS should promulgate standards for network adequacy.
- Expected best practices in behavioral health managed care include:
  - Appropriate risk sharing between payer (State) and plan.
  - A defined “floor” on services spending in sum (e.g., Medical Loss Ratio) and for key services or service categories.
  - Include Medical Loss Ratio (MLR) requirements in managed care contracts to ensure a certain percentage of funds go toward direct patient care.
  - Coordination with housing and other social services and supports, e.g., employment and rehabilitation, family support services.
- Managed care entities should focus on ensuring the appropriateness of ambulatory and inpatient services provided to enrollees through the following:
  - Expanded access to office-based ambulatory services (e.g. psychotherapy). Reduced use of inpatient care consistent with assured timely and appropriate access whenever it is clinically necessary
  - Appropriate development and substitution of less costly and more appropriate alternatives to inpatient care
- Managed care entities should be required to use standardized assessment and level of care protocols which should be made available to all network providers.
- Managed care entities should be required to use best practices in management of Electronic Health Information (EHI) (e.g. PSYCKES for medication management and reduction of polypharmacy). (See Section F)

#### **D. Eligibility for SNPs/BHO Enrollment**

- SSI status should not be the single determinant of eligibility of Medicaid recipients with behavioral health needs for specialty managed care. Eligibility should be based on clinical status and/or utilization. A mechanism should be established to ensure that disengaged individuals (those without a history of high utilization) can also be enrolled in SNPs. Clinical status should include the presence of either a mental illness or a substance use disorder (or both) and a level of illness severity and/or functional impairment.



**E. Promotion of Improved Behavioral Health care in primary care/non-specialty settings, including provided through mainstream managed care plans**

- OMH, OASAS, and DOH should review and revise clinic licensing requirements to allow for co-licensure, reduce duplicative or contradictory requirements, and incentivize more co-located behavioral health/physical health services.
- Mainstream plans should be evaluated on a more robust set of behavioral health performance measures than are currently used, including clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Depression and Screening Brief Intervention Referral and Treatment (SBIRT) screening should be required, measured, and strongly incentivized.
- Expected savings in the cost of psychiatric medications as patents expire and generic versions are made available, can be reinvested to implement collaborative behavioral health care in primary care settings.

**F. Health Information Technology and Information Exchange**

- Plans should require and promote the participation of their contracted providers with the SHIN-NY (State Health Information Network of New York) through promotion of electronic health records and information exchange and the elimination of barriers to participating in health information exchanges, such as financial challenges. . Health IT should be a target for investment.
- All Medicaid managed care entities should report all paid claims and encounter data to the State in a timely manner and according to statewide protocols. The State should share claims data in a timely manner with plans for any carved out services used by their membership.
- Plans should adopt comprehensive, consent-based data-sharing protocols and make claims data available to providers and the counties/City to ensure appropriate oversight, care and care coordination. Where there is statewide or national consensus on these protocols, plans should adopt those and not pursue proprietary methodologies.
- OMH, OASAS and DOH should develop statewide standard consent protocols and guidelines for use, including for electronic health information exchange. Plans should mandate that providers use these consent protocols (as opposed to creating their own proprietary ones).



#### G. Performance Metrics/Evaluation

- Performance Monitoring and Incentives. Managed care entities and their networks should be held accountable for outcomes, including providing and coordinating enrollees' health care.
- Plan payment should include a performance-based premium payment incentive program that measures performance and pays more for plans that perform better.
- Plan performance should be based on validated measures across a variety of different domains – including access, network adequacy, adoption of best practices, patient/consumer satisfaction, compliance, efficiency, care coordination and continuity, and clinical and recovery outcomes. Disparities in measures between racial/ethnic and other socio demographic groups also should be tracked. Managed care entities should be measured on their performance coordinating enrollees with social services and support needs.
- There should be public reporting, by plans and aggregated by State, of Medicaid spending on behavioral health services over time, including before and after reform initiatives are implemented. The reporting should include the behavioral health sector as a proportion of total Medicaid spending and absolute spending on behavioral health services and populations. Performance Metrics should be transparent.

#### H. Children, Youth and Families

*The Children's Subgroup met several times and submitted the following recommendations to address the unique and complex needs of children with behavioral health disorders in a managed care setting, which were adopted by the Work Group. (See appendix B for the Children's Subgroup's full report.)*

##### Findings:

***Intervening early in the progression of behavioral health disorders is effective and can reduce cost.*** Even with recent gains in children's behavioral health, harmful and costly developmental trajectories continue to be formed early in life:

- 30% of children in New York's public schools with a special education label of "emotionally disturbed" graduate with a standard high school diploma.
- Up to 80% of the children in the juvenile justice system have a behavioral health diagnosis.





- Adverse experiences in childhood (e.g., recurrent abuse, witnessing domestic violence, parental separation/divorce, growing up with parent with mental illness, substance abuse or incarceration) are important predictors of unhealthy behaviors, including tobacco, alcohol, and illicit drug use, and adult physical and mental illnesses .<sup>1</sup>

It is widely accepted that education for children has a greater return in human capital than interventions at later ages. Medicaid redesign in New York provides the opportunity for a greater return on investment in children's behavioral health by likewise investing early in preventive and therapeutic interventions that are more effective (and more cost-effective) in preventing a poor longitudinal course of emotional disturbance than interventions at later ages, when harmful developmental trajectories have already been established.

**Accountability across all payers is lacking.** Children are covered by a variety of insurance (public/private) products with historic dependencies on Medicaid rates and State general funds to support behavioral health needs, which increase the demand on state and county funded services. Medicaid redesign must address the historic reliance on safety net services and establish reasonable expectations for accessing services across all payers.

**The current systems are "siloed."** Families are often served by a disjointed, overlapping, non-comprehensive and costly series of services. Medicaid redesign must better align systems to yield continuity of care, access and cost efficiency, and promote greater integration of primary care and behavioral health. Special considerations may be required to address the complex needs of children in the foster care system.

**The current behavioral healthcare system for children and their families is underfunded.** Per capita investment in behavioral health for adults far outweighs investment in children, which could be remedied through reinvestment of existing resources.

#### Subgroup Recommendations:

- **Identify the core elements of the benefit package and priorities for the basic Medicaid Managed Care, Child Health Plus, Family Health Plus and commercial insurance plans.** Ensuring access to a number of front-line services/benefits to prevent, screen and treat behavioral health disorders are the most important components to preventing long-term disability, significantly altering the trajectory of disability as a child enters adulthood, and reducing long-term costs. These recommendations consist of ensuring robust access to a number of interventions (see Appendix B for complete list), including: routine screening, including at well-child visits; crisis services available on a 24/7 basis; first-level interventions available within seven days; assessment, using accepted tools/diagnostic methods and that serve as the basis for determination of medical necessity.

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<sup>1</sup> Green et al. Childhood adversities and adult psychiatric disorders in the NCS-R-I. *Arch Gen Psych*. 2010; 67:113-123. Shevlin M, et al. Childhood adversity and hallucinations: a community-based study using the National Comorbidity Survey Replication. <http://cdc.gov/ace/>



- **Identify the enhanced elements of the benefit package and processes for a Special Behavioral Healthcare Managed Care Plan for children with special needs.** For all children, eligibility for the specialty managed care program should be based on a combination of clinical/functional status, i.e., DSM diagnosis of serious emotional disturbance or substance use disorder or the presence of complex symptoms and behaviors even in the absence of a formal diagnosis, and utilization of specialty services or risk of such utilization. In addition, because of their high risk for behavioral health problems, children with an individualized educational plan (IEP) or who are served in the child welfare or juvenile justice systems should have presumptive eligibility for enrollment in the specialty managed care program; for these children, the clinical and utilization thresholds should be lower than for the general child population and enrollment processes should be streamlined and facilitated.
- Recommendations (see Appendix B for complete list) for components of the specialty benefit to be made available to those children that qualify include: residential treatment (MH and SUD), HCBS waivers (HCBW, B2H); Medication management; Family support and guidance; Cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school); Recovery-oriented services.
- **Develop outcome measurements and standards to review program performance.** A number of key outcomes should be used to anchor quality in both regular and specialty care and defined processes should be established to measure and use outcomes to appraise performance and improve quality. The outcomes were selected considering the following principles: 1) Meaningful - indicators capture progress toward symptom reduction, risk reduction, improved functioning and well-being; Easy to measure – include indicators universally used by all plans and not overly burdensome to implement; Validated and readily available - indicators are based on established measurement tools with established validity, reliability and are available in the public domain; Easy to use - indicators can be easily used to improve quality.

Overall, nine recommendations (see Appendix B) are submitted, along with specific ways in which outcomes should be measured and used. The critical outcomes are:

- Improvement in psychiatric symptoms for which treatment is sought
- Improvement in functional status (e.g. social, school function)
- Consumer satisfaction/involvement
- Critical incidents
- Success/failure at transition to less intensive level of care
- Access to care
- Medication management
- Cross-systems communication/case planning
- Network adequacy



### **I. Peer Services and Engagement**

Consistent with MRT 1058, it is appropriate to incorporate peer services into a new behavioral health managed care system that prioritizes physical and behavioral health as well as other necessary aspects of successful functioning in the community (housing, employment, education, etc.). A subgroup related to peer services and engagement identified the following core recommendations, which were adopted by the Work Group. (For the subgroup's full report, see Appendix C.)

- Promote acknowledgement and respect for the unique contributions and value of peers in delivering services that help people, promote wellness, and decrease costs.
- Facilitate ways to accommodate Medicaid funding for peer services, such as waivers, grants, and funding for programs rather than for the position itself. Funding for training and education, certification, and leadership development would strengthen the peer workforce.
- Establish an accreditation process for peer-run agencies which would professionalize the unique, whole health/wellness approach that peers provide.
- Incorporate peer services into Health Homes, given the recognition that peer series are evidence-based practices which can improve outcomes while being cost effective.
- Address children and their care separately from care of adults.

### **J. Services for the Uninsured.**

The Work Group agreed this issue warranted special attention and formed a subgroup to review issues related to the uninsured. The subgroup made the following recommendations which were adopted by the Work Group. (See appendix D for their full report.)

- A mechanism for funding an appropriate level of services to the uninsured and underinsured needs to be maintained as the system moves into managed Medicaid for all clients with mental health and substance use disorders and previous funding streams (such as disproportionate share hospital (DSH) payments) are reduced or no longer available.
- The uninsured population should access care coordination services in the same way as the insured population does in order to prevent inappropriate use of high cost emergency services, and cost-shifting to other systems.
- For the uninsured and underinsured, promote Medicaid buy-in options for people with behavioral health issues.
- For insurance offered in new health insurance exchanges, the State should promote benefit package designs that ensure appropriate coverage of services for individuals with SMI and SUD.



- For the underinsured, mental health and substance use parity as required by State and federal law needs to be enforced in all insurance programs, including commercial programs to which the laws apply.

## K. Health Homes

Consistent with its mandate to provide guidance on Health Homes, the Work Group reviewed current plans for development of health homes at its August 1 meeting. Because development of Health Homes proceeded prior to completion of this final report, the following interim recommendations were shared with the Department of Health to help shape the development process over the next several months.

- **Health homes must include behavioral health expertise and leadership.** Individuals with Serious Mental Illness (SMI) and those with substance use disorders (SUD) are a priority for early enrollment in health homes. The [Work Group] recognizes there is great potential to improve the quality and continuity of care for this population (e.g. by integrating medical with behavioral care). There is also potential for harm; many individuals in the population with SMI rely primarily on behavioral health providers, may have limitations or reluctance in using other health services, and need specialty attention. Therefore, the [Work Group] recommends that there should be health homes with specific specialty capacity (e.g., network, staffing, care coordination practices) to serve individuals with SMI and SUD. In addition to specialized capacity, health homes serving the SMI/SUD population should be evaluated on specific and robust performance and outcome indicators related to this population. Government behavioral health officials should play a key role in selecting and guiding the development of and overseeing these health homes.
- **A transitional strategy must be in place to assure the smooth transition of behavioral health services (especially “case management” services) from the 2 year enhanced FMAP stage into the SNP/BHO/IDS environment that will be put in place for 2013.** Before patient/consumers and funding are shifted to health homes, the State should formulate and articulate a strategy ensuring that people, funds and services are maintained and transitioned into the managed care environment now being designed for 2013. A critical part of such a strategy will be ensuring that funding at its current levels moves along with consumers into new models of care organization, payment and delivery, especially dollars slotted for targeted case management and Managed Addiction Treatment Services (MATS).
- **All Health homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.** An integrated approach to health and behavioral health care necessitates routine basic screening for BH disorders and other medical problems in all health homes, and the presence of routine ambulatory health services (e.g. internal medicine) and behavioral health services (e.g. addiction, mental health counseling) in all health homes. Current licensing barriers and rules that limit behavioral health providers billing for routine outpatient physical health services severely limit successful integration. These rules should be abolished. Health homes must also



- ensure access to essential specialty services such as obstetrics and gynecology that are often underutilized by BH clients.
- **Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.** Since health problems are often exacerbated by non-health situations—such as a lack of stable housing or employment—the State must assure that health homes take into account social and other non-health services when designing an approach to treatment, especially for seriously mentally ill patient/consumers. Part of this structure should be a requirement and procedure for health homes to work with county governments. Explicit partnerships with local governments, particularly those that employ a single point of access (SPOA) process, may be the only feasible way to provide key connections to non-health social services.
- **Screening and Brief Intervention for Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.** Use of these evidence based practices will greatly assist with proper assignment and care of patients and has been identified by SAMHSA as an important element of any Health Home program.
- **The State must clarify the roles and responsibilities of health homes participants.** At present, the roles of various entities, including providers and insurance plans, have not been adequately defined. While local collaborations leading to an application can help refine arrangements, the State must provide some direction. Among the issues that need immediate clarification are the roles, responsibilities, and lines of accountability for health homes, insurance plans, and participating providers. For example, an explanation of what happens to a patient/consumer who is assigned to a health home that uses providers with which the patient/consumer’s insurance plan does not have contracts is a pressing concern. Further special attention should be paid in clearly identifying the role of the first phase BHOs.
- **The State should work to preserve patient/consumer choice.** Certain individuals, such as people with significant BH issues, are much more likely to seek and accept care from providers with whom they are familiar. To the extent possible, patient/consumers should be allowed to choose which health home they join, and be permitted to transfer health homes when/if they change providers.
- **If patient/consumers are automatically assigned to health homes, the State should take steps to ensure that assignment is appropriate.** Before any patient/consumers are assigned to health homes, the State should establish and implement a process of ensuring that patient/consumers are funneled to appropriate health homes, and that critical service relationships (e.g. relationships with case managers or long term behavioral health treatment by a non-participating provider) are not impaired. One criterion of appropriateness is having a physical location the patient/consumer can easily travel to. It is critical to confirm the current residence



- of patient/consumers before health home assignment, as many patient/consumer records, especially those of the seriously mentally ill, are out-of-date on this point.
- **The State should incentivize health homes to reach culturally diverse communities and measure performance in this domain.** As part of this incentive structure, the State should encourage the use of peer and family services.
- **Clearer timelines and paths for the implementation of health homes are needed.** A key part of this timeline should be a detailed explanation of how complete a health home must be in order to start operation. A process of technical assistance and consultation by potential health home providers should include the responsible BH agencies. If there are different levels of readiness, contingencies for readiness to commence operations are important.
- **Both the State and health homes should present consumers with user-friendly information.** The transition to health homes can be a complicated one. It is incumbent on both the State and health homes themselves to create user-friendly documents to distribute to consumers to educate them about the process and their rights, and the availability of personal advice/assistance to explain these rights. These documents should be written at a grade-school reading level.
- **Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.** The development of health homes will bring an expanded role for care managers and other sorts of health-industry employees.
- **The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.** The implementation of health homes should proceed in an expedited fashion with an eye towards mandate and regulatory relief.
- Children's issues related to Health Homes are still under discussion and will need to take child/family/insurance issues specific to children into account.



## **Report Appendices** **(following recommendations 1-12)**

- A. MRT Recommendation number 93
- B. Children, Youth, and Family Subgroup Documentation
- C. Peer Services
- D. Services for the Uninsured
- E. MRT Behavioral Health Subcommittee Meeting Agendas\*
- F. MRT Behavioral Health Subcommittee Meeting Minutes\*
- G. MRT Behavioral Health Subcommittee Meeting Presentations\*

**\*Appendices E-G can be accessed at the link below**

[http://www.health.state.ny.us/health\\_care/medicaid/redesign/behavioral\\_health\\_reform.htm](http://www.health.state.ny.us/health_care/medicaid/redesign/behavioral_health_reform.htm)



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 1

**Recommendation Short Name:** Create Risk-Bearing Managed Care Entities for High-Need Behavioral Health Populations

**Program Area:** Behavioral Health

**Implementation Complexity:** High

**Implementation Timeline:** Enrollment/Implementation by April 2013

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

**Proposal Description:**

- Develop managed care systems using risk-bearing Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), and/or Behavioral Health Organizations (BHOs), consistent with MRT recommendation #93 and State statutes. In New York City, based on its population and its delivery system infrastructure, develop full-benefit SNPs or IDSs that cover the full range of mental health, substance use, and physical health benefits.
- Limit the number of managed care entities in a region in order to ensure accountability and access.

**Financial Impact:** short term - neutral; long term - savings

**Health Disparities Impact:** Disparities in behavioral health take multiple forms, including significantly higher mortality rates and rates of chronic diseases among those with serious mental illnesses and substance use disorders compared to the general population and differences in access to behavioral health care and in behavioral health outcomes between different racial/ethnic, socioeconomic, or other groups. In addition, the disability associated with having a behavioral health disorder often leads to poverty, housing instability, and other social disadvantages. Instituting a managed care system that focuses on accountability, measurement and monitoring, and outcomes will improve the overall health and recovery of these often vulnerable populations and promote equity among all New Yorkers affected by these disorders.





### Benefits of Recommendation:

- This proposal helps to achieve the MRT goal of ensuring that all Medicaid enrollees are in care management within 3 years
- It recognizes variation in health care infrastructure and population with behavioral health needs across all of New York's regions
- It promotes the integration of mental health, substance use, and physical health treatment and care management

### Concerns with Recommendation:

- Risk of transition disruptions for enrollees and providers
- Structure does not guarantee good outcomes – there are critical implementation decisions and challenges, many addressed in subsequent recommendations

### Impacted Stakeholders:

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral health and physical health providers



## **Medicaid Redesign Team**

### **Behavioral Health Reform Work Group**

# **Final Recommendations – October 15, 2011**

**Recommendation Number:** 2

**Recommendation Short Name:** Financing for Behavioral Health Managed Care Entities

**Program Area:** Behavioral Health

**Implementation Complexity:** High

**Implementation Timeline:** By April 2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input checked="" type="checkbox"/> State Plan Amendment	<input checked="" type="checkbox"/> Federal Waiver

#### **Proposal Description:**

- Base initial premium levels for managed care entities on prior service spending for all services and populations covered, including Health Home and Targeted Case Management services, with appropriate growth and other adjustments. For full-benefit SNPs and IDss, prior spending on physical and behavioral health care services should be included.
- Do not target savings for the first year of risk-based behavioral health managed care.
- Establish formal mechanisms, within and/or outside managed care entities, for reinvestment of resources into clinical and non-clinical services that can improve the outcomes, quality, and cost-effectiveness of care for people with serious mental illnesses and substance use disorders.
  - Focus reinvestment on high priority areas, including housing, employment services, peer services, family support, and health information technology.
- SNPs/BHOs/IDsSs will be given responsibility to pay for and separately track spending on inpatient care at State psychiatric hospitals, and to coordinate discharge planning. State psychiatric hospital resources that are freed through gradual facility downsizing should be reinvested into community-based services, with a modest amount taken as savings.
- If appropriate arrangements can be developed with CMS, Medicaid and Medicare benefits for dually eligible individuals will be integrated through the SNPs, BHOs, or IDss.
- Incorporate recommendations, into the 1115 waiver being developed by the State DOH, where appropriate.



- There must be transparency and tracking with respect to the portion of BHO/SNP/IDS premium or capitation and actual plan spending attributable to behavioral health services; also, savings in behavioral and physical health care attributable to improved care and care coordination of behavioral health populations should be tracked.
- Track non-Medicaid savings in State and local systems serving patients/consumers in behavioral health managed care and appropriately attribute savings to behavioral health care reform. These systems include criminal and juvenile justice; homeless services; child welfare; Special Education.

**Financial Impact:** Short term - neutral; Long Term - Substantial savings possible from care management

**Health Disparities Impact:** Reduce, see explanation on #1

#### **Benefits of Recommendation:**

- Reinvestment will help to strengthen the community-based system of care, which could improve quality and outcomes for patients/consumers while further reducing costly use of institutional care.
- Avoiding first-year savings targets for new managed care entities will help to support up front plan investment in cost-effective, evidence-based practices, services, and capacity. Eliminating a blanket “carve out” for State psychiatric hospitals aligns incentives with State and managed care entities to provide institutional care only when absolutely necessary.

#### **Concerns with Recommendation:**

- Savings will not be available in first year of implementation

Successful negotiations with CMS are critical to ensuring that the specialty behavioral health system can best serve dual eligibles.

#### **Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral health and physical health providers
- Taxpayers



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 3

**Recommendation Short Name:** Governance of Behavioral Health Managed Care Entities

**Program Area:** Behavioral Health

**Implementation Complexity:** Medium

**Implementation Timeline:** Implementation by April, 2013

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

### Proposal Description:

- OMH/OASAS will have contracting responsibility for BHO/SNP/IDS, coordinated with NYS DOH and in consultation with the counties/New York City (“City”). Managed care entities in New York City will be overseen jointly by the State and City behavioral health agencies, with close NYS DOH collaboration.
- OMH and OASAS will promulgate specific standards for behavioral health managed care network adequacy and set standards for contract performance and outcome/performance measurement.
- Require SNPs/BHOs/IDSs to participate in coordination activities with the relevant social and human services system, including the criminal and juvenile justice systems and children’s services systems.
- Require SNPs/BHOs/IDSs to coordinate with the local planning process as provided for in Article 41 of the Mental Hygiene Law and in the county/City behavioral health agencies’ ongoing oversight and monitoring activities around access to mental health, substance use, and social services in the region.
- Tailor the operations of behavioral SNPs/BHOs/IDSs to local health care delivery infrastructure and populations.
- Reinvestments from system savings to support community-based care and treatment based on county/City planning processes and include input from consumers, managed care entities, providers, and other stakeholders, with approval by the State.



- The BH Reform Work Group will continue to deliberate and provide guidance and recommendations as budget projections, 1115 waiver applications, and regulatory efforts are developed to implement these recommendations.

**Financial Impact:** Neutral

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:**

- Agencies with the greatest expertise in special needs of individuals with serious mental illnesses and substance use disorders must have a lead role in regulating managed care entities serving those populations.
- Local behavioral health agencies/LGUs must play key roles and ensure coordination with other systems serving this population; system reinvestments from savings should be aligned with local planning activities.
- This recommendation sets up a functional and necessary partnership between government agencies with different capacities to oversee specialty managed care plans.

**Concerns with Recommendation:**

- Functional partnership among agencies requires good communication and commitment to coordinating activities

**Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Local governments
- Managed care entities
- Behavioral health and physical health providers



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 4

**Recommendation Short Name:** Eligibility for Behavioral Health Managed Care Entities

**Program Area:** Behavioral Health

**Implementation Complexity:** High

**Implementation Timeline:** Enrollment /Implementation by April, 2013

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

### Proposal Description:

- SSI status will not be the sole determining factor regarding eligibility of Medicaid recipients with behavioral health needs for specialty managed care. Rather, eligibility for BHO/SNP/IDS enrollment will be based on clinical status and/or utilization. A mechanism should be established to ensure that disengaged individuals (i.e., those without a history of high utilization) can also be enrolled in SNPs/IDSs and/or served by BHOs.
  - Clinical status includes the presence of either a mental illness or substance use disorder and a level of illness severity and/or functional impairment
- Enroll Medicare/Medicaid dual eligibles in SNP/BHO/IDS arrangements, assuming a favorable arrangement can be established with CMS.

**Financial Impact:** Substantial long-term savings possible

**Health Disparities Impact:** Reduce, see explanation in #1.

### Benefits of Recommendation:

- Eliminate distinctions based on Medicaid “eligibility pathway” (e.g., SSI vs. non-SSI Medicaid enrollee), which has little bearing on care management needs of Medicaid enrollees.

Given the high percentage of individuals with behavioral health disabilities who are dually eligible for Medicaid and Medicare, many high need individuals will be excluded from the benefits of specialty care management if dual eligibles are not included in the SNP/BHO/IDS system.



**Concerns with Recommendation:**

- Implementation complexity

**Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities – both mainstream and specialty plans



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 5

**Recommendation Short Name:** Behavioral Health Managed Care Contract Requirements

**Program Area:** Behavioral Health

**Implementation Complexity:** High

**Implementation Timeline:** Implementation by April, 2013

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

### Proposal Description:

These requirements should apply to all types of behavioral health managed care entities:

- BHOs/SNPs/IDs offer comprehensive behavioral health benefits and full-benefit SNPs also offer comprehensive physical health and pharmacy benefits.
  - Care coordination, care management, and other Health Home services will be fully integrated into SNPs and into BHOs for management and coordination of behavioral health services.
  - Non-clinical services, including peer services, are included in the behavioral health service package.
- Managed care entities will develop robust care coordination activities that include intensive data-driven strategies to identify high-need consumers (e.g., those disengaged from care; those at high risk of suicide; those with history of violence); policies and procedures to exchange information with and among clinical providers; and programs of direct, community-based engagement with consumers.
- Contract requirements must place special attention on points of transition – discharge from hospital or Emergency Department, from jail, prison, or shelter; and outreach to people disengaged from care.
- Managed care entities must have networks of providers that are appropriate to enrollee needs and existing provider relationships, and that foster plan/provider partnerships focused on highest quality and performance. Continuity of care, access to an appropriate array of providers, and opportunities for consumer choice in providers will be prioritized.





- Managed care entities will be required to use standardized assessment and level of care protocols that will be made available to all network providers.
- Managed care contracts must promote the use of best practices in behavioral health managed care and in management of electronic health information (e.g. PSYCKES for medication management and reduction of polypharmacy)
- Managed care contracts will establish appropriate Medical Loss Ratio minimums for overall spending and for spending on key services and service categories

**Financial Impact:** Long-term savings from appropriately managed high need populations

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:**

- Detailed contract requirements will facilitate effective implementation of specialty managed care and promote effective care management across plans and regions

**Concerns with Recommendation:**

- Costs associated with plan implementation of detailed requirements

**Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral and physical health care providers and peers



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 6

**Recommendation Short Name:** Improving Behavioral Health Care in Primary Care/Non-Specialty Settings

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate

**Implementation Timeline:** 2012

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

**Proposal Description:**

- OMH, OASAS, and DOH must review and revise clinic licensing requirements to allow for co-licensure, reduction of duplicative or contradictory requirements, and incentives to increase co-located behavioral health/physical health services.
- Evaluate mainstream Medicaid managed care plans on a more robust set of behavioral health performance measures as part of the Quality Incentive Program than are currently used. These measures will include clinical outcomes for depression and anxiety disorders; access to specialty services; and continuity of care. Plans will be required to measure, promote and incentivize routine depression screening and Screening Brief Intervention Referral and Treatment (SBIRT) for alcohol and substance abuse in primary care settings.
- Reinvest expected savings in the cost of psychiatric medications as patents expire while implementing collaborative behavioral health care in primary care settings.

**Financial Impact:** Neutral

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:**

- Implementation will facilitate increased use of collaborative care and earlier identification of depression and substance use disorders



**Concerns with Recommendation:**

- Implementation complexity

**Impacted Stakeholders:**

- Medicaid beneficiaries with mild/moderate mental illnesses and substance use disorders or those early in their course of illness.
- Managed care entities: mainstream plans
- Behavioral and physical health care providers



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 7

**Recommendation Short Name:** Promoting Health Information Technology and Information Exchange

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate

**Implementation Timeline:** Implementation/Enrollment April 2013

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

**Proposal Description:**

- Managed care entities will require and promote the participation of their contracted providers with the State Health Information Network of New York.
- Managed care entities will report all paid claims and encounter data to the State in a timely manner and according to statewide protocols. The State will share claims data in a timely manner with plans for any carved out services used by their membership.
- Managed care entities must adopt and promote comprehensive, consent-based data-sharing protocols and make claims/encounter data available to providers and the counties/City. Where there is statewide or national consensus on these protocols, plans will adopt those and not use proprietary methodologies.
- OMH, OASAS and DOH will develop statewide standard consent protocols and guidelines for use, including for electronic health information exchange. Managed care entities will be required to mandate the use of these protocols for providers.

**Financial Impact:** Some cost, funded through reinvestment

**Health Disparities Impact:** Reduce, see explanation in #1.



**Benefits of Recommendation:**

- Improves care coordination and reduce system fragmentation via information exchange
- Improves clinical care and promote best practices via meaningful use of electronic health records
- Standardizes protocols across plans and providers

**Concerns with Recommendation:**

- Statewide and federal standards and guidelines development is a complex and ongoing process

**Impacted Stakeholders:**

- State and local government
- Managed care entities
- Physical and behavioral health care providers
- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families



## **Medicaid Redesign Team**

### **Behavioral Health Reform Work Group**

# **Final Recommendations – October 15, 2011**

**Recommendation Number:** 8

**Recommendation Short Name:** Managed Care Performance Measurement/Evaluation

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate

**Implementation Timeline:** Enrollment/Implementation April 2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

**Proposal Description:**

- Hold managed care entities and their networks accountable for patient/consumer outcomes, as well as for providing and coordinating enrollees' health care.
- Include a performance-based payment incentive program that pays more for plans with higher performance outcomes in all forms of behavioral health managed care.
- Assess performance using validated measures across a variety of different domains – including access, network adequacy, adoption of best practices, patient/consumer satisfaction, compliance, efficiency, care coordination and continuity, coordination with social services and supports, and clinical and recovery outcomes.
- Track disparities in measures between racial/ethnic and other socio-demographic groups.
- Make performance measures and managed care entity performance transparent and available to the public.
- Require public reporting by plans - aggregated by the State - of Medicaid spending on behavioral health services over time, including before and after reform initiatives are implemented.



**Financial Impact:** Moving to a managed care structure is anticipated to result in the movement of funds from an overuse of inpatient care to expansion of community services. The movement of funds into community services will promote and sustain improved outcomes for those with behavioral health needs. Public monitoring of performance and outcome evaluation for individuals served by managed care plans will provide a level of transparency that ensures accountability not only for positive outcomes, but for promoting the continued reduction of costs.

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:** Moving to managed care is intended to improve outcomes and reduce costs. This recommendation provides a level of accountability to that process, tracking the outcomes for populations served by managed care entities. Without robust measurement and monitoring, performance toward the goal of moving to a better managed care system would be unknown.

**Concerns with Recommendation:** Poor performers will be identified via the publicity of performance and outcome data, which could lead to the necessity for action on the part of the State.

#### **Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families
- Managed care entities
- Behavioral and physical health care providers
- Taxpayers



## **Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011**

**Recommendation Number:** 9

**Recommendation Short Name:** Children, Youth, and Families

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate

**Implementation Timeline:** 2012

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:**

The children’s behavioral health system lacks capacity to best serve the needs of the State’s children and youth; community-based care should be targeted for planned investments and reinvestments. This need for investment must be taken into account when savings targets are being considered.

In sum: Behavioral Health services should promote wellness and healthy development and meet the secondary and/or tertiary mental health and/or substance use/addiction needs of children and their families.

The following identifies the building blocks that support a comprehensive operating framework:

- Children and their families should be looked at through a holistic lens that sees health, behavioral health and ability to function at home, in school and in the community as necessary capacities to be supported and enhanced for each child.
- Healthy development takes many paths and is dynamic. Accordingly, children’s unique individual, social, cultural, linguistic and learning needs must be fully assessed and integrated into all efforts to promote and restore healthy development.
- Peer and family support, self help and natural supports should be integrated with other behavioral health services to empower children and their families, offer choice in approach to care and reduce reliance on formal systems of care.





- All children must have access to effective behavioral health services where and when needed. Services should be responsive, timely and adaptable to complex and changing needs and evolving situations.
- Intervention should occur at the earliest possible juncture through screening and other methods of early identification. Health and behavioral health services should be provided through a perspective that is informed about childhood trauma, child and adolescent development, family life and is adept at identifying and providing effective services to this significant population.
- Outcomes of behavioral health services for children and their families should be clearly articulated, measured, reported and used to inform policy, services, reimbursement and practice quality.
  - Accountability mechanisms should focus on achieving specific child outcomes.
  - Accountability should occur at the BH provider level and occur across relevant child-serving systems. BH outcomes for children are often achieved by services that extend beyond the BH system.
  - Outcome data should be used to improve the quality of services and be linked to performance incentives. Outcomes measures should be reported at the child, provider, system and population levels.
- Efficiencies can be achieved by ensuring that services and case planning is integrated, coordinated and lead to outcomes that can be achieved both within the behavioral health system and other relevant systems.
- Current regulatory and process management requirements should be replaced by systems oriented around accountability for outcomes.
- Continuity of the child’s care and relationship with primary care and behavioral health providers should be maintained regardless of changes in health insurance coverage or managed care plan.
- Technology should be financed and harnessed to improve outcomes, communication (electronic health records) and access to specialty care (telemedicine).
- Financing mechanisms should incentivize clinical outcomes and coordinated case planning. Entities receiving behavioral health financing must exercise the highest degree of fiscal integrity, transparent reporting and quality practice to create a high-performing, high-quality system of care.



- Behavioral health services for children and families are significantly underfunded and not sufficiently available. Investments in early identification and effective interventions for children yield short and long term savings for government as well as improvement in the lives of children. Commitments should be made to return savings generated from Medicaid managed care arrangements associated with children for use in developing additional BH services, supports and clinical capacity in the community.
- Managed care arrangements must support providers across child-serving systems in maintaining compliance with statutory, court ordered and/or public obligations for child safety, public safety, access to appropriate education and primary and preventive health care.

(\*Children relates to infants, children, adolescents and young adults from birth to 21 years)

### Summary Listing of Recommendations:

1. General Behavioral Health Recommendation for Basic Behavioral Health Benefits for Children in Medicaid Managed Care, Child Health Plus, Family Health Plus or Commercial Insurance

The behavioral health benefit in mainstream managed care for children should include routine screening, including at well-child visits; crisis services available on a 24/7 basis; first level interventions available within 7 days; assessment using accepted tools/diagnostic methods and that serve as the basis for determinations of medical necessity.

2. Specific Recommendation for Specialty Behavioral Health Managed Care for SED/SUD or Categorically Eligible Children with Medicaid

The behavioral health specialty benefit should be comprehensive and include residential treatment, services currently available through home and community based waivers (HCBW and B2H), medication management; family support and guidance; cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school); recovery-oriented services.

Eligibility for specialty behavioral managed care should be based on a combination of clinical/functional status, i.e., DSM diagnosis of serious emotional disturbance or substance use disorder or the presence of complex symptoms and behaviors even in the absence of a formal diagnosis; and utilization of specialty services or risk of such utilization. In addition, because of their high risk for behavioral health problems, children with an individualized educational plan (IEP) or who are served in the child welfare or juvenile justice systems should have presumptive eligibility for enrollment in the specialty managed care program; for these children, the clinical and utilization thresholds should be lower than for the general child population and enrollment processes should be streamlined and facilitated.



3. Behavioral Health Outcomes to be Tracked, Reported and Incentivized for all Managed Care Plans

Outcome measures should be developed and applied to appraise performance and improve quality. Critical outcomes are:

- Improvement in psychiatric symptoms for which treatment is sought
- Improvement in functional status (e.g., social, school function)
- Consumer satisfaction/involvement
- Critical incidents
- Success/failure at transition to less intensive level of care
- Access to care
- Medication management
- Cross-systems communication/case planning
- Network adequacy

**Financial Impact:**

- Early identification and treatment will reduce emergency room visits, inpatient stays and costs associated with these services. School-based or school-linked services will reduce symptoms and behaviors that drive referrals to and placement in high-cost special education settings and/or out of home placement. Reinvest savings from reduced ER, inpatient length of stay and diverted special education placements and build out treatment and support services in the community.
- Incentives tied to performance outcomes
- Reduced emergency room visits and inappropriate hospital stays
- Controls on pharmacy spending

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:**

- A cross-system integrated, comprehensive system of care will diminish silo approaches to care, improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.



**Concerns with Recommendation:**

- Presupposes adequate resources and reasonable utilization of children’s services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.
- Behavioral health providers will need regulatory realignment and/or relief to achieve network access and performance outcome expectations.

**Impacted Stakeholders:**

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 10

**Recommendation Short Name:** Peer Services and Engagement

**Program Area:** Behavioral Health

**Implementation Complexity:** Low/Moderate

**Implementation Timeline:** Enrollment/Implementation April 2013

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

### Proposal Description:

- Peer services are incorporated into the new behavioral health specialty managed care system.
- To the extent possible, Medicaid funding will be sought for peer services through waivers, grants, and program funding.
- Advance and improve the peer workforce through funding for training and education, certification, and leadership development, as well as through the establishment of an accreditation process for peer-run agencies.
- Peer services will be incorporated into Health Homes

**Financial Impact:** Peer engagement is a proven cost-effective means of engaging individuals with behavioral health needs. Therefore, it is anticipated that this recommendation would in the very least result in long-term budget neutrality, if not produce savings, including potentially large savings.

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:** Peer engagement is recognized as a very effective means of engaging individuals with behavioral health needs. Individuals with experience in dealing with mental health and/or substance use issues are often best situated to related to and engage individuals currently dealing with behavioral health issues. This recommendation will help establish peer involvement in the new managed care structure and support it as it continues to grow.



**Concerns with Recommendation:** None

**Impacted Stakeholders:**

- Individuals with behavioral health needs and their families
- Managed care entities
- Providers of service
- Taxpayers



## Medicaid Redesign Team Behavioral Health Reform Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 11

**Recommendation Short Name:** Services for the Uninsured

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate

**Implementation Timeline:** Enrollment/Implementation April 2013

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

**Proposal Description:**

- Maintain a mechanism for funding an appropriate level of services to the uninsured and underinsured as the system moves into Medicaid managed care and previous funding streams (e.g. Disproportionate Share Hospital and Comprehensive Outpatient Program Services) are reduced or no longer available.
- The uninsured population with serious mental health or substance use disorders must be able to access care coordination services in the same way as the insured population does in order to prevent inappropriate use of high cost emergency services and/or cost-shifting to other systems.
- Promote the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) for the uninsured and underinsured with behavioral health issues.
- The State should promote benefit package designs in forthcoming health insurance exchanges that are appropriate for individuals with serious mental illness and substance use disorders.
- Enforce State and Federal mental health and substance use parity laws across all insurance programs to which the laws apply.

**Financial Impact:** Moving to a managed care structure is anticipated to result in savings, much of which must be re-invested into services that promote and sustain improved outcomes for those with behavioral health needs. Moderate re-investments in services for the uninsured will result in short-term costs that will quickly produce savings through improved health outcomes for this population who – one way or another – will receive health services at the expense of government, either in emergency rooms, State psychiatric centers and addiction treatment centers, prisons/jails, etc.



**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:** This recommendation addresses the needs of those individuals with behavioral health needs that are not, or are not yet, eligible to receive Medicaid. Without addressing this population, individuals with untreated/undertreated mental health and substance use disorders will continue to show up emergency rooms, state-operated psychiatric hospitals and addiction treatment centers, and become involved with the criminal justice system. Implementing this recommendation will provide the opportunity to engage individuals with appropriate behavioral health services before they show up in costly settings and assist with getting them enrolled with Medicaid. Without these measures, the flow of people with serious mental health and substance use disorders needing the most extensive and expensive care will continue in the front door of hospitals, inpatient settings, and into various other systems.

**Concerns with Recommendation:** Engaging and enrolling individuals without Medicaid is technically outside the scope of this work group, however, given the potential benefits outlined above, and the potential negative impact on the lives of uninsured individuals with behavioral health care needs and the health care delivery system that currently serves them, the group reached consensus that an attempt needs to be made to mitigate the impact on this group as the overall system redesign takes place.

**Impacted Stakeholders:**

- Uninsured New Yorkers with behavioral health care needs and their families
- Behavioral health care providers
- Taxpayers





## Medicaid Redesign Team Behavioral Health Work Group Final Recommendations – October 15, 2011

**Recommendation Number:** 12

**Recommendation Short Name:** Health Home Recommendations

**Program Area:** Behavioral Health

**Implementation Complexity:** High

**Implementation Timeline:** Through June 2012

**Required Approvals:**

<input type="checkbox"/>	Administrative Action	<input type="checkbox"/>	Statutory Change
<input checked="" type="checkbox"/>	State Plan Amendment	<input type="checkbox"/>	Federal Waiver

**Proposal Description:**

- Health Homes must include behavioral health expertise and leadership
- A transitional strategy must be in place to assure the smooth transition of behavioral health Health Home services and funding into the SNP/BHO/IDS systems that will be implemented in 2013.
- All Health Homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care.
- Health Homes must coordinate with non-health service providers – especially housing and employment service providers and county governments -- and have explicit relationships with local governments that often coordinate these services.
- Screening and Brief Intervention, Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.
- Health Homes should preserve patient/consumer choice to the extent possible, including being allowed to transfer Health Homes when/if they change providers.
- If patients/consumers are automatically assigned to Health Homes, the State should take steps to ensure that assignment is appropriate, by maintaining critical service relationships (e.g., relationships with case managers or long-term behavioral health treatment by non-participating providers) and ensuring that the physical location is easily accessed by the consumer.
- The State should incentivize Health Homes to reach culturally diverse communities and measure performance in this domain.



- Both the State and Health Homes should present consumers with user-friendly information to assist with a complicated transition.
- Health Home employees should be held to appropriate qualification standards, in which the standards of OMH and OASAS should be considered.
- Children should not be enrolled in Health Homes until special issues related to the children's system are considered by the Subcommittee and relayed to the Department of Health.

**Financial Impact:** With 90/10 Federal match, savings to the State for the first two years.

**Health Disparities Impact:** Reduce, see explanation in #1.

**Benefits of Recommendation:** Improved care coordination of health and behavioral health integration, reduced readmission rates and improved health outcomes.

**Concerns with Recommendation:** Implementation complexity.

**Impacted Stakeholders:**

- Medicaid beneficiaries with serious mental illnesses and substance use disorders and their families Managed care entities
- Behavioral health and physical health providers



## Appendix A

# Behavioral Health Organizations

One of the many MRT recommendations enacted into law is the creation of BHOs. When fully implemented, all currently unmanaged Medicaid behavioral health services will be managed through some combination of regional Special Needs Plans (SNPs), Integrated Delivery Systems (IDSs), or Behavioral Health Organizations (BHOs).

Implementation of the BHOs is divided into two phases with Commissioners of OMH and OASAS having the authority to determine readiness for Phase II (Chapter 59 of the laws of 2011, Part H Section 42.d). In Phase I, regional BHOs will perform the following functions:

- Monitor behavioral health inpatient length of stay;
- Reduce unnecessary behavioral health inpatient hospital days;
- Reduce behavioral health inpatient readmission rates;
- Improve rates of engagement in outpatient treatment post discharge;
- Improve understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED);
- Profile provider performance; and
- Test metrics of system performance.

In addition to reducing the incidence and length of unnecessary inpatient behavioral health care and increasing the rate of engagement in outpatient care, Phase I is designed to assist stakeholders in transitioning from the current unmanaged, fee-for-service environment to an environment in which the delivery and financing of behavioral health services is managed.

Implementation of Phase I is scheduled to begin on Nov. 1, with the BHOs fully operational by Jan. 1, 2012. Additional information is available at: <http://www.omh.state.ny.us/omhweb/rfp/2011/bho/>

For Phase II of BHOs, OMH, OASAS, and DOH will implement one or more risk bearing care management options. These include:

- Special Needs Plans (SNPs). These are specialty managed care networks that manage physical and behavioral health services for a defined behavioral health population;
- Integrated Delivery Systems (IDS). These are provider operated risk bearing entities that take on financial risk and manage the physical and behavioral health services for a defined behavioral health population;
- Carve-out BHOs. These are risk bearing managed care entities with a specialization in behavioral health. They only manage behavioral health services.
- The mechanism for care management may be different in different regions of the State, but payment will be risk-based for all of them. In New York City, full-benefit SNPs or IDSs should be implemented by April 1, 2013.



## Appendix B1 Medicaid Redesign Team Children's BHO Work Group Final Recommendations – October 15, 2011

### Recommendation Number: 1

**Recommendation Short Name:** Basic behavioral health benefits for children in Medicaid Managed Care, Child Health Plus, Family Health Plus or Commercial Insurance Plans

**Program Area:** Behavioral Health

**Implementation Complexity:** Moderate. Align scope of services and amend contracts to provide consistent BH coverage, benefits and access across plans

**Implementation Timeline:**

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:**

The following core behavioral health standards for children should be met by all public and private health insurance plans.

**Access: Early identification and intervention with children reduces long term disability and cost burden.**

Networks must be adequate to ensure access to care within the following parameters: Crisis services are available 24/7, preventive and screening must be available at well child visits and behavioral health first-level intervention and consultation within seven days. Geographic network adequacy should be measured by access within 30 miles or 30 minutes. Access to service should include flexible, non-traditional hours as well as office based, mobile, school-based/school-linked and home visitation approaches.

**Medical Necessity: Medical necessity is an important tool to ensure that the right service is provided at the right time in the right amount.**

Medical necessity determination criteria should be clearly stated in operational terms. The determination of medical necessity should be based upon an individualized clinical assessment of service or therapeutic need using accepted tools and/or diagnostic methods within the context of availability of services and capacity of the child's primary caregiver.



Court ordered behavioral health services and those needed to ensure the safety of children in the child welfare and juvenile justice systems should not be subject to medical necessity determination.

**Basic Behavioral Health Benefit:**

- Routine behavioral health and developmental screening, early detection and assessment
- Screen, Brief Intervention and Referral for Treatment (SBIRT for Substance Use Disorders)
- Behavioral Intervention
- Outpatient Treatment (i.e. Clinic)
- Day Rehabilitation
- Inpatient Treatment
- Crisis Intervention
- Peer Support (Youth and Family)
- Toxicology Screening
- Residential Rehabilitation
- Detoxification Services
- Primary Care Coordination
- Services to collaterals directly involved in the care of the child (parents/caregivers, teachers, etc)
- Pre-School and school age school-based or school-linked services
- Psycho-education, anticipatory guidance, behavior management

**Provider Network:**

Individual practitioners providing care should be credentialed and/or licensed in New York State (exception for Youth Peer Support) and should be screened prior to employment in compliance with current Federal and State requirements regarding safety assessments for those working with children. Priority should be given to practitioners who demonstrate cultural competence and aptitude in engaging children and their families. Provider networks should include a mix of trained and experienced primary care practitioners as well as behavioral health specialists.

**Reimbursement/Fiscal:**

A risk-adjusted rate structure with rates based upon acuity and regional variation.  
Reinvestment of savings

**Outcomes:**

The primary way in which accountability will be determined is accountability for meeting benchmarks for outcomes. Please refer to recommendation #3 for detailed information.



## Financial Impact:

Early identification and treatment will reduce emergency room visits, inpatient stays and costs associated with these services. School-based or school-linked services will reduce symptoms and behaviors that drive referrals to and placement in high-cost special education settings and/or out of home placement. Reinvest savings from reduced ER, inpatient length of stay and diverted special education placements and build out treatment and support services in the community.

## Benefits of Recommendation:

- Early identification and intervention with children reduces long term disability and cost burden for families and New York State.
- A cross systems integrated, comprehensive system of care will diminish silo approaches to care, improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

## Concerns with Recommendation:

- Presupposes adequate resources and reasonable utilization of children's services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.

## Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice



## Appendix B2

### Medicaid Redesign Team

### Children's BHO Work Group

## Final Recommendations – October 15, 2011

#### Recommendation Number: 2

**Recommendation Short Name:** Children with SED/SUD, Complex Symptoms and Behaviors Should Be Served in Specialty Behavioral Health Managed Care for Children with Medicaid.

#### Program Area: Behavioral Health

**Implementation Complexity:** Significant. Despite conversion challenges, gains in access and improved service availability, cross-system communication and case planning can result if BH outcomes are incentivized, additional resources invested and savings reinvested in the development of a managed system of care for SED/SUD children and their families.

#### Implementation Timeline:

**Required Approvals:**

<input type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

#### Proposal Description:

A specialty managed care program should be designed for children eligible for Medicaid who meet defined clinical criteria (DSM diagnosis of serious emotional disturbance or substance use disorder) or who display complex symptoms and behaviors AND meet a risk assessment threshold. Children meeting the clinical criteria above and who also have an individualized educational plan (IEP) or are served in the child welfare or juvenile justice systems would have presumptive eligibility.

**Access: Early identification and intervention with children reduces long term disability and cost burden.**

Networks must be adequate to ensure access to care within the following parameters: Crisis services available 24/7. Outpatient treatment access within 5 days and inpatient treatment within 24 hours. Geographic network adequacy should be measured by access within 30 miles or 30 minutes. Access to service

Should include flexible, non-traditional hours as well as office based, mobile, school-based/school-linked and home visitation approaches. Links must be made to pediatric primary care, child welfare, juvenile



and special education to facilitate referral, enrollment, and continuity of care, communication, case planning and coordination of care.

**Medical Necessity: Medical necessity is an important tool to ensure that the right service is provided at the right time in the right amount.**

Medical necessity determination criteria should be clearly stated in operational terms. The determination of medical necessity should be based upon an individualized clinical assessment of service or therapeutic need using accepted tools and/or diagnostic methods within the context of availability of services and capacity of the child's primary caregiver.

Court ordered behavioral health services and those needed to ensure the safety of children in the child welfare and juvenile justice systems should not be subject to medical necessity determination.

**Specialty Behavioral Health Benefit:**

- Behavioral Intervention
- Outpatient Treatment (Clinic, Day Treatment, Partial Hospital)
- Inpatient Treatment
- Crisis Intervention
- Peer Support (Youth and Family)
- Toxicology Screening
- Residential Treatment (MH and SUD)
- Detoxification Services
- Respite
- Transitional Care
- Care Coordination (ICM)
- HCBS Waivers (HCBW, B2H)
- Services to collaterals directly involved in the care of the child (parents/caregivers, teachers, etc)
- Pre-school and School age school-based or school-linked services
- Psycho-education
- Medication Management
- Family Support and guidance
- Cross-system communication and coordinated case planning (reports to Family Court, status updates to foster care agency, juvenile justice program and/or school)
- Primary care coordination
- Recovery-oriented services

**Provider Network:**

Individual practitioners and licensed providers should be credentialed and/or licensed in New York State (exception for Youth Peer Support) and should be screened prior to employment in compliance with current Federal and State requirements regarding safety assessments for those working with children. Priority should be given to practitioners who demonstrate cultural competence and aptitude





in engaging children and their families. Provider networks should include a mix of trained and experienced primary care practitioners coupled with access to behavioral health specialists.

### **Reimbursement/Fiscal:**

- A risk-adjusted rate structure with rates based upon acuity and regional variation.
- Stratified case payments for high/medium/low risk
- Incentivized rate structure to ensure that the child receives the right level of service
- Incentivize Outcomes
- Reinvestment of savings

### **Outcomes:**

The primary way in which accountability will be determined is accountability for meeting benchmarks for outcomes. Please refer to recommendation #3 for detailed information.

### **Financial Impact:**

- Reduced ER and inpatient stays

### **Benefits of Recommendation:**

- A cross-systems integrated, comprehensive system of care will diminish silo approaches to care improve continuity for children and families; resulting in decreased disability, reduce reliance on crisis oriented services and decrease costs.
- Consistency of care provision will enhance engagement and retention of children and families in lower levels of care system.
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

### **Concerns with Recommendation:**

- Presupposes adequate resources and reasonable utilization of children's services.
- Presupposes non-traditional relationships between BHO and other child-serving systems.
- Behavioral health providers will need regulatory realignment and/or relief to achieve network access and performance outcome expectations.

### **Impacted Stakeholders:**

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice



## Appendix B3

### Medicaid Redesign Team

### Children's BHO Work Group

## Final Recommendations – October 15, 2011

#### Recommendation Number: 3

**Recommendation Short Name:** Behavioral Health Outcomes to be Used by All Plans and Payers

#### Program Area:

**Implementation Complexity:** Moderate. Align scope of work and requirements and amend contracts with all plans.

#### Implementation Timeline:

**Required Approvals:**

<input type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

#### Proposal Description:

Recommendations #1 and #2 place the locus of accountability for providers and managed care entities on the achievement of benchmarks related to outcomes. This recommendation details how outcomes may be used to achieve accountability. It is beyond the scope of our work to recommend specific measures or instruments. Rather, these recommendations relate to the requirement that a small number of key outcomes be used to anchor quality in both regular and specialty care; and defined processes are established to measure and use outcomes to appraise performance and improve quality. Overall outcomes should be specific and relevant to children. Nine recommended outcomes are listed in table one. Table one also provides examples of ways the outcomes can be measured and used. The following four principles were used in selecting the nine outcomes. The selected outcomes must be:

1. Meaningful: they are indicators that capture what we are trying to achieve through BH interventions including: symptom reduction, risk reduction, improved functioning and well-being
2. Easy to measure: they are indicators that will be used universally by all plans and must not be too burdensome to implement



3. Validated and readily available: they are indicators that are based on established measurement tools with established validity, reliability and are available in the public domain (don't require purchase)
4. Easy to use: they are indicators that can be used relatively easily to improve quality.

<b>OUTCOMES: Regular and Specialty Behavioral Health Managed Care for Children with Medicaid</b>		
<b>Outcome</b>	<b>Examples of Measure</b>	<b>Example of Process</b>
Improvement in psychiatric symptoms for which treatment is sought	Select measure depending on primary psychiatric diagnosis	Require baseline and reassess every X months and specify improvement goal (e.g. 20% improvement in symptoms within 1 year of treatment). Inpatient and residential standards need to be adjusted accordingly.
Improvement in functional status (e.g. social, school function)	Global Assessment of Function (GAF), SDQ, GAIN	Require baseline and reassess every X months and specify improvement goal (e.g. 20% improvement in function within 1 year of treatment). Inpatient and residential standards need to be adjusted accordingly.
Consumer Satisfaction/Involvement	Assessment of the degree to which family and child (when age appropriate) feel satisfied with treatment and involved in the process of treatment.	Assess every X months or at the end of treatment and specify improvement goal (ex. 75% satisfied and involved). Inpatient/residential assessment at discharge
Critical incidents	Define critical incident (e.g. suicidal or violent episode for which ER visit is required) and assess number of incidents within a period of time (e.g. 1 year)	Assess based on cohort of consumers/patients managed by a given agency.
Success/failure at transition to less intensive level of care	Mean length of time between discharge from one level of care (e.g. inpatient, residential, emergency) and child's return to that same level of care.	Assess based on cohort of consumers/patients managed by a given agency.



Access	Mean length of time between referral call and first visit. Mean length of time between discharge from one level of care (e.g. inpatient) and first visit at next level of care (e.g. outpatient).	Assess based on cohort of consumers/patients managed by a given agency.
Medication Management	Monitoring poly-pharmacy and interaction of medication for BH and medical conditions.	Deviations from standard practice are 'flagged' in OMH's <b>PSYKES</b> system. Cases in this system are sampled yearly at the provider level. Number of deviations per agency per year are flagged. Performance is appraised based on number of deviations
Cross Systems Communication/Case Planning	Proportion of children/families within a given agency who receive a required yearly family collaborative meeting with all relevant providers. HIPPA compliant reports and clinical updates submitted timely to Family Court, Child Welfare Agency, Juvenile Justice Program, and/or schools	All children in specialty care are required to have one provider meeting per year with the family to develop and monitor the treatment plan. Representation from each service agency that provide care for the child should be represented at this yearly meeting. The proportion of children/ families who receive such a required meeting will be the metric for this outcome.
Network Adequacy	30 minute/30 mile geographic access.	

All children's behavioral health plans should report on child specific outcomes measures in HEDIS or CAHPS. Measures related to Access, Network Adequacy and Cross-System Communication/Case Planning should be included.

**Financial Impact:**

- Incentives tied to performance outcomes
- Reduced emergency room visits and inappropriate hospital stays
- Controls on pharmacy spending



### Benefits of Recommendation:

- An outcome driven system of care will improve results for children and families. Most current outcome standards are focused on adult care.
- Clearly defined outcome measures will help establish provider performance standards
- Outcomes and using outcome information to improve services will establish a formal Quality Improvement system.
- Improved functioning in children.

### Concerns with Recommendation:

- Contracts to be written to ensure measurement of the standards.
- Standards need to be flexible enough to accommodate changes in care, information technology, etc.

### Impacted Stakeholders:

- Children and Families
- Medicaid Managed Care Providers
- Behavioral Health Providers
- Child Welfare
- Juvenile Justice



## Appendix C

**Introduction** The Medicaid Redesign Team (MRT) Peer project #1058, merges suggestions received through the MRT process regarding peer support services as a cost effective, successful way to assist in the recovery wellness process. This MRT project committee's charge is to submit a report with recommendations for maximizing the use of peers in a redesigned health care system that is more efficient, effective and person-centered.

Public suggestions to the MRT on this topic included: comprehensive care coordination teams that recognize individualized needs, including peer supports that target independent living skills; peer-run respite as diversion from hospitalization; peer-run recovery centers; peer services in Behavioral Health Homes, Patient Centered Medical Homes, and Health Homes; regionally managed behavioral health care carve outs to preserve peer services and the integrity of peer agencies; State (Department of Health) certification for peer support specialists, support and recovery coaches, to facilitate Medicaid reimbursement; Medicaid funding for peer services; and NOT having direct Medicaid reimbursement per service but paying peer-run organizations for providing appropriate, needed supports; opposition to managed care plans (HMOs) handling special needs of people with mental health disabilities.

To carry out its charge Department of Health (DOH) staff held four meetings, and had significant correspondence with representatives of the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), Office for People with Developmental Disabilities (OPWDD), DOH Long Term Care (LTC), DOH Chronic Illness Demonstration Projects, and 16 other stakeholders, including several who had provided input to the MRT process (Attachment 1), and conducted a survey of forty-six stakeholder organizations from across the state (Attachment 2) and had input from an OMH Regional Advisory meeting of approximately 400 individuals. Participants represent the interests of persons with mental health, substance use, developmental and intellectual delays, multiple disabilities, chronic and/or severe physical disabilities, and the parents/families of children with any of these conditions. The purpose was to learn more about how peers are currently providing various services throughout New York State (NYS), and to discuss how they might be included to further the Medicaid Reform initiative.

This Report summarizes the input DOH received from peer agencies including the scope of peer support services currently operating throughout NYS, concerns and recommendations of representatives from several populations utilizing peer support services, and suggestions about how peer services could be further utilized in the Medicaid Redesign of NYS's health care system.

**Peer Supports are Unique** Peer support programs have grown out of the Independent Living Movement, the emergence of self help groups, the movement of people with special needs out of institutions into the community, and ideas of consumer inclusion and of recovery. Peer support is a relationship system of giving and receiving help founded on principles of respect, shared responsibility and mutual agreement as to what is helpful.



The basis of peer support differs from the traditional medical model. Introducing and incorporating peer services into health homes or other medical models changes the focus to the well being of the whole individual and can provide necessary connections to community supports. Shifting from a Medical Model to a Recovery Model changes the provider focus from tasks of stabilization and custodial care based on staff wisdom to education and involvement in an environment conducive to recovery based on consumer wisdom, increased self-advocacy and taking responsibility for one's own recovery.

Peer support also differs from case management in that case management primarily should be a link and brokerage service, to help the consumer locate and obtain services delineated in the service or treatment plan. Peer support models recovery and or wellness, and engages the individual as a co-equal with mutual responsibility, while case management is a relationship with a professional, someone at a different level. Because of the differences described here, many peer support organizations express concerns about having peers work in a medical environment, although they believe that their services are very appropriate and effective in promoting wellness.

Research Supports Theory Research is too broad to summarize here but is available in the Resources provided (Attachment 3). The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized peer supports as evidenced based, and research reviews indicate that the impact of peer supports is sufficiently rigorous and outcome based to consider peer support services as an evidence-based practice. Studies show symptom improvement, reduced hospitalization/shorter in-patient stays, improved daily functioning, self-esteem and illness management, all with associated cost benefits. Including families in care and treatment has shown to promote treatment adherence and psychiatric stability, and to reduce relapses and substance use. The impact of peer services is as effective as those of non-peers when peer-delivered services are the alternative to traditional mental health services. Peer-run respite as alternative to hospitalization shows a marked decrease in number of hospitalizations/length of inpatient stays, and increased recipient satisfaction.

### **Survey Results**

Forty-six peer stakeholder organizations from across the state completed a survey detailing the populations they serve, types of services provided, qualifications and training, documentation and supervision, settings, if and how the services are paid, and other concerns and best practices. Great variability in types of services, qualifications and sources of reimbursement/payment was reported. From stakeholder discussion subsequent to the survey, other differences between and within disability groups became apparent. Terminology is population-specific but the relational aspect of peer supports is key to all concerned. For example, "increased wellness and quality of life" may be more useful goals for some than "recovery". Whether as wellness or recovery, the peer model expands the health home ideal of linking individuals to community supports, beyond a psychiatric or medical condition to whole health well-being.

All the participant peer groups offered in-depth definitions of the special and unique characteristics of peer services as applicable to particular populations (Attachment 4). Funding sources and compensation range from donations, grants, state, county and local funding to Medicaid funded waiver services and from volunteers to salaried employees. NYS agencies have facilitated the following credentials for peer



workers within their own organizations: OMH initiated a civil service title of peer support specialist and trains peer specialists who work throughout the state; OMH's Division of Children and Families is working with Families Together of NY to achieve a family advocate credential; OASAS sponsors a Recovery Coach credential based on CCAR training; Long Term Home Health Care's Nursing Home Diversion /Transition waiver has a peer mentor waiver service.

Concerns expressed through the survey include that Medicaid funding may reduce services through capitation and managed care; governmental regulation may hamper ability to provide customized flexible services; peers may be ineffective when under oversight of traditional providers. Current challenges for provider agencies include limited funding, disparity from other providers in pay and in opportunities for growth and advancement, limited number of peers relative to demand, Medicaid documentation requirements as a disincentive, limited access to services due to lack of transportation, confidentiality issues when peers receive services in the same agency, and potential conflict of interest concerns if peers will have to go against their employer when advocating for a recipient. Stakeholders indicated barriers to recovery coaching that include lack of understanding of the peer role, lack of respect for peers by professional staff, and lack of certification for peers.

At present, most of the peer-run groups recommend and advocate for funding of peer services that is flexible and grant based (e.g. via state and local aid and Medicaid managed care contracts) to ensure fidelity to true peer support and self-directed recovery centered approaches. They support the concept of peer agency/program accreditation rather than peer practitioner credentialing which would more likely lead to placing peer staff in non-peer supported roles supervised by non-peer staff. The following suggestions were made as important to program administration: clearly defined role of peer, provider qualifications and/or certifications, service oversight responsibilities, payment mechanisms, state entity oversight of health homes with peer & family representation. Choice and careful matching of individuals with peers is very important; personal characteristics may mean that some people are better in certain peer roles than others. To avoid the drift toward traditional medical model structure a clear job description, standards, qualifications and expectations should be communicated prior to hiring. A culturally appropriate and sensitive approach allows more individuals to respond to peers. Peers should be independent of managed care, not trying to convince people to join a plan.

Services suggested that peer run programs could deliver to managed care programs include Wellness Recovery Action Planning (WRAP), advance directives, cultural and gender specific issues groups, alternative and holistic supports, self advocacy, a recovery- focused, trauma informed approach to services, hospital diversion/peer respite services, 24/7 peer support line. Further suggestions included implementing the CIDP model in the Forensic Hospitals and for people with mental illness in the Department of Corrections; using a transition or Bridger program for inpatient/forensic recipients coming into the health homes.





## **Peer Services in NYS**

### **Mental Health**

In 1994, the NYS Office of Mental Health created a Civil Service position of Peer Specialist, Grade 9, which currently has 48 filled positions. Approximately 2000 peer support specialists, trained under OMH auspices, are employed around the state in OMH facilities and in agencies that OMH supports. OMH utilizes Family Advocates of which there are 10 employed fulltime across the state. There are 400 trained advocates.

OMH recently has undertaken two initiatives to promote peer services: 1. the State's Medicaid Infrastructure Grant (MIG) "New York Makes Work Pay" (NYMWP), a statewide initiative to improve the rate of employment among people with disabilities, with a strategic planning goal to improve the use of peer-driven employment services; 2. a Transformation Transfer Initiative Grant to explore Recovery Centers which would be run by peers and provide supported education and employment.

New York has three peer-run crisis centers/respites which provide a cost-effective alternative to psychiatric hospitalization: Rose House Hospital Diversion Program operated by PEOPLE, INC.; Essex County Crisis Alternatives Program operated by the Mental Health Association; and Voices of the Heart, Inc. Respite Program. For 2010, the annual cost for Rose House to provide care for 227 guests, for 748 resident days was \$264,000 compared to \$1,047,200 based on the average cost in local hospitals. Parents with Psychiatric Disabilities (PWPD) need programming to support families for reunification or to stay intact as they often are reluctant to reach out for mental health services for fear of being under scrutiny that will result in losing custody of their children. Offering respite to allow these parents to get necessary help to stay out of hospitals and participate in treatment is cost effective and helps families stay intact.

### **Substance Use**

Primary peer services for people with substance use are provided by Recovery Coaches. OASAS reports nine paid trainers and 117 recovery coaches statewide who are trained through a self-directed program modeled on the Connecticut Center for Addiction and Recovery (CCAR) and paid by organizations that receive state funding. OASAS hopes to establish a NYS Recovery Coach Academy to ensure the integrity of the CCAR model, to develop standards and a code of conduct, and to maintain a database of recovery coaches and a statewide learning collaborative.

Recovery Community Centers (RCC) offer nonclinical specialty services such as linkages to clinical services, peer-led support groups, transportation support, training in parenting, nutrition and meal planning, financial management, facilitating education and career planning, resume writing and computer skills. OASAS recently awarded funding to three Recovery Community Centers which have served about 1000 people to date: Phoenix House of New York, Inc., Center for Community Alternatives in Rochester and Friends of Recovery of Delaware and Otsego Counties, Inc.



OASAS has a SAMSHA grant to implement the New York Supports Opportunities for Accessing Recovery Services (NY SOARS) initiative, a vouchering system for consumer- determined choices of faith based and community based recovery support services and/or enhanced opportunities for treatment services including Recovery Coaching. Recent revisions to Part 822 of 14NYSRR include changes to facilitate Ambulatory Patient Group (APG) Medicaid billing for peers to deliver Peer Support Services in clinics.

### Multiple Disabilities

At least a quarter of the individuals who have the greatest behavioral needs, often have both substance use and mental health issues, and are in both the OMH and OASAS system. Many people have a combination of disabilities that include physical impairment and chronic conditions. NYS agencies are working to help those with cross-system problems get the proper help they need but the current governmental structure is not organized to facilitate this.

Advocacy groups such as Centers for Independent Living (ILCs) address the multiple needs of individuals with multiple needs and several survey respondents were ILCs. The New York State Independent Living Council (NYSILC) is a not-for-profit, non-governmental, consumer controlled organization, with 37 independent living centers (community-based organizations) statewide, directed by and for people with disabilities. The council is composed of 27 appointees from around the state, a majority with disabilities, representing diverse cultures and needs. The council's state plan partners are New York State Education Department/Office of Vocational and Educational Services for Individuals with Disabilities (VESID) and the Office of Children and Family Services and Commission for the Blind and Visually Handicapped (CBVH).

### Intellectual/Developmental Disabilities

The Office for People with Developmental Disabilities (OPWDD) provides peer support through family support services for those families who have a child with a developmental and/or intellectual disability, most of whom are in the Home and Community Based Services waiver.

The Developmental Disabilities Planning Council (DDPC) includes a Consumer Caucus of peers who are involved throughout Council functions. DDPC sponsored *The Peer Mentoring and Supports in Employment*, a collaboration to implement peer-based support, mentoring and other consumer-led approaches that positively impact individuals' with disabilities ability to obtain, maintain and sustain employment. Individuals who successfully utilized the vocational rehabilitation system (e.g., VESID, CBVH, One Stops) were paired with individuals just entering the system or who had previously been unsuccessful in benefitting from vocational rehabilitation. Participating agencies developed new service opportunities through the VESID Unified Contract Services (UCS). In January 2009, twenty-five independent living centers established VESID UCS contracts totaling about \$1 million.

The Self-Advocacy Association of New York State, Inc. (SANYS) is a not-for profit, grassroots organization run by and for people with developmental disabilities with the goal to create a person-centered and person-directed system of supports. Through supporting self-advocates and self-advocacy groups regionally and statewide, SANYS is providing peer supports to its members.



## Chronic Conditions

Four of the six DOH Chronic Illness Demonstration Projects (CIDP) utilize peers as part of Interdisciplinary Care Teams composed of a registered nurse, social worker, care manager and peer support specialist (PSS). The PSS services include outreach and enrollment, health coaching, relapse prevention, reminding enrollees of appointments and escort services, assisting with links to needed services, assisting enrollees with building social skills, identifying recovery goals with enrollee, and participating in treatment meetings and case rounds. An example of cost savings for one individual in this project: the year prior to enrollment in CIDP \$52,282 was spent in Medicaid claims, and for the year in CIDP \$20,650 was paid in Medicaid claims.

DOH's Office of Long Term Care Nursing Home Transition Diversion Medicaid waiver utilizes Peer Mentoring as an individually designed service intended to improve the waiver participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community through education, teaching, instruction, information sharing, and self-advocacy training. Peer Mentoring is a short-term service only, to address specific goals for waiver participants (seniors and people with disabilities) who have recently transitioned into the community from a nursing home, or as needed during times of crisis.

## Serving Children and their Families in NYS

Children are best treated within the structure of their families who will continue to care for and support them. Best practices include programs that promote mental and physical wellness for the entire family, parents/caregivers and children. A special Children's Team for MRT Behavioral Health Reform is considering how best to address children's issues in the BHO model. To prevent the progression of children's mental health problems, intensive parenting skill building and supports, continuity of primary care provider, direct assistance and skill building in systems navigation, natural supports and resiliency, therapeutic mentoring and respite, could all be provided by peer support services.

The Medicaid waivers that currently provide peer support through a variety of family support services are Home and Community Based Services 1915(c) waivers for Children and Adolescents with Serious Emotional Disturbance (OMH SED); the Long Term Home Health Care Waiver for Medically Fragile Children; the HCBS Comprehensive Waiver for People with Developmental Disabilities (OPWDD); and the Bridges to Health Waivers for children in all three disability areas (SED, Developmentally Disabled, and Medically Fragile). Parent to Parent of NYS is a statewide organization staffed by parents or close relatives of individuals with disabilities, health care and/or behavioral needs, who provide support, information, referral and training to families of individuals with similar disabilities. Parent matching and systems navigation are important family to family peer services.



## **Other States - What have they done?**

To date, over 30 states have some form of peer support in place although not all are Medicaid reimbursable. The following are examples of peer support programs recommended by our participants as possible models.

Arizona – This state’s program is recommended as an exciting model because of its unique training and certification set-up and its extensive use of peers throughout its programs. Arizona is distinguished for promoting family roles in its children’s behavioral health system. The Arizona Community Services Agencies Waiver for peer and family services maximizes the ability of peer-run programs to offer creative services by not “certifying” workers, by using more than one curriculum, by not requiring a licensed clinician to sign off on everything done by peers and by offering a career ladder for peer supervisors and a specialized type of licensure, developed just for peer- and family-run programs. For Medicaid reimbursement, a service must be a measureable step toward stated goals. The Arizona Department of Health Services as the single state Medicaid agency contracts with BHOs. (Attachments 5 and 6)

Georgia was the first state to implement peer support as a Medicaid billable service under the Medicaid Rehabilitation option. The service is structured with scheduled activities that promote recovery, self-advocacy, development of natural supports and maintenance of community living. The Certified Peer Specialist (CPS) is under the direct supervision of a mental health professional, who is a psychiatric rehabilitation specialist credentialed by the US Psychiatric Rehabilitation Association and who is also a CPS. CMS approved Peer Supports Services directed to specific individualized service plan (ISP) goals, supervised by Mental Health Professional, provided in a clinic or the community. Georgia has also used a CMS Real Choices Grant to develop a position of peer supports to help people with disabilities learn to advocate for themselves through a “train the trainer” program. This program focuses on skills such as listening and communicating, understanding self-directed care, connecting to community services, developing relationships, knowing when to refer or dealing with a crisis and employment issues.

Minnesota uses Community Health Workers (CHWs) 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.

Pennsylvania In February, 2007 CMS approved Pennsylvania’s State Plan Amendment to include Peer Support Services in rehabilitation services for behavioral health. Efforts are underway to expand these



services to seniors, transitional youth and forensics. This state's program is similar to, and perhaps based on Arizona's and has been recommended by some stake holders as outcome based.

Rhode Island. The Pediatric Practice Enhancement Project (PPEP), one of the most successful and innovative programs nationwide, is a medical home initiative that seeks to increase the capacity and quality of care for children with special health care needs through the use of Family Resource Specialists in pediatric primary and specialty care practices. These Family Resource Specialists are true "peers" to parents raising children with disabilities and special health care needs—they are all family members in similar situations themselves. Family Resource Specialists work in medical practices for 20 hours per week, five of which are paid for by the physician practice. They save staff time and provide patient families with support and information and the medical staff with help in understanding the family's questions and perspective. Data from 2004-7 show 38% lower average inpatient utilization for PPEP participants, and 15% lower annual healthcare costs than for non-PPEP participating families, and high satisfaction ratings from PPEP participants.

### **Federal Involvement and Funding**

The CMS State Medicaid Directors' letter dated August 15, 2007 supplied guidance to states interested in providing peer support services under Medicaid in the mental health field. With the emphasis on recovery, "a process in which people are able to live, work, learn and participate fully in their communities", peer support services are considered an evidenced-based mental health model of care for mental illness and substance use in which peer support services are part of a comprehensive service delivery system.

To qualify for federal Medicaid funding and receive Federal Medical Assistance Percentage (FMAP), states must provide a core set of services to all eligible persons under the State Plan. An option allows for providing additional services and supports using the rehabilitation services option under the State Plan 42 CFR 440.130(d) and under the 1115 and 1915 waiver authority. Section 1915(b) (3) allows states to use cost savings from a Freedom of Choice Waiver to provide additional services. In 2010, CMS amended the section 1915(i) waiver benefits allowing states to provide "other services" as permitted under the 1915(c) waiver.

The Medicaid Rehabilitation Option is designed for mental health and substance abuse services and has been used by states adopting a recovery model for their state-funded programs, so that consumer-driven values for recovery can be integrated into all mental health services. Section 1905(a) (13) allows states to provide rehabilitative service in the Medicaid State Plan. Additionally, states can use CMS's Real Choice Systems Grants for Community Living to increase opportunities for people with disabilities living in the community.

**Pillars of Peer Support** (a joint initiative by SAMHSA, Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), OptumHealth, Carter Center, Wichita State University, Appalachian Consulting Group, Georgia Mental Health Consumer Network) was designed to develop and foster the use of Medicaid funding for peer support services in mental health settings. Two summit conferences were held. The



first, in 2009, included those states currently providing formal training and certification for peer providers in mental health systems to identify the state support necessary for a strong workforce. Nationally recognized experts and stakeholders identified twenty-five “pillars” as strengths for a peer specialist certification program. Seventeen states surveyed indicated that they had a distinct certified peer support service that was Medicaid billable. Fifteen of the 17 indicated that they had certification processes. The most common barriers to implementing peer services were: acceptance of peers in mental health centers, financial issues, and understanding of the Certified Peer Service (CPS) role. (Attachment 7 includes the 8/15/07 CMS letter to state Medicaid Directors.)

The second Pillars summit in 2010 gathered several states not currently billing Medicaid for peer support services to identify opportunities and assistance to begin the process. Reported results of a survey on states’ use of peer supports listed some concerns also expressed by our MRT participants: need to recognize the uniqueness of peer support providers, system co-option of peers addressed by adequate training and job description, and incorporating peers into routine operations. Supervisor training is essential and must include focus on recovery. The supervisor should also be a peer, who has had the same training as those being supervised. Half of the 22 responding states indicated that their Medicaid reimbursement was embedded in payment to another entity, e.g. MCOs, behavioral health carve out vendors. Five states (23%) received Medicaid payment for peer services as a distinct service.

The SAMHSA Evidence Based Practices publication “Building Your Program” lists the following funding sources that have been or are being used for consumer-operated services: Federal Mental Health Block grants; other community federal sources such as SAMHSA, National Institute of Disability and Rehabilitation Research (NIDRR), Departments of Veterans Affairs (VA) and of Housing and Urban renewal (HUD); state or county general funds; other state funds such as Vocational Rehabilitation; community reinvestment; Medicaid; grants from foundations; contracts with MCOs and BHOs.

**Certification, Accreditation, Assessment and Evaluation:** Evaluation can foster program improvement and add intrinsic value to services. As the value of peer supports gains recognition and acceptance, peer-run provider agencies seek association with delivery models such as health homes and behavioral health organizations, as well as continued funding for their own programs in the community. Lack of certification for individuals and accreditation for programs and agencies may disadvantage consumer operated support programs in competing for Medicaid and other funding. States, Medicaid and Medicare, and insurance companies who would reimburse provider agencies for peer services will have requirements for workers to be qualified or certified on a comprehensive set of workforce competencies.

Certification for the individual worker fosters a qualified, ethical, diverse workforce through a test-based certification and/or licensing process and enforcement of code of ethics. Some states run their own certification programs for peers, with accepted curriculum and other criteria. Peer-run organizations need valid, reliable skill assessment tools, training protocols and management information systems to measure outcomes. They need to identify program functions and staff competencies and to develop appropriate information management systems. Fidelity is a systemic effort to identify critical operational components of programs that are key to producing desired outcomes. SAMHSA’s Multisite Study identified common elements in peer programs: program structure, program environment, belief systems, peer support, education and advocacy. The Fidelity Assessment Common Ingredients Tool



(FACIT) is an anchored scale based on the identification and definition of the common program ingredients above. The Peer Support Outcomes Protocol Project developed, validated and field-tested a peer outcomes protocol (POP) that measures the effectiveness of peer support services for persons with mental illness.

**Recommendations:** It is appropriate and cost effective to incorporate peer services into the Medicaid Redesign shift toward whole wellness by integrating physical and behavioral health with other necessary aspects of successful functioning in the community (housing, employment, education, etc.)

1. **Promote acknowledgement and respect for the unique contributions and value of Peers in delivering services that help people, promote wellness and decrease costs.** Peer support providers need the respect of others in their fields as well as the support of upper management wherever they work, and in the health care industry and in government. All boards, committees, advisory groups and planning activities for organizations or programs pertaining to peers and peer services must have meaningful and significant peer representation.
2. **Facilitate ways to accommodate Medicaid funding for peer services, such as waivers, grants and funding for programs rather than for the position itself. Funding for training and education, certification, and leadership development would strengthen the peer workforce.** Currently in NYS peer services are delivered in many ways addressing different types of needs. This allows providers more flexibility than would be possible if a position were to be specifically defined in regulation.
3. **Establish an accreditation process for peer-run agencies which would professionalize their activities and require that supervision be provided by a trained peer to preserve the unique, whole health/wellness approach that peers provide.** A core evaluation would be appropriate for all peer-run organizations with additional modules for the specific populations. Model development must include consultation with and active participation of peers in the field.
4. **Incorporate peer services into health homes as a required element in health home applications, given the recognition that peer services are evidence-based practices which can improve outcomes while being cost effective.** Peer-run organizations are optimal for providing peer services and therefore, the model of a Health Home contracting with an outside peer support agency to provide services is the best model for integrating peer services and Health Homes. Any contract or RFP must identify how peer services will be incorporated into the Health Home. Peer support services should appropriately and effectively be extended into more situations, such as hospitals and nursing homes, to augment transitions to the community.
5. **Address children and their care separately.** Services appropriate for families and caregiver needs must be addressed by the same health care unit. Family peer support must be a required service of each Health Home. Best practices include programming that promotes mental and physical wellness for families, parents and children.



## Appendix D

### PROBLEM STATEMENT/PRINCIPLES REGARDING THE UNINSURED

#### ISSUE

As all Medicaid recipients of mental health and substance use services are moved into a managed care system of care in two years there could be serious unintended consequences for the uninsured seriously chronically mentally ill and substance abuse clients currently served in our system. The care provided to these high risk and vulnerable clients must continue to be available, especially the community treatment and support services which prevent avoidable hospitalizations and maintain clients safely in our communities. The current state of services for the uninsured, followed by principles and recommendations for future planning are presented for consideration.

#### CURRENT STATE

1) Clients are uninsured or underinsured for multiple reasons which increase the complexity of providing appropriate services to this population. The uninsured and underinsured include:

- Clients who are not eligible for Medicaid, Medicare or commercial insurance.
- Clients in transition who are eligible for Medicaid or Medicare services but are temporarily uninsured due to changes in financial status, failure to reapply, unaware that benefits are available. These clients can receive benefits once properly enrolled.
- Clients may have commercial insurance but have exhausted their mental health or substance use benefit and be unable to afford needed care.
- Clients may have high co-pays for insurance that prevents their access to care.
- Undocumented clients are uninsurable

2) Treatment and supportive services to uninsured clients are currently financed to be able to be seen in our system of care through a variety of ways that ensure they can access appropriate care. These include but are not limited to:

- Some state funded services such as TCM, ACT and some OMH and OASAS grant programs are deficit funded to cover some program costs related to serving the uninsured.
- Housing programs receive deficit funding for a percent of uninsured served.
- City and County tax levy fund services to the uninsured in addition to local tax levy paying the 20% local share of Medicaid.
- Prior funding through mechanisms such as COPS enabled agencies to have the flexibility to design their services to also include varying numbers of uninsured clients while remaining fiscally viable. (We are aware that this is being phased out for mental health as part of clinic restructuring.)





- Public sector city, state and county hospitals and agencies provide extensive community based services to the uninsured. For example, 13% of HHC's ambulatory mental health services for the seriously mentally ill and 14% of substance abuse services are for uninsured clients.
- DSH (Disproportionate Share) and UPL (Upper Payment Limit) dollars support hospital based services in safety net providers throughout New York State. These dollars will be significantly decreased as the Affordable Care Act is implemented.
- Current community based services to the uninsured help to decrease the costs to Medicaid for emergency room visits and emergency inpatient care and to localities for the cost in jail services.

## **PRINCIPLES**

- 1) As all behavioral Medicaid patients are moved into managed care, the needs of the uninsured that our system of care currently provides must continue to be addressed.
- 2) If appropriate services are not provided for this high risk vulnerable population there will be further cost shifting to other systems such as the criminal justice and juvenile justice systems and increased expenditures in the inpatient and emergency room services, inflating emergency Medicaid costs.
- 3) All children need to have appropriate mental health and substance use services in the benefits provided by their insurers.

## **RECOMMENDATIONS**

- 1) A mechanism for funding the appropriate current level of services to the uninsured and underinsured needs to be maintained as the system moves into managed Medicaid for all clients with mental health and substance use disorders as previous funding streams are no longer available.
- 2) The uninsured population that accesses services in the same way as insured clients needs to be managed and have access to care coordination services in order to prevent inappropriate use of high cost emergency services, and cost shifting to other systems that is a wasteful and inappropriate use of resources.
- 3) For the uninsured and underinsured, increasing the ability to buy into Medicaid and the design of the proposed insurance exchanges need to address the complex issues for seriously chronically ill adult and child clients in need of behavioral health and substance abuse services.
- 4) For the underinsured, parity as required by state and federal law needs to be enforced in all insurance programs including commercial programs subject to the parity laws.



**PARTICIPANTS:**

Andrea Cohen, Director of Health Services, Office of the Mayor

Lauri Cole, Executive Director, NYS Council for Community Behavioral Healthcare

Philip Endress, Commissioner, Erie County Department of Mental Health

Kelly Hansen, Executive Director, NYS Conference of Local Mental Hygiene Directors

Adam Karpati, MD, MPH, Executive Deputy Commissioner, NYS DOHMH

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**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Managed Long Term Care Implementation  
and Waiver Redesign Work Group

**FINAL RECOMMENDATIONS**



## Medicaid Redesign Team

### Managed Long Term Care Implementation and Waiver Redesign Work Group

### Final Recommendations – October 28, 2011

#### WORK GROUP CHARGE:

- Advise DOH on the development of care coordination models (which may include Long Term Home Health Care Programs) to be used in the mandatory enrollment of persons in need of community-based long term care services.
- Review processes to ensure that sufficient patient protections exist. Promulgate guidelines for network development and contractual arrangements which are sufficient to ensure the availability, accessibility and continuity of services.
- Discuss ways to promote access to services and supports in homes and communities, so individuals may avoid nursing home placement and hospital stays.

#### WORK GROUP MEMBERSHIP:

The members of the Managed Long Term Care Implementation and Waiver Redesign Work Group were selected by co-chairs and MRT members Eli Feldman and Carol Raphael.

- **Co-chair: Eli Feldman**, President & CEO, Metropolitan Jewish Health System and Chairman, Continuing Care Leadership Coalition
- **Co-chair: Carol Raphael**, President & CEO, Visiting Nurse Service of New York
- **Michael Birnbaum**, Vice President, United Hospital Fund
- **Courtney Burke**, Commissioner, Office of People with Developmental Disabilities
- **Jo-Ann A. Costantino**, Chief Executive Officer, The Eddy
- **Doug Goggin-Callahan**, NYS Policy Director, Medicare Rights Center
- **George Gresham**, President, 1199-SEIU
- **Mary Harper**, Executive Deputy Commissioner, Medical Insurance & Community Services Administration, New York City Human Resources Administration
- **Joseph M. Healy, Jr. PhD**, Chief Executive Officer, Comprehensive Care Management Corp.
- **Tom Holt**, President & CEO, Lutheran Social Services
- **Mark Lane**, President & CEO, New York State Catholic Health Plan, Inc., Fidelis Care New York

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- **David McNally**, New York Manager of Government Relations and Advocacy, AARP
- **Alan R. Morse, JD, PhD**, President & CEO, The Jewish Guild for the Blind, GuildNet, Inc.
- **Betty Mullin-DiProsa**, President & CEO, St. Ann's Community
- **Carol Rodat**, New York Policy Director, PHI
- **M. Kate Rolf**, President and CEO, VNA of Syracuse
- **Marilyn Saviola**, Director of Advocacy, Independence Care System
- **Melanie Shaw, JD**, Executive Director, New York Association on Independent Living (NYAIL)
- **Kathleen Shure**, Senior Vice President, Managed Care & Insurance Expansion, Greater New York Hospital Association

## MEETING DATES AND FOCUS:

- **July 8, 2011** – The first meeting of the Work Group reviewed the charge and background material on the MRT recommendations; the status of the managed long term care program and certain 1915 (c) waivers. In addition, data was reviewed related to current expenditures and demographics on current participants in FFS and managed long term care. Jim Verdier from Mathematica Policy Research provided a presentation on Dual Initiatives in Other States. A comprehensive discussion was undertaken on the following questions so that care coordination model principles and guidelines can be created:
  - What long term care services should be included in the benefit package?
  - What requirements should there be for plans/models in regard to size, expertise, network, financial viability, etc.?
  - What should be the essential ingredients in care coordination?
  - Which approaches to care coordination and management would have the most beneficial impact on beneficiaries, service use and Medicaid expenditures?
  - How can we ensure consumer rights and protections?
  - How do we improve the care and outcomes of the target population?
  - How should monitoring of performance and outcomes be conducted?
  - What should payment model be to ensure clear accountability for good outcomes for a target population?
  - Is there any feasible accountability model that is not full risk that will enable full integration down the road?
  - What should the future be of current non-capitated care coordination models?
  - How can we best transition from current long term care system to new plans and models including incorporating consumer directed care?
  - How should we best approach the dual eligible population, i.e., to ensure integration and coordination?
  - How can we ensure needed capacity?
  - How do we accommodate regional variation?



- **August 16, 2011** – The members worked to review the initial Care Coordination Model (CCM) Principles that would be applied to the development of models of care. There were twelve principles discussed and each member had the opportunity to provide comments and recommend modifications to the principles. As a result, principles were modified and reissued to members for comment prior to being released to the public for review.
- The proposed CCM principles were the basis for the public hearing that took place on September 19, 2011 at the NYC College of Technology.
- **September 28, 2011** – The members received an update on MLTC applications; reports from the Fair Hearing and Quality Metrics Subcommittees; an overview of the testimony presented at the MLTC Public Hearing; a presentation of recommendations identified by the Program Streamlining and State/Local Responsibilities Work Group; presentations on consumer protections in mainstream Medicaid managed care plans and an overview of the 1115 waiver process. The Work Group then spent significant time to complete the CCM Principles. At the end of the meeting the Co-Chairs requested that a subgroup of members take the opportunity to revise the CCM Principles so that they can be finalized. As a result of the ongoing revisions the Work Group determined a need for another meeting beyond the October 20<sup>th</sup> deadline which is scheduled for October 27<sup>th</sup>. It is anticipated that final recommendations will be made on the CCM Principles so that DOH staff can complete guidelines by November 15, 2011.
- **October 27, 2011** – The members completed their review of the Care Coordination Principles and made revisions resulting in the adoption of the set of principles by majority vote. Two members abstained and one member voted no. Members also reviewed and revised the Quality and Fair Hearing Subcommittee reports. All members supported the inclusion of those sets of revised recommendations. In addition, the members identified consumer direction as an integral part of the Care Coordination Model Principles and Managed Long Term Care and therefore recommend establishment of a separate work group.

#### Outside Experts Consulted with:

Jim Verdier from Mathematica Policy Research provided a presentation on Dual Initiatives in Other States for the first Work Group meeting.

Two subcommittees were established that included the participation of individuals beyond the membership of the Work Group. The subcommittees covered two critical areas: Long Term Care Quality Metrics (meetings held on 9/13/11 and 10/20/11) and Fair Hearings (meeting held on 8/31/11).



## LONG TERM CARE QUALITY METRICS SUBCOMMITTEE

Work Group Participants and Interested Parties: Carol Raphael (Chair); Michael Birbaum; Kevin Finnegan; Joe Healy; Bryan Marcou-O'Malley; Marilyn Saviola; Helen Schaub; Melvyn Tanzman; Courtney Burke; Jo-Ann Costantino; Betty Mullin-DiProsa; Leah Farrell; David McNally; Mary Kate Rolf; Mary Ellen Connington; Kathryn Haslanger; and Andrew Segal, who served as Secretary of the meeting. DOH Staff: Mark Kissinger; Carla Williams; Linda Gowdy; and Patrick Roohan

**Subcommittee charge:** Identify measures that advance quality in a redesigned long-term care system. The Subcommittee considered the following:

- How to make measures relevant to consumers and capture consumer choice and preference.
- How to capture quality of life, which involves maintenance of function, prevention of decline, as well as improvement.
- Overview of the SAAM tool and consumer surveys of current managed long term care plans.
- Quality Measurement System that will be embedded in the health home application.
- Uniform Assessment System –NY (UAS-NY) which will be web-based and replace the SAAM for home and community based programs including managed long term care and care coordination models.
- Quality measures being considered by the National Quality Forum (NQF) Post-Acute/Long-Term Care Work Group. The NQF Work Group agreed after studying the field that the 4 priority areas of measurement in a long-term care system are:
  - Function (patient factors such as ADLs, IADLs, and stage of illness);
  - Goal Attainment (e.g. improvement, maintenance, palliation);
  - Care Coordination (dual eligible individuals in a long-term care system experience multiple settings of care and providers); and
  - Cost/Access (specifically addressing the issue of cost-shifting)

A substantial amount of time was also focused on the principles and criteria that should guide the development of quality measures and improvement systems. It was recommended that quality measures must be measurable, actionable, risk-adjusted, and consistent across sectors, and have an impact on care.



## FAIR HEARING SUBCOMMITTEE

**Work Group members and interested parties:** Eli S. Feldman, Valerie Bogard, Evelyn Frank, Mark Lane, Alan Morse, J.D., Ph.D., Chris Palmieri, Marilyn Saviola, Melanie Shaw, J.D., Meghan Shineman, Zeynep Sumer, Roxanne Tena-Nelson, Mark Ustin (representing James Lytle.) DOH staff: Mark L. Kissinger, Carla Williams, Linda Gowdy, Vallencia Lloyd, Jane McCluskey, James Deering, Dan Tarantino, Karen Meier. Office of Temporary Disability Assistance (OTDA): Maria Vidal, Hank Pedicone, Dan Bloodstein, Inez Haettenswiller and Dave Amiraian.

**Subcommittee charge:** Discuss how the fair hearing process intersects with and impacts on and MRT initiatives.

### ***The Subcommittee considered the following:***

- The decision in *Shakhnes v. Doar*, requiring final Administrative Law Judge (ALJ) rulings within 90 days for Medicaid-funded home care applicants and recipients, should – and so far has – improved the timeliness of decisions. OTDA noted that *Shakhnes* affects only a small class of recipients and has been appealed.
- Attention needs to be paid to voluntary enrollments as well as mandatory enrollment.
- Standardized process to ensure that people’s needs are met in the transition from the current fee-for-service system to mandatory managed long-term care.

### ***The Subcommittee discussed the following recommendations:***

- The MLTC Implementation & Waiver Redesign Work Group and the MRT, as a whole, should consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models. OTDA was asked for data related to the current number of ALJs and their current caseload. That data request is still outstanding.
- Providers should receive notice of fair hearings requested by their clients; plans should make clear to members who their plan is in order to facilitate this.
- Training for ALJs pertaining to state law, rules, and regulations pertaining to managed long term care and care coordination models should be evaluated and enhanced. Consumers and plans should have input to the training.
- Consumers requested the right to have a fair hearing resolved within 60 days of the request for the hearing. OTDA should be provided the resources if needed after an analysis of current work process to schedule hearings within 21 days of a request and to issue decisions within 60 days.
- Regulations should be amended to require documented receipt of written notice of fair hearings to MLTC/CCM administrators of record or legal counsel whose enrollees are exercising fair hearing rights.





***Other issues that were not agreed upon:***

- To expedite the Appeals and Fair Hearing Process, where there is disagreement over the initial proposed MLTC/CCM Plan of Care, either by the consumer or the MLTC/CCM, either should have the right to ask for an independent clinical assessment by an independent external organization. If the assessment conflicts with the proposed PoC, the MLTC/CCM has 5 days in which to agree with and/or propose an alternative PoC. If the consumer decides not to accept the result of the assessment and/or the PoC, s/he may file for a fair hearing within 5 days of reviewing the new PoC. Agreement could not be reached on the two assessments being presumptive evidence of the needed plan of care when reviewed by the ALJ.



## WORK GROUP SUMMARY OF RECOMMENDATIONS:

### **RECOMMENDATION 1: Preamble and Principles for Care Coordination Models**

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**Preamble:** These principles will inform guidelines for the development of Care Coordination Models (CCM). The resulting guidelines will allow for flexibility in model design while protecting the consumer. In addition a reasonable phase-in period for providers and consumers is necessary during implementation of the major changes advanced by the Medicaid Redesign Team.

Individuals who need long term care should have access to Medicaid enrollment and eligibility assistance. To assure consistency with other MRT activities, the Work Group supports the Program Streamlining and State/Local Responsibilities Work Group Recommendations related to Long Term Care and Enrollment.

#### **Principle #1**

***A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.***

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services. The CCM must meet financial solvency standards to assure protection of the members, such standards shall include a phase-in period.

The CCM will receive a periodic payment to cover the services in the benefit package to promote the appropriate, efficient and effective use of services for which it is responsible. Payment to the CCM will be based on the functional impairment level and acuity of its members. Risk factors could include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services. CCM rates shall be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration. Payments shall incentivize community-based services.



## Principle #2

***A CCM must include a person-centered care management function that is targeted to the needs of the enrolled population.***

Every enrolled CCM member must have a care manager or care management team that is responsible for person-centered assessment and reassessment, care plan development and implementation, care plan monitoring, service adjustment, safe discharge and transition planning, and problem solving. The CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. The needs and preferences of the member will guide the intensity and frequency of the care management, encompassing both high-touch and low-touch care management.

## Principle #3

***A CCM must be involved in care coordination of other services for which it is not at risk.***

Transition to fully integrated models of care which include all Medicare and Medicaid services is the goal of NYS over the next three to five years. As an interim approach, the CCM will coordinate care with primary and acute care services and other services not in the CCM service package to promote continuity of care and improve outcomes.

## Principle #4

***The member and his/her informal supports must drive the development and execution of the care plan.***

Eliciting the goals and preferences of members and their informal supports must be a critical component of person-centered care plan development and is essential to promoting quality of life. All members and, where appropriate, a member's representative, shall be given the opportunity to participate in decisions about the type and quantity of service to be provided.



## Principle #5

***Care coordination is a core CCM function. For benefit package services, CCM members will have a choice of providers.***

A CCM must ensure that individualized care coordination is provided to all members, and have adequate capacity to do so. Within the CCM, members will be able to select among a choice of at least two providers (where available) of each benefit package service. CCMs shall have a network that takes into account the cultural and linguistic needs of the population to be enrolled.

There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.

## Principle #6

***A CCM will use a standardized assessment tool to drive care plan development.***

CCMs shall use the same standardized assessment tool as other long term care entities (the UAS-NY when available) to be used for initial assessments, scheduled reassessments and other reassessments resulting from a change in condition. The standardized assessment tool must be used to engage the member, the member's physician and informal supports to assure a complete review of member needs.

## Principle #7

***A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.***

Consistent with the federal Olmstead decision, CCM care planning shall provide benefit package services in the most integrated setting appropriate to the needs of members with disabilities, include the members in decision-making, address quality of life, and actively support member preferences and decisions in order to improve member satisfaction.



## Principle #8

***A CCM will be evaluated to determine the extent to which it has achieved anticipated goals and outcomes and to drive quality improvement and payment.***

CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. The Department will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on the Department's website.

## Principle #9

***Existing member rights and protections will be preserved.***

Members are entitled to the same rights and protections under CCM as they are under current law and practice, including the Federal and State Law or regulations governing MCOs. CCMs must follow clear criteria established by the Department for involuntary disenrollment and members must be informed about them and the attendant appeals and grievance rights.

## Principle #10

***A CCM with demonstrated expertise will be able to serve specified population(s).***

Some populations have unique needs that can be best addressed by an entity that is skilled in the assessment, care plan development, service networks and monitoring of that group or to address specific medical conditions or illnesses. A CCM shall develop and implement a model of care appropriate to the specific population and use its expertise to serve those members.

## Principle #11

***Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers and opportunity for appropriate transition of the existing service system in the county.***

The Department of Health shall review existing long term care programs and seek to remove barriers that may prevent contracting with a CCM.



## Principle #12

***Members shall have continuity of care as they transition from other programs.***

Consumers already receiving long term care services through another Medicaid program have the right to continue to receive the same type and amount of services until the CCM conducts a new assessment, authorizes a new plan of care and provides notice to the member including appeal rights.

## Principle #13

***Prospective members will receive sufficient objective information and counseling about their choices before enrolling.***

Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about options shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.



## RECOMMENDATION 2: Quality Measures

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1. The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported.
2. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care.
3. The quality measurement system should cover the following domains:
  - *Reduce inappropriate utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions;*
  - *Improve quality of life, emotional and behavioral status and preventive care and patient safety;*
  - *Improve care management;*
  - *Improve or stabilize functional status;*
  - *Ensure continuity of worker and care to fullest extent possible.*
4. The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by SDOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other work groups should be achieved.

## RECOMMENDATION 3: Fair Hearing

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1. Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.
2. Providers should receive notice of fair hearings requested by their clients.
3. Ongoing training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input and access to the training.
4. The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.
5. Regulations should be amended to require documented receipt of written notice of fair hearings to CCM administrators of record or legal counsel.

## RECOMMENDATION 4: Consumer Direction

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Establish a work group to advise the Department on the integration of self directed program models, including the consumer directed personal assistance program (CDPAP), into CCMs and Managed Long Term Care.



## Medicaid Redesign Team Managed Long Term Care Implementation and Waiver Redesign Work Group Final Recommendations – October 28, 2011

**Recommendation Number:** 1

**Recommendation Short Name:** Care Coordination Principles

**Program Area:** Long Term Care

**Implementation Complexity:** High

**Implementation Timeline:** Short-Term

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

**Proposal Description:** Preamble and Principles for Care Coordination Models

**Preamble:** These principles will inform guidelines for the development of Care Coordination Models (CCM). The resulting guidelines will allow for flexibility in model design while protecting the consumer. In addition a reasonable phase-in period for providers and consumers is necessary during implementation of the major changes advanced by the Medicaid Redesign Team.

Individuals who need long term care should have access to Medicaid enrollment and eligibility assistance. To assure consistency with other MRT activities, the Work Group supports the Program Streamlining and State/Local Responsibilities Work Group Recommendations related to Long Term Care and Enrollment.





## Principle #1

***A CCM must provide or contract for all Medicaid long term care services in the benefit package. CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served.***

The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services. The CCM must meet financial solvency standards to assure protection of the members, such standards shall include a phase-in period.

The CCM will receive a periodic payment to cover the services in the benefit package to promote the appropriate, efficient and effective use of services for which it is responsible. Payment to the CCM will be based on the functional impairment level and acuity of its members. Risk factors could include functional status, cognitive status, diagnoses, demographics or other measures found to be correlated to increased cost of services. CCM rates shall be actuarially sound and sufficient to support provision of covered long term care services and care coordination and efficient administration. Payments shall incentivize community-based services.

## Principle #2

***A CCM must include a person-centered care management function that is targeted to the needs of the enrolled population.***

Every enrolled CCM member must have a care manager or care management team that is responsible for person-centered assessment and reassessment, care plan development and implementation, care plan monitoring, service adjustment, safe discharge and transition planning, and problem solving. The CCM must use Health Information Technology, as feasible, to document, execute and update the plan of care and share information among appropriate staff and providers. The care management function shall address the varying needs of the population. The needs and preferences of the member will guide the intensity and frequency of the care management, encompassing both high-touch and low-touch care management.



### Principle #3

***A CCM must be involved in care coordination of other services for which it is not at risk.***

Transition to fully integrated models of care which include all Medicare and Medicaid services is the goal of NYS over the next three to five years. As an interim approach, the CCM will coordinate care with primary and acute care services and other services not in the CCM service package to promote continuity of care and improve outcomes.

### Principle #4

***The member and his/her informal supports must drive the development and execution of the care plan.***

Eliciting the goals and preferences of members and their informal supports must be a critical component of person-centered care plan development and is essential to promoting quality of life. All members and, where appropriate, a member's representative, shall be given the opportunity to participate in decisions about the type and quantity of service to be provided.

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There are geographic differences in the availability of service providers and CCMs should not be prevented from operating when market forces (lack of availability or unwillingness to contract) preclude a CCM network from offering choice or, perhaps in some instances, a particular service. However, CCM's must have the ability to authorize services from an out-of-network provider if no provider is available in-network that can adequately meet the needs of the member.



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Consistent with the federal Olmstead decision, CCM care planning shall provide benefit package services in the most integrated setting appropriate to the needs of members with disabilities, include the members in decision-making, address quality of life, and actively support member preferences and decisions in order to improve member satisfaction.

## Principle #8

***A CCM will be evaluated to determine the extent to which it has achieved anticipated goals and outcomes and to drive quality improvement and payment.***

CCMs will submit data to the State, which will be made available publicly, to compare and evaluate entities on an ongoing basis, determine the success of individual CCMs, and create transparency about CCM service delivery. Data will include, but will not be limited to: financial cost reports, provider networks, consumer satisfaction, grievances and appeals, assessment data, care outcomes and encounter data, and disenrollment data (both voluntary and involuntary). The CCM will use its own data and information to develop and conduct quality improvement projects. The Department will track experience of CCMs in relation to quality and costs, and will publish this data annually in a consumer-friendly format on the Department's website.



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## Principle #11

### ***Mandatory enrollment into CCMs in any county will not begin until and unless there is adequate capacity and choice for consumers and opportunity for appropriate transition of the existing service system in the county.***

The Department of Health shall review existing long term care programs and seek to remove barriers that may prevent contracting with a CCM.

## Principle #12

### ***Members shall have continuity of care as they transition from other programs.***

Consumers already receiving long term care services through another Medicaid program have the right to continue to receive the same type and amount of services until the CCM conducts a new assessment, authorizes a new plan of care and provides notice to the member including appeal rights.



**Principle #13**

***Prospective members will receive sufficient objective information and counseling about their choices before enrolling.***

Prospective members shall be provided with appropriate materials educating them about their choices and shall have the opportunity to have questions answered before enrollment. Information about options shall be posted on a website that is accessible to prospective members and the public. This information shall also be included in a printed brochure listing all CCMs in their geographic service area, which shall be sent by the enrollment broker to all prospective members.

**Financial Impact:** None

**Health Disparities Impact:**

Expansion of care management models of all types is expected to reduce disparities.

**Benefits of Recommendation:**

Provides a framework from which required guidelines can be developed.

**Concerns with Recommendation:** Transition period and consumer choice.

**Impacted Stakeholders:** All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.



## Medicaid Redesign Team

### Managed Long Term Care Implementation and Waiver Redesign Work Group

### Final Recommendations – October 28, 2011

**Recommendation Number:** 2

**Recommendation Short Name:** Quality Measures

**Program Area:** Long Term Care

**Implementation Complexity:** High

**Implementation Timeline:** Short-Term

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

**Proposal Description:** Quality Measures

1. The goal should be to achieve improvement over time and to enable consumers and purchasers to compare CCM performance. This necessitates that the quality measures be transparent and publicly reported.
2. The criteria for determining measures should include that they be measurable, actionable, risk-adjusted, consistent across sectors, parsimonious, and have an impact on care.
3. The quality measurement system should cover the following domains:
  - *Reduce inappropriate utilization associated with nursing home admissions, emergency and urgent care and inpatient admissions.*
  - *Improve quality of life, emotional and behavioral status and preventive care and patient safety*
  - *Improve care management*
  - *Improve or stabilize functional status*
  - *Ensure continuity of worker and care to fullest extent possible*



4. The MRT Managed Long Term Care Quality Subcommittee should continue to convene to review progress made by SDOH in developing and implementing quality measurement system based on recommendations. Wherever possible, alignment with recommendations of MRT Payment Reform and other workgroups should be achieved.

**Financial Impact:** None

**Health Disparities Impact:**

Expansion of care management models of all types is expected to reduce disparities.

**Benefits of Recommendation:**

To measure and compare service delivery for consumers and payors.

**Concerns with Recommendation:**

Potential reporting burden and need for consistency with other initiatives.

**Impacted Stakeholders:**

All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.



## Medicaid Redesign Team Managed Long Term Care Implementation and Waiver Redesign Work Group Final Recommendations – October 28, 2011

**Recommendation Number:** 3

**Recommendation Short Name:** Fair Hearing

**Program Area:** Long Term Care

**Implementation Complexity:** High

**Implementation Timeline:** Short-Term

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

**Proposal Description:** Fair Hearing

1. Consider the possibility of a targeted increase in resources to handle the move to mandatory enrollment in managed long term care or other care coordination models.
2. Providers should receive notice of fair hearings requested by their clients.
3. Ongoing training for ALJs pertaining to state law, rules, and regulations should be evaluated. Consumers and plans should have input and access to the training.
4. The target timeframe for fair hearing resolution should be within 60 days of the request for the hearing.
5. Regulations should be amended to require documented receipt of written notice of fair hearings to CCM administrators of record or legal counsel.





**Financial Impact:** To be determined

**Health Disparities Impact:** Not applicable

**Benefits of Recommendation:**

Improved fair hearing process.

**Concerns with Recommendation:**

Some Work Group members felt the recommendations did not address all of the issues impacting consumers and providers.

**Impacted Stakeholders:**

All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry.



## Medicaid Redesign Team Managed Long Term Care Implementation and Waiver Redesign Work Group Final Recommendations – October 28, 2011

**Recommendation Number:** 4

**Recommendation Short Name:** Self Directed Work Group

**Program Area:** Long Term Care

**Implementation Complexity:** High

**Implementation Timeline:** Short-Term

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

**Proposal Description:** Consumer Direction

Establish a work group to advise the Department on the integration of self directed program models, including the consumer directed personal assistance program (CDPAP), into CCMs and Managed Long Term Care

**Financial Impact:** None

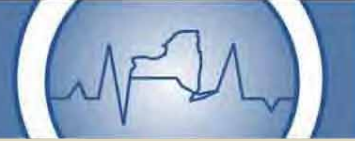
**Health Disparities Impact:** Not applicable

**Benefits of Recommendation:** Increased communication and improved policy making.

**Concerns with Recommendation:** This is to assure that the complexities of integrating self direction are addressed as CCM and MLTC are implemented.

**Impacted Stakeholders:** All Medicaid long term care consumers; MLTC; LTHHCP; home care industry, managed care industry

**Redesigning**  
THE MEDICAID PROGRAM

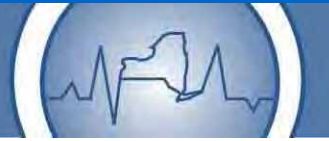


NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Health Disparities Work Group

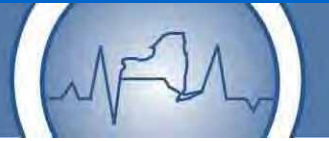
FINAL RECOMMENDATIONS



## **Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011**

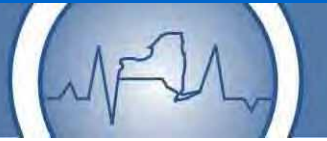
### **Work Group Charge:**

- This work group will advise the Department of Health (DOH) on initiatives, including establishment of reimbursement rates, to support providers' efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation and gender expression.
- The work group will also advise DOH about incorporating interpretation and translation services to patients with limited English proficiency and who are hearing impaired.
- This workgroup will advise DOH about data collection efforts related to health disparities including advice to ensure consistency with Federal Requirements as defined under section 4302 of the Affordable Care Act.
- This workgroup will advise DOH about use of a Disparities Impact Assessment to evaluate all MRT recommendations.
- The work group will also address health disparities among people with disabilities, including people with psychiatric disabilities and substance use disorders, and their need for equal access to primary and preventive health care services.
- The work group will explore issues related to charity care and the uninsured.
- Work group membership will include individuals from a range of racial and ethnic groups and community-based organizations with experience serving them; the New York City Health and Hospitals Corporation; other safety net providers; community-based immigrant groups; and legal services representatives.
- This work is related to MRT recommendation # 990, Explore the Establishment of Reimbursement Rates to Support Efforts to Address Health Disparities.



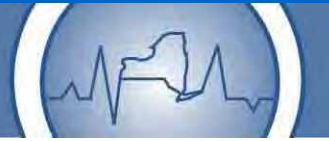
**WORK GROUP MEMBERSHIP:**

- **CO-CHAIR: Arlene Gonzalez-Sanchez**, Commissioner, NYS Office of Alcoholism and Substance Abuse Services
- **CO-CHAIR: Elizabeth Swain**, Chief Executive Officer, Community Health Care Association of NYS
- **Noilyn Abesamis-Mendoza**, MPH, Manager, Health Policy, Coalition for Asian American Children & Families
- **Nisha Agarwal**, Director, Health Justice, New York Lawyers for the Public Interest
- **Diana M. Babcock**, Dual Recovery Peer Specialist, Mental Health Empowerment Project
- **LaRay Brown**, Sr. Vice President, Corporate Planning, Community Health and Intergovernmental Relations, NYC Health and Hospitals Corp.
- **Jo Ivey Boufford**, MD, President, New York Academy of Medicine
- **Carla Boutin-Foster**, MD, MS, Associate Professor of Medicine, Weill Cornell Medical College
- **Neil Calman**, MD, President and CEO, Institute for Urban Family Health
- **J. Emilio Carrillo**, MD, VP for Community Health, NY-Presbyterian Hospital
- **Susan Dooha**, Executive Director, Center for Independence of the Disabled in NY
- **Rosa M. Gil**, DSW, President and CEO, Comunilife
- **Charles King**, President and CEO, Housing Works
- **Jonathan Lang**, Director of Governmental Projects & Community Development, Empire State Pride Agenda
- **Glenn Liebman**, CEO, Mental Health Association of NYS
- **Pamela Mattel**, LCSW, CASAC, Chief Operating Officer, Promesa Systems, Inc.
- **Dennis Mitchell**, Associate Dean for Diversity & Multicultural Affairs, Columbia University College of Dental Medicine
- **Ngozi Moses**, Executive Director, Brooklyn Perinatal Network, Inc.
- **Theo Oshiro**, Director of Health Advocacy & Support Services, Make the Road New York
- **Gregson H. Pigott**, MD, MPH, Director, Office of Minority Health Suffolk County Department of Health
- **Chau Trinh-Shevrin**, Director, NYU Center for the Study of Asian American Health
- **Jackie Vimo**, Director of Advocacy, NY Immigration Coalition



## MEETING DATES AND FOCUS:

- **Tuesday, August 9, 2011** - The first meeting focused on providing background information to ensure that the Disparities Work Group targeted its work from a common knowledge base and identifies major issue areas where specific recommendations are to be developed.
- **Friday, September 16, 2011** - Following a welcome to the Workgroup's newest member, Glen Liebman, and an overview of the MRT process provided by Jason Helgerson, the majority of the meeting focused on report outs from each of the topical working groups including: Data Collection; Disparities Impact Assessment; Health Homes ; Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning; Chemically Dependent Individuals; Homeless Persons; Persons with HIV (sexual health); and Immigrant Populations. The depth of each of the presentations and number of unique topic areas to be addressed precluded the workgroup from completing the defined agenda. As a result an additional meeting was scheduled for October 3rd to permit full discussion of all issue areas.
- **Monday, October 3, 2011** - This meeting provided an opportunity to complete report outs from the topical working groups which included : Systemic Reform and Access to Health Services; Language Access; Persons Living with Mental Illness; Persons with Disabilities; Maternal, Infant and Child Health and Disease-Specific Proposals. The meeting concluded with a review of next steps including a process to prioritize recommendations.
- **Wednesday, October 12, 2011** - The fourth and final meeting of the workgroup focused on a discussion of the results of the prioritization exercise and identification of fourteen distinct proposals that scored highest using the scoring and ranking criteria established for this purpose. In addition to the fourteen proposals identified that will be officially forwarded to the full MRT for consideration there were multiple other proposals that will be forwarded for consideration to other MRT workgroups such as the Training and Benefits workgroups. Finally, some broad-based recommendations will be conveyed through a formal letter from the workgroup co-chairs to the Commissioner of Health for consideration for implementation by the Department of Health.



#### **OUTSIDE EXPERTS CONSULTED WITH:**

No outside experts participated apart from members of the group.

#### **BRIEF SUMMARY OF DISCUSSIONS THAT LED TO FOCUS ON RECOMMENDATIONS INCLUDED IN THIS REPORT:**

The Work Group began with a review of the data on health disparities in different population groups defined by race/ethnicity, gender and gender identity, disability status, etc. The Work Group then devoted a considerable amount of time to soliciting, developing, reviewing and discussing proposals relevant to specific populations impacted by health disparities. Some Work Group members convened focus groups representing their communities for the purpose of generating proposals. The Work Group developed an overarching recommendation that all MRT Work Groups conduct a health disparities assessment of each MRT proposal. This recommendation was transmitted early on to the other Work Group chairs and is now included as a standard part of the MRT proposal template. Another overarching recommendation of the Work Group relates to the need for enhanced data collection to better measure health disparities by race/ethnicity, gender identity, and housing status for the purposes of program and policy development and targeted interventions as appropriate.

Following review, discussion and analysis of multiple proposals the workgroup undertook a prioritization exercise ranking the 69 proposals that had been proposed. At the last meeting of the group, this prioritization formed the basis of the discussion that result in the 14 final recommendations that were transmitted to the full MRT. These recommendations address the following populations all of which suffer health disparities: persons with disabilities; persons with limited English proficiency; immigrants; Lesbian, Gay, Bisexual and Transgender persons; persons with mental illness, substance use disorders and persons at risk of suicide. In addition several cross-cutting public health proposals were recommended to address health disparities in chronic disease and maternal and child health. These recommendations are listed in order of the priority assigned by the Health Disparities Working Group.



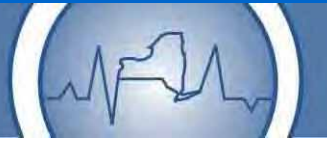
**Summary Listing of Recommendations: *(list each recommendation by short name; supplemental information is to be provided on recommendation form)***

- 1) **Data Collection/Metrics To Measure Disparities:** The Medicaid Redesign Team Health Disparities Workgroup recommends that NYS DOH implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status. In addition the workgroup recommends that funding be provided to support data analyses and research to facilitate SDOH work with internal and external partners to promote programs and policies that address health disparities. This research will improve quality and promote appropriate and effective utilization of services including the integration and analysis of data to better identify, understand and address health disparities.
- 2) **Improve Language Access to Address Disparities:** The Health Disparities Workgroup recommends that Medical Assistance rates of payment for hospital inpatient and outpatient departments, hospital emergency departments, diagnostic & treatment centers, and federally-qualified health centers are amended to provide reimbursement for the costs of interpretation services for patients with limited English Proficiency (LEP) and communication services for people who are deaf and hard of hearing.
- 3) **Promote Language Accessible Prescription s:** The workgroup recommends that actions be taken to require all chain pharmacies to provide translation and interpretation services for limited English proficient (LEP) patients, that standardized prescription labels be required to ensure understanding and comprehension especially by LEP individuals and that prescription pads be modified to allow prescribers to indicate if a patient is LEP, and if so, to note their preferred language.
- 4) **Promote Population Health through Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services:** The Workgroup recommends that Medicaid be expanded to include coverage of pre-diabetes group and individual counseling services (fee-for-service and managed care); lead poisoning, asthma, home visits and automated home blood pressure monitors for patients with uncontrolled hypertension.
- 5) **Streamline and Improve Access to Emergency Medicaid:** It is recommended that the State take actions to increase awareness about emergency Medicaid among consumers, providers, and local Social Services districts. In addition, it is recommended that the application process be streamlined through prequalification and extend certification periods for certain medical conditions. These actions will enable providers to receive appropriate reimbursement from federal funds and reduce hospital and institutional reliance on state charity care dollars.
- 6) **Address Disparities in Treatment at Teaching Facilities:** The Health Disparities Workgroup recommends that actions be taken to ensure that existing standards of care are enforced in teaching hospitals and training clinics to ensure that the care provided to persons who are uninsured, to people covered by Medicaid, and to the privately insured is consistent, is of the highest quality and is equivalent to those services provided by private faculty practices in the same institutions.





- 7) **Address Disparities Through Targeted Training for NYS' Health Care Workforce:** Mandated cultural competency training is recommended to promote care and reduce disparities for all individuals including but not limited to people with disabilities, Lesbian, Gay, Bisexual and Transgender persons, persons with mental illness, substance use disorders and persons at risk of suicide.
- 8) **Enhance Services to Promote Maternal and Child Health:** The health disparities workgroup recommends that the following Medicaid enhancements and expansions be implemented to promote maternal and child health: expanded access to contraception and other family planning services including inter-conceptional care following an adverse pregnancy; breastfeeding education and lactation counseling during pregnancy and in the postpartum period; and support of initiatives to demonstrate effective and efficient use of HIT technology between hospitals/health care systems and community-based health organizations to improve care delivery.
- 9) **Enhanced Services for Youth in Transition with Psychiatric Disabilities:** The workgroup recommends that comprehensive programs to serve youth in transition with psychiatric disabilities be developed across all systems of care including foster care, school populations that have youth with a Serious Emotional Disorder diagnosis and the juvenile justice population to ensure that youth with psychiatric disabilities do not end up homeless or in the criminal justice system.
- 10) **Promote Effective Use of Charity Care Funds:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the charity care reimbursement system be revised to ensure that charity care funding is transparent, is used to pay for the care of the uninsured and that there is greater accountability for use of these funds.
- 11) **Promote Hepatitis C Care and Treatment Through Service Integration:** The Health Disparities Workgroup recommends that efforts be taken to promote the integration of hepatitis care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.
- 12) **Promote Full Access to Medicaid Mental Health Medications:** The Health Disparities Workgroup recommends that actions be taken to ensure that all Medicaid recipients who are in managed care plans where the pharmacy benefit is no longer carved out continue to have full access to mental health medications.
- 13) **Medicaid Coverage of Water Fluoridation:** To address disparities in access to dental services the Workgroup recommends that Medicaid funding be made available to support costs of fluoridation equipment, supplies and staff time for public water systems in population centers (population over 50,000) where the majority of Medicaid eligible children reside.
- 14) **Medicaid Coverage of Syringe Access and Harm Reduction Activities:** The Health Disparities Workgroup recommends that actions be taken to promote and address health care needs of persons with chemical dependency including allowing medical providers to prescribe syringes to prevent disease transmission; allowing harm reduction therapy as an appropriate and reimbursable treatment modality in OASAS facilities and by authorizing NYS DOH AIDS Institute Syringe Exchange providers to be reimbursed by Medicaid for harm reduction/syringe exchange program services provided to Medicaid eligible individuals.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Data Collection/Metrics to Measure Health Disparities

**Program Area:** Health Disparities

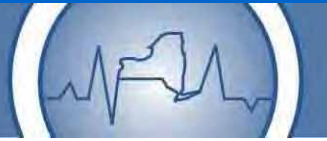
**Implementation Complexity:** Medium

**Implementation Timeline:** January 2013

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

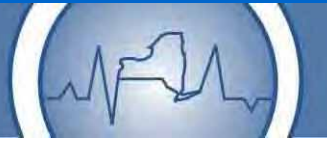
**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends the following to improve Data Collection and Analyses to Reduce Health Disparities:

1. Implementation and expansion upon data collection standards required by Section 4302 of the Affordable Care Act (ACA) by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), augmented to correct for undercounting (Hearing, vision, cognitive, ambulatory, self care or independent living difficulty) and housing status.
2. Review of federal Office of the National Coordinator for Health Information Technology (ONC) data requirements to assure consistency.
3. Review of existing disparity and cultural competence measures (HEDIS, QARR, CON, National Quality Forum, PQI and Ambulatory Sensitive Conditions data) for completeness, appropriateness and consistency with ACA and ACS data collection standards.
4. Provision of funding to support data analyses and research to facilitate SDOH work with internal and external partners to promote programs and policies that address health disparities, improve health care and public health program quality and promote appropriate and effective utilization of services including the integration and analysis of child health data to better identify, understand and address health disparities among children.



***More specifically:***

- Broad Implementation of Enhanced Data Collection Across Payer Types: Ensure implementation of Section 4302 of the ACA data standards by federally supported programs such as Medicaid, and the state health insurance exchanges as well as non-federally-funded health data collection systems such as the Statewide Planning Research Cooperative Systems (SPARCS). The integration of the ACA data provisions as part of public programs, health insurance exchanges, and hospitals will ensure that the state is compliant with Title VI of the Civil Rights Act of 1964 at the same time align with the goals of Healthy People 2020 and the National Stakeholder Strategy for Achieving Health Equity.
- Race/ Ethnicity: NYS is urged to adopt HHS proposed data standards which recognize diversity by addressing the need for disaggregated race and ethnicity data. In particular, breakdown of 3 granular Hispanic or Latino, 7 Asian, and 4 Native Hawaiian and Pacific Islander categories which aggregate to broader Office of Management and Budget (OMB) race categories. Additionally, HHS provides an option for individuals from multi-racial heritages to choose more than one race. The “race and ethnicity” questions can be strengthened by including an open-ended option for “Yes, another Hispanic, Latino, or Spanish Origin”, “Other Asian”, and “Other Pacific Islander” where a respondent can identify his/her ethnicity if it is not listed among the 14 Hispanic or Latino, Asian, and Native Hawaiian and Pacific Islander options. This open-ended option is similar to the proposed language standard which allows a respondent to fill-in his/her language. Given that Asian Pacific Americans comprise over 50 different ethnicities and Latinos comprise over 28 ethnicities, providing the ability for self-reported data of smaller Asian, Pacific Islander, and Latino subgroups will give NYS a more accurate picture of the health of these communities.
- Sexual Orientation and Gender identity. The Institute of Medicine (IOM) in its March 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, emphasized the need for collection of gender identity and sexual orientation data on federally supported surveys. HHS is now in the process of developing a national data progression plan intended to begin the integration of sexual orientation and gender identity variables into HHS national surveys. Roundtable discussions on this topic will be completed in 2011; initial field testing of sexual orientation data collection and presentation of a strategy to include gender identity data collection in HHS surveys will be completed in the Spring of 2012 followed by a large scale field test of sexual orientation data collection and finally, if the field test is successful, new data collection on sexual orientation will be implemented in 2013. New York is urged to follow these activities and implement consistent data collection accordingly.



- **Primary Language.** Limited access to language services in the health care setting can impair discussions of symptoms and alternative treatment regimens, resulting in misdiagnoses or poor treatment decisions. Communication barriers also impede the understanding and compliance of treatment plans and therapies among patients with limited English proficiency. The HHS proposed data standards include questions to assess a person’s ability to speak English primary language spoken at home, and language spoken at the health care setting. This is an important first step in addressing the needs of Limited English Proficient individuals. To strengthen these measures, the Workgroup recommends the following:
  - ✓ That NYS expand the collection and reporting of the spoken language category to also incorporate measures that assess preferred language at the health care setting as well as understanding and reading ability in English. The following modifications and additions based on the 2009 Institute of Medicine’s “Race, Ethnicity, and Language Data” are offered for consideration:
    - That NYS use the top six languages spoken according to the latest U.S. Census. Using the top six languages threshold is similar to NYS’s Executive Order 26 and NYC’s Executive Order 120 (Citywide Policy Executive Order 26 on Language Access) uses to determine languages to translate and provide interpretation for at city agencies.
    - In addition to the expanded spoken language categories, sign language for the spoken language and Braille for written language should be part of the national standard language list.
    - Expansion of language options beyond “Spanish” and “Other Language (identify)” for question “What is this language?”
    - Addition of a question on the preferred spoken language in a health care setting.
    - Addition of a question on the preferred language a person would like to receive written materials in.
    - Addition of a question assessing English literacy level.
    - Addition of a question assessing English comprehension and understanding.
- **Disability:** The workgroup recommends that New York State implement data collection standards required by Section 4302 of the Affordable Care Act by including the six disability questions used in the 2011 American Community Survey (ACS), augmented to correct for undercounting. Further, the workgroup notes that the Office of Minority Health of the U.S. Department of Health and Human Services proposed data collection standards for Race, Ethnicity, Primary Language, Sex, and Disability status do not capture: people with activity limitations due to severe cognitive disabilities or sensory disabilities; speech impediments; learning disabilities; people with chronic health conditions; nervous system conditions and some other conditions. (Correspondence of the American Association on Health and Disability to Garth Graham, Deputy Assistant Secretary for Minority Health, Office of Mental Health, U.S. Department of Health and Human Services, July 27, 2011.) It is recommended that New York State implement data collection standards that address this expanded definition of persons with disabilities.



- Reporting and Small Sample Size. The workgroup recommends that NYS undertake actions to enhance reporting on small ethnic communities and in small geographic units when possible and permissible given existing confidentiality protections and with sufficient funding. Given relatively small numbers in some rural towns or for small ethnic communities data may not be available with which to assess unique health status indicators.
- Housing Status. The workgroup recommends that New York collect information regarding individual's housing status such as: *"Are you homeless?" "Do you reside in a shelter?" and "Do you reside in a domestic violence shelter?" "Do you have a permanent home?"* Additional questions that might be considered as indicators of risk factors for homelessness include: *"Do you live with friends or relatives?" and "Do you have an eviction notice?"* These questions are recommended as a means of learning about the causes of homelessness, to identify strategies to prevent homelessness, and how best to serve people who are homeless.
- Funding to Support Data Integration and Analysis. Funding to support SDOH data integration and data analysis by internal and external researchers is critical to effectively utilize the data collected and will result in numerous benefits including:
  - ✓ Assisting providers with the delivery of timely preventive, diagnostic, and treatment services.
  - ✓ Lowering providers' risks of not having critical medical information about patients to render proper treatment and intervention.
  - ✓ Improving coordination of care across multiple programs and providers.
  - ✓ Reducing potential for duplicative services and delays in care while waiting to manually collect patient records across providers.
  - ✓ Assisting providers in reporting statutorily mandated information.
  - ✓ Enabling clinicians to have a full public health picture of an individual's medical history and public health services to facilitate clinical care and follow-up in a timely manner for improved service delivery and health outcomes; and to monitor the population health of New Yorkers and identify and assess public health needs and issues.
  - ✓ Enabling effective tracking of NYS compliance with national policies.
  - ✓ Support efforts to estimate and monitor the prevalence of select health outcomes to better target interventions, assistance and health care services.
  - ✓ Investigation of and addressing service gaps among different socioeconomic, race/ethnicity, and gender groups.
  - ✓ Evaluation of screening and case management guidelines to identify and better manage individuals and children with chronic health conditions.



**Financial Impact:** Costs associated with revising data collection forms and to support data analyses and research. (\$2.0M)

**Health Disparities Impact:** High – Collection of detailed data will facilitate enhanced analyses of health status indicators, identification of trends, and development of targeted interventions and ultimately reduction of health disparities.

**Benefits of Recommendation:** Overall this recommendation will achieve the following broad health care system goals:

- Enhanced and more detailed data collection will support improved and more effective service delivery, system development, health care access and population-based health programs
- Collection of detailed data will facilitate enhanced data analysis: program and policy development and measurement of goal achievement with respect to reductions in health disparities.
- Increased data consistency and reliability across systems.
- Reduced time and money from more effectively targeted programs and services.
- Facilitation of disease prevention and health promotion.
- Improve quality of care and service delivery.

**Background:** This proposal is particularly important and germane to health care in New York State for the following reasons:

- *Diversity* - New York State is home to 11% of all the immigrants in the United States. One important aspect in which New York differs from many other parts of the United States is the extraordinary diversity of immigrants to New York. Individuals from nearly every country in the world are represented in New York State. Asian Pacific Americans trace their heritage to more than 50 different countries and speak more than 100 different languages. Latinos in the U.S. represent 28 countries. While many Latinos are bilingual and speak Spanish, many have also retained proficiency in indigenous languages and dialects. Blacks today are not only African American, but also Caribbean and African, adding new layers to what it means to be a black New Yorker.
- *Immigration Status* - 22% of New York State's (NYS) population are immigrants. More than one third of children in New York State (34%) live in a family with at least one foreign-born adult. While the overwhelming majority is immigrants in the Asian Pacific American and Latino communities, New York's diverse communities represent the full spectrum of immigration status.
- *Language* – 13% of the population aged 5 years and older in New York State speaks English less than “very well” compared with nearly 9% of the U.S. population.
- *Poverty* – According to the New York City Center for Economic Opportunity, Latinos have the highest rate of poverty at 30%, followed by 26% of Asian Pacific Americans, and 24% of Blacks. Twenty percent of all children in New York City live in households with incomes below 100% of the poverty level.



- *Health Insurance* – Racial/ethnic communities in New York City have higher rates of un-insurance than Whites. (27% of Latinos, 16% of Blacks, 14% of Asian Pacific Americans, and 9% of Whites). In addition, many immigrants are self-employed, working in small businesses or in cash-based industries that are less likely to offer health benefits. Uninsured rates are further magnified in the immigrant community due to immigration status, language barriers, and cultural stigmas of accessing public benefits.

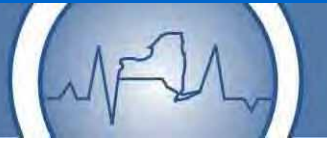
Despite these needs, there continues to be a dearth of data on particular racial/ethnic populations. Data collection and reporting efforts for communities of color remains problematic. The reasons are many, including lack of funding and/or staff, confidentiality issues, insufficient sample sizes, and organizational capacity to translate research studies into multiple languages. Ultimately, these inadequacies result in an inaccurate picture of the state of health for particular racial groups, especially for its specific ethnic subgroups.

Many racial and ethnic minorities, people with disabilities, lesbian, gay, bisexual, and transgender (LGBT) communities, and other commonly underserved populations face unique health challenges, have reduced access to health care and insurance, and often pay the price with poorer health throughout their lives. These underserved populations are less likely to get the preventive care they need to stay healthy and are more likely to suffer from serious illnesses like diabetes and heart disease. When these populations do get sick, they are less likely to have access to quality health care. As a result, health disparities persist.

Collection of detailed data will facilitate enhanced data analysis; program and policy development and measurement of goal achievement with respect to reductions in health disparities. New York State is advancing a coordinated strategy and multiple initiatives to improve quality and the health of the population by leveraging existing data systems within the NYS Department of Health (DOH). For example, the Child Health Information Integration (CHI<sup>2</sup>) project is underway to integrate multiple systems to provide a timely, seamless integration of the health information of New York's children. A child health portal will aggregate a context-relevant view of the data into a single interface, and ultimately be integrated within an electronic health record system (EHR) directly within the clinician workflow, to provide decision support for public health practitioners and the clinical community.

More broadly, providers, public health agencies, and researchers, will be able to study, identify, and address disparities and health care delivery while reducing overall costs. This work of this proposal can also enable the evaluation of critical issues such as regional and patient demographic variations in utilization, quality, and cost and examine the impact of reimbursement methodologies, public health interventions, and health care resources on utilization, quality, outcomes, and costs.

Anticipated financial benefits would be due to the increase in the number of individuals who are not lost in the system, and would thus receive early interventions to prevent complications from disorders that would benefit from improved treatment and follow-up. The financial savings would be reflected in such things as a decrease in medical expenditures, special education costs, and an increase in lifetime productivity.



In addition, there are savings from improved efficiency and effectiveness of treatment as a result of practitioners having access to more complete records for each individual that are readily accessible to those involved in their care.

Once implemented, this solution will have several technical benefits as well, by reducing duplication of effort in systems operations, supporting greater standardization in data collection and exchange, and enabling data exchange through the Regional Health Information Organizations (RHIOs) and Qualified Entities (QEs) which provide governance and technical services for health information exchange at the community level.

**Concerns with Recommendation:** Concerns regarding data integration efforts center on data ownership and privacy which will have to be carefully addressed. In addition, this proposal depends upon the existence or creation of a technical infrastructure design and development and data modeling and management expertise to ensure timely and reliable system and data integration. Resources will be required to perform the various technical tasks associated with establishing the data linkages, and creating mechanisms to make the data readily available to clinicians, consumers and others. Appropriate privacy and security policies and practices will need to be established and monitored to ensure that state requirements are met.

**Impacted Stakeholders:** Data collection, analysis, and dissemination are integral components in properly identifying, monitoring, and addressing health disparities for growing and diverse NYS communities. The collection of this data allows providers, advocates, funders, and decision makers to identify needs and resources and develop vital programs. Data can also bring to light when unequal access and treatment occurs within the health care system. Without adequate mechanisms with which to collect, analyze, and report data, it is impossible to measure improvements in the health and healthcare for communities. Entities and organizations that will benefit from this proposal include:

- Individuals from throughout the State, particularly those who are most at risk for health disparities including racial and ethnic minorities; sexual minorities, persons with disabilities, persons who are homeless and persons of limited English proficiency;
- Children , families and individuals who can expect to benefit from improvements in the quality of care and care outcomes;
- Healthcare providers, who will benefit from the ability to view timely and complete patient clinical data to provide better care and reduce unnecessary tests and procedures;
- Local, state, and national public health agencies and practitioners, who will benefit from timely retrieval of comprehensive health data on multiple health concerns ranging from chronic and communicable disease, hospitalization, immunizations and reportable conditions;
- Other health and human services agencies;
- Medicaid and other third party payers, including private insurers, who will benefit from enhanced information with which to develop programs and policies and integrated data sets that support coordinated delivery modes;
- Vendors of health electronic exchange, who will develop products to efficiently transfer standardized information across the relative points of service.





## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Improve Language Access to Address Disparities

**Program Area:** Health Disparities

**Implementation Complexity:**

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

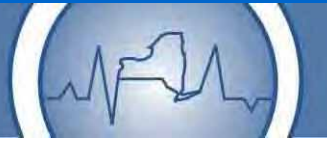
Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that an adjustment be made to Medical Assistance rates of payment (inclusive of fee-for-service and managed care plans) for all hospital inpatient and outpatient departments, hospital emergency departments, diagnostic & treatment centers, and federally-qualified health centers throughout the State to specifically provide for reimbursement for the costs of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. To date the Medicaid reimbursement for language services has been limited to \$38M that has been included in the expenditure base that is included in the statewide base price for hospitals. \*

Further, it is recommended that this reimbursement be made for interpretation services provided during the course of a clinical encounter as well as in the process of billing and making appointments. Reimbursement shall only be available for interpretation services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology. In order to be eligible for reimbursement, the provision of language services must be documented in such a manner as to enable reporting to and audit by the Commissioner of Health.

Patients with limited English proficiency” shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff. “Interpretation services” means language assistance services provided by individuals with sufficient bilingual skills in both English and the relevant language to communicate information necessary for the patient to access services and, in the case of interpretation services provided during the course of a clinical encounter, services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology.

\* Similar proposals have been introduced in the NYS Legislature. See A 661 (Gottfried).



**Financial Impact:** Researchers have found that language assistance services result in lower costs. The use of interpreters “was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without a simultaneous increase in LOS [length of stay] or cost of visit.”<sup>1</sup> When interpreters were not available during a pediatric emergency room visits by LEP patients “physicians performed more extensive evaluations (more frequent and more expensive diagnostic testing) and treated children more conservatively (more intravenous hydration and more frequent hospital admission).”<sup>2</sup> One study recorded a significantly higher test cost, \$145, for patients with whom a physician encountered a language barrier as compared to when they did not, \$104.<sup>3</sup> Such data suggest a net cost savings to the Medicaid program as a whole if language assistance services are reimbursed, as the cost of such services is significantly less than \$104 per visit.

All told there are significant cost savings, not to mention federal matching funds to be gained, by enabling Medicaid reimbursement for language assistance services. In a time when the state is in financial distress, it is incredibly important that we allocate our dollars in a smart manner, which maximizes the benefits to Medicaid beneficiaries. Drawing down federal funds to reimburse providers for already required services is in line with the goals of the MRT.

### **Other States’ Expenditures:**

Thirteen states and the District of Columbia are already providing reimbursement for language services for LEP individuals and drawing down federal matching funds. Maine and Texas also provide reimbursement for interpreters for deaf and hard of hearing individuals. Below is a brief description of the cost some states incur for providing services. Of the six states listed below, all of them are spending less than \$1.50 per year per LEP resident.<sup>4</sup> Most of the data available is from before the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which included a provision for enhanced federal CHIP and Medicaid matching rate of up to 75% for translation and interpretation services provided to children. This means that these states’ costs are probably lower now that they can take advantage of such a high matching rate.

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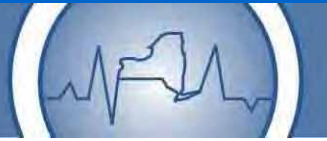
<sup>1</sup> Bernstein, Judith, *et. al.*, “Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,” *Journal of Immigrant Health*, Vol. 4, No. 4, October 2002.

<sup>2</sup> Hampers, L. and McNulty, J., “Professional interpreters and bilingual physicians in a pediatric emergency department: Effect on resource utilization,” *Archives of Pediatrics & Adolescent Medicine* 156 (11), 1108–1113, 2002.

<sup>3</sup> Hampers, L., Cha, S., Gutglass, D., Binns H. and Krug, S., “Language barriers and resource utilization in a pediatric emergency department.” *Pediatrics* 103, 1999.

<sup>4</sup> Cost data: National Health Law Program., “MEDICAID AND SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES.” 2007.

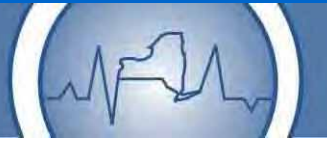
LEP Statistics: U.S. Census, American Community Survey, *Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for the United States*, April 2010, <http://go.usa.gov/bsl> (Excel spreadsheet with a workbook for each state).



- Virginia: In FY06 the state spent a total of \$8,546 for 507 hours of interpretation services; Virginia has an LEP population of 393,554 individuals which means they spent approximately \$0.02 per LEP resident.
- Utah: In FY06 Utah spent \$180,000 for foreign language services. The state's LEP population is 140,456 individuals, so they spend approximately \$1.28 per LEP person per year.
- Hawaii: In 2002, the state spent approximately \$144,000 per year on 2,570 visits. Hawaii has 133,631 LEP residents. This amounts to approximately \$56 per visit and \$1.07 per LEP individual per year in the state.
- Kansas: In 2006 the state spent \$46,479.74 for 41,193 minutes of interpretation services. Their LEP population is 111,696 which means the state spends approximately \$0.40 per LEP individual per year.
- Idaho: In 2006, the state spent \$87,913 on 7,438 interpretive services. Idaho has an LEP population of 56,065. This amounts to approximately \$12 per service and \$1.50 per LEP resident per year.
- Washington: Following a brokering system that is inconsistent with the way the NYS proposal recommended to the MRT is structured, Washington State spent \$1 million per month on all language services, of which \$38,225 was Medicaid spending. This cost was to provide services for 217,865 encounters. The state has 458,999 LEP individuals which means the state's Medicaid spending is approximately \$0.08 per LEP individual per year.

### **New York State Estimates:**

Using the upper limits of the amount these states are spending on language services per LEP resident, if NYS required a similar rate of language assistance services for the LEP population, it is estimated that the total expenditure would be approximately \$3,611,772 ( $\$1.50 \times 2,407,848$  LEP residents). Federal matching dollars should be subtracted from this amount to arrive at the estimated cost to the state, which is anticipated to be at or slightly above \$1M, in view of the 75% FMAP for SCHIP enrollees and the 50% FMAP for others. This is a fraction of a percent of the overall state budget.



**Health Disparities Impact:** High as all Medicaid eligible persons of limited English proficiency will benefit.

**Benefits of Recommendation:** Provision of language services in health care settings improves quality of care, reduces use of costly and unnecessary testing, and improves patient outcomes. As one reviewer noted, “research amply documents that language barriers impede access to health care, compromise quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency.”<sup>5</sup> Another study went on to show that Spanish-speaking patients who had an attending physician fluent in Spanish significantly reduced post-discharge ED visits, reducing costs by \$92 per Spanish-speaking patient over the study period.<sup>6</sup> In a State such as New York with such a large LEP population, there will be significant financial benefits to providing language services.

Among the individual benefits, researchers have found evidence that LEP individuals benefit from the immediate receipt of services, and the availability of longer-term preventative measures. One study showed that “language barriers are associated with poor quality of care in emergency departments (EDs); inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors.”<sup>7</sup> This study also showed that LEP patients “have fewer physician visits and receive fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators or ethnicity are controlled for.”<sup>8</sup> Researchers have found that during hospital visits, LEP individuals suffer from a statistically higher incidence of adverse events resulting in physical harm than English-speaking patients. When asked, most doctors listed “communication” as the most significant factor leading to the events in cases of LEP patients.<sup>9</sup>

Researchers have found that language assistance services result in lower costs. The use of interpreters “was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without a simultaneous increase in LOS [length of stay] or cost of visit.”<sup>10</sup> When interpreters were not available during a pediatric emergency room visits by LEP patients “physicians performed more extensive evaluations (more frequent and more expensive diagnostic testing) and treated children more conservatively (more intravenous hydration and more frequent hospital admission).”<sup>11</sup> Thirteen states and the District of Columbia are already providing reimbursement for language services for LEP individuals and drawing down federal matching funds. Maine and Texas also provide reimbursement for interpreters for deaf and hard of hearing individuals.

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<sup>5</sup> Ku, Leighton and Glenn Flores, “Pay Now Or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, Number 2, 2005.

<sup>6</sup> Jacobs E, Sadowski L, Rathouz . “The Impact of Language Barriers on Hospital Costs and Length of Stay,” *Journal General and Internal Medicine*. S2: 306-11, 2007.

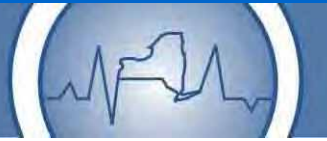
<sup>7</sup> Brach, Cindy, Irene Fraser and Kathy Paez, “Crossing the Language Chasm,” *Health Affairs*, 24, no. 2, 2005.

<sup>8</sup> *Id.*

<sup>9</sup> Divi, Chandrika, Richard Koss, Stephen Schmaltz and Jerod Loeb, “Language proficiency and adverse events in US hospitals: a pilot study,” *International Journal for Quality in Health Care*, February 2, 2007.

<sup>10</sup> Bernstein, Judith, *et. al.*, “Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,” *Journal of Immigrant Health*, Vol. 4, No. 4, October 2002.

<sup>11</sup> Hampers, L. and McNulty, J., “Professional interpreters and bilingual physicians in a pediatric emergency department: Effect on resource utilization,” *Archives of Pediatrics & Adolescent Medicine* 156 (11), 1108–1113, 2002.



**Concerns with Recommendation:** Implementation of this proposal will require a statutory change.

**Impacted Stakeholders:** Over 2.3 million New Yorkers are limited English proficient (LEP).

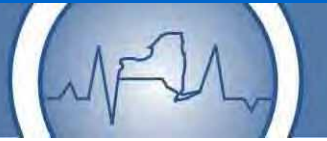
Organizations/Individuals in Support:

- Bronx Health Link
- Language Line Services.
- Farm worker Legal Services of New York, Inc.
- Community Healthcare Network
- International Medical Interpreters Association
- The Korean Community Services of Metropolitan New York, Inc.
- Community Engagement/Outreach Center for the Elimination of Minority Health Disparities  
University at Albany, SUNY
- Office of Government & Community Relations, University of Rochester

**Background:**

National: Over 2.3 million New Yorkers are limited English proficient (LEP) and have the right to health care in a language they understand. Title VI of the federal Civil Rights Act of 1964 prohibits any recipient of federal funding, including health care facilities, from discriminating on the basis of race, color or national origin. According to the U.S. Supreme Court, the failure to provide interpretation and translation services to LEP individuals constitutes discrimination on the basis of national origin under Title VI. Likewise, the Americans with Disabilities Act (ADA) requires that health care providers make communication assistance services available to people who are deaf or hard of hearing to ensure equal access to health services. In 2000, the Centers for Medicare & Medicaid Services issued a letter to State Medicaid Directors reminding them that federal matching funds are available for states' expenditures related to the provision of language assistance services. Further, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included a provision for enhanced federal CHIP and Medicaid matching rate of up to 75% for translation and interpretation services provided to children.

The context in New York: Since 2003, advocates and health care providers from across New York State have supported legislation that would enable Medicaid reimbursement for interpretation services at hospital inpatient and outpatient departments and Emergency Rooms; diagnostic and treatment centers; and federally-qualified health centers. The legislation authorizes reimbursement only for interpretation services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology, and only to the extent that the provision of services is documented so as to ensure that state and federal funds are distributed for the purposes intended.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Language Accessible Prescription Labels

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

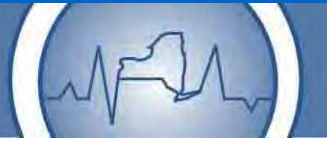
State Plan Amendment

Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the public health law and the education law be amended to require that the State Board of Pharmacy develop regulations and standards to guide the following: creation of standardized prescription label instructions; to require that pharmacies with five or more stores and mail order pharmacies provide translation and interpretation services for limited English proficient (LEP) patients; and that NYS prescription pads be modified to allow prescribers to indicate if a patient is LEP. These provisions would build upon existing requirements codified in New York City law and as a result of a 2009 agreement reached by the State of New York with seven major pharmacy firms in New York City and would extend the requirements of the current New York City law to chain pharmacies in all regions of New York State. More specifically, the Workgroup recommends that the New York City law pertaining to the provision of language assistance services in pharmacies be extended to apply to those pharmacies through the State of New York that are part of a group of five or more (pharmacies) that are owned by the same corporate entity. \*

Patient advocates and researchers agree that language barriers and information inconsistencies are the a major cause of patient confusion over how to properly take prescription medications and result in lack of adherence to prescribed medications that threaten the health of the patient. Standardizing the information on prescription labels and providing translation and interpretation services will prevent costly adverse outcomes. This proposal has four components, the first two are consistent with existing New York City law; the second are new proposals:

\* Similar legislation has been introduced in the NYS Legislature. See A7342-A(Gottfried)/S.5000-A (Hannon).

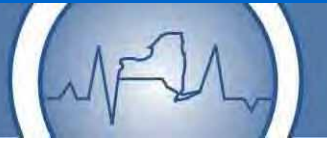


1. Pharmacies should be required to make available written translations of the standardized prescription drug labels into the top six languages of patients who are LEP in New York. Pharmacies with five or more stores and mail order pharmacies should also be required to have interpretation services available for all patients who are LEP.
2. Pharmacies should be given flexibility to decide if bilingual staff, telephonic translation services, or other modalities of interpretation are the best option for them. This will ensure that most patients receive prescription drug information and counseling in a language they understand.
3. The State Department of Health should modify the official New York State prescription forms and electronic prescriptions to include a section for prescribers to indicate whether their patients are LEP, and if so, what their preferred language is. This will assist pharmacists in serving patients who are LEP by allowing them to easily determine and accommodate customers' language preferences.
4. In addition, the Workgroup recommends that the State Board of Pharmacy be given the authority to develop regulations and standards to assure clear and understandable prescription drug labels that address unique patient needs such as those of the elderly and those with limited vision. This will improve comprehension of labels by all consumers and provide unambiguous and straightforward directions for prescription drug use. The effective date would be flexible (one to two years) to allow compliance at the next scheduled software update.

## Background

State Agreement: On April 21, 2009 the New York State Attorney General [signed agreements](#) with seven major pharmacy chains requiring that they provide limited English proficient customers with interpreting and translation services in all of their New York stores. These agreements were signed with seven of the largest pharmacy chains in New York State: A&P, Costco, CVS, Duane Reade, Rite-Aid, Target and WalMart. For purposes of this agreement an individual is considered to be LEP if his or her knowledge of English is not sufficient for communicating about the safe and effective administration of prescription medications. For written translation, the agreement covers 11 languages. Six languages are fixed at the start: Chinese, French, Italian, Polish, Russian, and Spanish. Within 6 months after full implementation of their new pharmacy computer systems (scheduled to take place by March 31, 2010), each pharmacy chain is to add five additional languages based on their assessment of demographics and need in each chain's service area.

The pharmacies have to provide their LEP customers whose primary language is one of the 11 languages identified translated versions of the following: directions for use of the drug; warning labels with information regarding the safe and effective use of the drug, including common side effects or adverse effects and contraindications; notices of privacy practices; and written offers of counseling. If an LEP customer does not speak one of the 11 primary languages for the pharmacy, the above-specified information does not need to be provided to the person in written form in their language. However, that information has to be relayed to the person orally (e.g., via telephone interpreting) in their primary language.



Oral Interpreting requirements: Interpreting is to be available in **all languages** reasonably expected to be requested by each chain's customers. Pharmacy staff who are not able to communicate adequately with an LEP individual in their primary language have to utilize, free of charge to the customer, an interpreter, either in-store or over the phone, when soliciting information to maintain in a patient medication profile, offering prescription drug counseling, providing prescription drug counseling where such counseling is not "refused by the customer," and accepting prescription refill requests, either in-person or over the telephone.

New York City Legislation: Legislation enacted by the New York City Council effective 2009 requires that every chain pharmacy provide free, competent translation of prescription medication labels, warning labels and other written material to each LEP individual filling a prescription at such chain pharmacy if that individual's primary language is one of the pharmacy primary languages in addition to providing such labels and materials in English. Under this law chain pharmacies are permitted to provide dual- or multi-language medication labels, warning labels or other written materials to LEP individuals who speak one of the pharmacy primary languages if one of the languages included on such labels or sheets is the LEP individual's primary language.

**Financial Impact:** Proposal costs will be borne by the impacted pharmacies. In conversations between the New York State Board of Pharmacy with both chain and independent pharmacies, the regulated parties indicated that the cost of standardizing prescription labels may be significant. According to Health Disparities Work Group members, experience with similar legislation passed in California suggests that development of standardized labels may not be significant.

Costs for translation services (as currently required by NYC local law) are as follows based on information from two translation vendors and one pharmacy:

- **Vendor 1:** Monthly subscription fees – no limit on transaction - \$.83/ day/ store (even lower price per store if huge pharmacy); volume pricing available; 17 languages (will soon have 20)
- **Vendor 2:** Both interpretation and translation costs (computer-based system) \$1 - \$2/ day or \$62/month/ store (retail list price is \$90/month/store, but they always scale their contracts to make it as cost effective as possible). All languages are included for the same price. The current languages include: English, Spanish, Mandarin, Cantonese (Note: Chinese written text is available in both Simplified and Traditional), Korean, Bengali, Arabic, Haitian Creole, Italian, French, Russian, Polish (coming soon)
- **Vendor 3:** This is from a small independent pharmacy, which pays the following for translation for 7 languages: \$500 startup, plus about \$25/month subscription fee; \$2100 per year for 7 languages plus the \$500 initial fee.





**Health Disparities Impact:** Significant - particularly with respect to persons of limited English proficiency.

**Benefits of Recommendation:** The consequences of misunderstanding prescription labels can be dire and costly. Unintended misuse of prescription medications causes over one million yearly “adverse drug events,” resulting in visits to the emergency room, hospitalization and, in some cases, even death. Indeed, patient non-adherence with prescription instructions due to low levels of health literacy and other factors is responsible for 22% of all hospitalizations nation-wide. This problem places additional burdens on already under-resourced emergency rooms and hospitals and costs an extra \$3 billion per year in healthcare spending.

Injuries related to medication used in the outpatient setting result in over 700,000 emergency room visits annually, and over 100,000 of these emergency room visits result in hospitalizations. Over a quarter of emergency room visits for medication-related injury are by seniors, and over half of the patients hospitalized in these situations are seniors.<sup>12</sup> Emergency room visits and hospitalizations are a very expensive form of care. A study conducted by researchers at the Harvard Medical School found that the cost per preventable drug injury at a major urban hospital was \$10,375, resulting in a total cost for a single hospital of \$1.2 million per year.<sup>13</sup> As the state seeks to reduce unnecessary Medicaid expenditures, reducing the rate of needless, preventable, and costly Emergency room visits and hospital admissions is a strong initial step.

Recent data also shows that hospital readmissions cost New York State \$3.7 billion this year.<sup>14</sup> Ensuring medication compliance is one of the most straightforward and effective methods for preventing re-admissions. If enacted, this policy will help hospitals to reduce readmissions and increase treatment quality while also conserving financial resources.

With dozens of ways for a pharmacist to write “take once a day,” it is often challenging for patients to understand and act correctly on just one prescription instruction. For those who take multiple medications, such as the elderly, this challenge is even greater. Age-related declines in vision, memory and cognitive skills means that small print and cluttered labeling are particularly problematic for the elderly. Similarly, for the over 2.4 million LEP New Yorkers, the lack of translation makes labels literally incomprehensible.

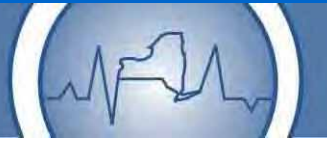
Without standardized prescription labels or consistent access to translation and interpretation services, millions of elderly and LEP individuals are unable to fully understand medication information. As such, they are deprived of effective care, and their health and safety is seriously jeopardized. Despite this,

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<sup>12</sup> Daniel Budnitz, et al, *National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA) vol. 296, no. 15 (October 18, 2006), pp. 1858-1866.

<sup>13</sup> Ashish K. Jha, et al, *Identifying Hospital Admissions Due to Adverse Drug Events Using a Computer-Based Monitor*, PHARMACOEPIDEMIOLOGY AND DRUG SAFETY vol. 10 (2001), pp. 113-119.

<sup>14</sup> NYS Health Foundation, “Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives,” available at [http://www.nyshealthfoundation.org/userfiles/NYSHF\\_Mathematica%20Final\\_v5.pdf](http://www.nyshealthfoundation.org/userfiles/NYSHF_Mathematica%20Final_v5.pdf)



there is no state law that requires chain pharmacies to print prescription drug labels in a standardized format to aid in consumer comprehension or to translate them so that all patients can understand them.

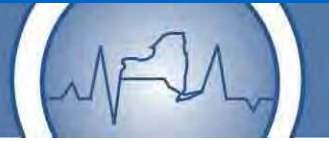
This proposal gives New York, and New York's chain pharmacies, the opportunity to be industry leaders in not only curbing unnecessary medical costs, but doing so while simultaneously ensuring that all patients, including the elderly and patients who are LEP, can understand their prescription drug labels. As the MRT seeks ways to spend money more wisely while improving health care, and given the simple, cost-effective, and efficient solutions to this serious health problem, enacting this proposal is a practical way to increase access to and improve the quality and safety of health care for all New Yorkers.

**Concerns with Recommendation:** In conversations between the New York State Board of Pharmacy with both chain and independent pharmacies, the regulated parties indicated that the cost of standardizing prescription labels may be significant. These costs may be alleviated by allowing adequate time to phase in the requirement.

#### **Impacted Stakeholders:**

##### **Organizations/Individuals in Support:**

- Fort Greene Strategic Neighborhood Action Partnership
- Coalition for Asian American Children & Families (CACF)
- Polyglot Systems, Inc.
- Community Healthcare Network
- Hispanic Counseling Center
- Bronx Health REACH
- Department of Pediatrics New York Presbyterian Hospital - Weill Cornell Medical Center
- The Korean Community Services of Metropolitan New York, Inc.
- Health Literacy Special Interest Group Academic Pediatric Association
- University at Albany, SUNY, Community Engagement/Outreach Center for the Elimination of Minority Health Disparities
- New York Asian Women's Center
- South Asian Bar Association of New York



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services.

**Program Area:** Health Disparities

**Implementation Complexity:**

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

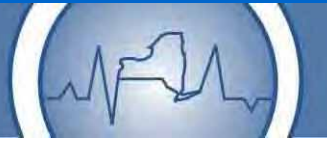
Statutory Change

State Plan Amendment

Federal Waiver

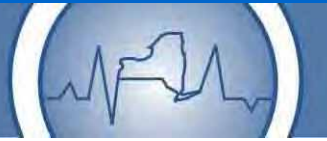
**Proposal Description:** Promote Population Health through Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services, by adding the services listed below to the basic benefit package. Large disparities in health outcomes attributable to chronic disease persist in the United States and in New York State. Racial and ethnic minorities are among the fastest growing of all communities in the U.S. and comprise approximately 34 percent of the total U.S. population. Yet data on health status point to significant evidence of poorer health outcomes among racial and ethnic minorities with respect to death and preventable disease. Racial and ethnic minority communities experience higher rates of heart disease, stroke, cancer, obesity and diabetes. Within the African American and Hispanic demographic, nearly 40 percent of children are overweight or obese. Some examples of chronic disease health disparities are:

- High blood pressure – a major risk factor for coronary heart disease, stroke, kidney disease and heart failure – is nearly 40 percent greater in African Americans than in Whites. In addition, African Americans continue to experience a higher rate of strokes, have more severe strokes, and are twice as likely to die from strokes as White Americans.
- Diabetes. Racial and ethnic minorities, especially the elderly, are disproportionately affected by diabetes. On average, African Americans are 2.1 times as likely as Whites to have diabetes, and are more likely than Whites to experience complications of diabetes, such as amputations of lower extremities. American Indians/Alaska Natives are 2.3 times as likely as non-Hispanic Whites of similar age to have diabetes. Hispanics are 1.7 times as likely to have diabetes as Whites, with Mexican Americans – the largest Hispanic subgroup – more than twice as likely.



The Health Disparities Workgroup recommends the following changes/enhancement to ensure Medicaid coverage of primary and secondary chronic disease prevention and treatment:

1. Diabetes. Currently New York State does not cover pre-diabetes treatment, a condition that affects 1 in 3 adults in the nation, 40% of whom will go to develop diabetes. In New York State, diabetes disproportionately impacts people of color and low income persons. Individual and group lifestyle counseling has been demonstrated to lead to a 58% success rate in delaying or preventing onset of diabetes. The Workgroup proposes that Medicaid (fee-for-services and managed care) cover pre-diabetes group and individual counseling services including services offered by community-based providers.
2. Asthma. Extending Medicaid coverage for home-based assessments is expected to reduce asthma hospitalization and ED visits for children and adults with poorly controlled asthma by reducing exposure to common asthma triggers that contribute to preventable exacerbations, by helping parents and children learn self-management skills such as using medication properly and what to do when asthma symptoms worsen, and by assisting individuals with accessing medical care. These actions will both improve health and reduce overall costs. Current funding and infrastructure to provide environmental services to this population are limited. This funding constraint means that individuals who may benefit from environmental services (in terms of both improved quality of life and reduced healthcare utilization) may currently lack access to these services. New Yorkers with asthma often live in environments that can exacerbate their symptoms and lead to preventable hospitalizations and ED visits. Compared to the nation, New York has higher asthma, ED and hospital discharge rates for all age groups and New York State's rates are roughly two times higher than the levels targeted in Healthy People 2010. The financial impact of New York's higher burden of asthma is significant. In 2007, the total annual cost of asthma hospitalizations in NYS was estimated to be \$535 million<sup>3</sup>. For 2005-2007, Medicaid accounted for 43% of the total asthma hospitalizations and incurred 37% of the total asthma hospitalization costs in NYS (Medicare accounted for 23% of the total asthma hospitalizations and 34% of the costs)<sup>3</sup>.
3. Lead Poisoning. To address this critical public health issue which disproportionately impacts minority children it is proposed that Medicaid be expanded to include coverage for costs associated with environmental investigations, and care coordination for children on Medicaid with lead poisoning. It is estimated that coverage of these services, and reduction in the number of children exposed to lead and for those exposed, assuring prompt access to appropriate care and treatment will result in \$1.15 million in State and local savings. Clinical lead screening, confirmatory and follow up testing are currently eligible for reimbursement by Medicaid however the cost of environmental investigations and care coordination for lead poisoned children are not. Previous analysis of NYC and upstate data has demonstrated that approximately 77 % of lead poisoning cases identified were to MA-eligible children, i.e. approximately 825 children annually with incident blood lead levels of 15 mcg/dL or higher. Provision of follow-up services by local Health Departments' costs on average \$ 2,750 per child.



4. Medicaid reimbursement for automated blood pressure cuffs for home use. Validated automated home blood pressure monitors are inexpensive, easy to use and becoming widely available. [Pickering, Hypertension 2008] Several short term studies have suggested cost neutrality to payers, based on reduced need for hypertension-based office visits or changes in medication [Shogikan, Med Care 1992; McManus, BMJ 2005] Currently, although MCO's can provide this benefit at their discretion, there is no requirement to do so and there is currently a cumbersome prior authorization process which limits use in populations that could benefit. Manual blood pressure cuffs where the patient must manually inflate a cuff, use a stethoscope for auscultation of Korotkoff sounds and visualize blood pressure readings from a manual dial are currently covered. However these are of questionable utility in patients with limited numeracy, health literacy, older patients, and in patients with limited eye-sight and manual dexterity. In addition, the majority of high quality studies have used automated cuffs, so inasmuch there is evidence of benefit it lies in use of automated blood pressure cuffs.

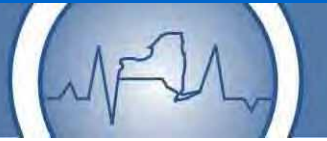
The challenge to New York is to adequately address poor racial and ethnic minority health status and persistent racial and ethnic health disparities at a time of rapidly increasing racial and ethnic diversity. In a report issued in September, 2009, the Urban Institute reported that by simply addressing racial and ethnic health disparities overall national health care costs could be reduced by nearly \$24 billion per year. The study examined a select set of preventable diseases among the Latino and African American communities, including diabetes, hypertension and stroke, and concluded that if the prevalence of such diseases in the African American and Latino communities were reduced to the same prevalence as those diseases occur in the non-Latino white population \$23.9 billion in health care costs would be saved in 2009 alone.

Nationwide health care costs for all cardiovascular diseases are \$442 billion annually; diabetes-associated costs are approximately \$174 billion annually; obesity related costs are approximately \$147 billion annually; and lung disease costs are approximately \$154 billion annually. In fact, cigarette smoking costs the nation an astounding \$193 billion in health costs and lost productivity each year. Society—and business—also incurs the indirect costs of these conditions, including absenteeism, disability and reduced productivity. A proven program that prevents diabetes can save costs within 3 years. A 5% reduction in the prevalence of hypertension would save \$25 billion in 5 years.<sup>15</sup>

The Trust for America's Health, in an analysis of potential annual net savings and return on investment (ROI) for states within five years of an investment of \$10 per person per year in strategic disease prevention programs in communities, found that New York would realize potential annual savings of \$1.3 billion or a 7: 1 return on investment see (<http://www.healthyamericans.org/reports/prevention08>) These economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. They found that many effective prevention programs cost less than \$10 per person, and that these programs have delivered results in lowering rates of diseases that are related to physical activity, nutrition, and smoking. The evidence shows that implementing these programs in communities reduce rates of type 2

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<sup>15</sup> TESTIMONY OF HOWARD K. KOH, M.D., M.P.H ASSISTANT SECRETARY FOR HEALTH  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, "THE STATE OF CHRONIC DISEASE PREVENTION" COMMITTEE ON HEALTH, EDUCATION,  
LABOR AND PENSIONS U.S. SENATE OCTOBER 12, 2011



diabetes and high blood pressure by 5 percent within 2 years; reduce heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduce some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years.

The Affordable Care Act also provides States the option to provide recommended preventive services with no cost-sharing requirements for patients in Medicaid, with incentives for eliminating cost sharing. A primary example of services that would both enhance health outcomes and reduce health care costs is pre-diabetes treatment. Currently New York State does not cover community-based services for pre-diabetes treatment, a condition that affects 1 in 3 adults, 40% of whom will go on to develop diabetes. In New York State, diabetes disproportionately impacts people of color and low income persons. Individual and group lifestyle counseling has been demonstrated to lead to a 58% success rate in delaying or preventing onset of diabetes (citation). The workgroup recommends that Medicaid fee-for-service and managed care plans cover pre-diabetes group and individual counseling services.

**Financial Impact:** Potential savings of at least \$1.3 billion annually based on the Trust for America's Health analysis. Savings specific to identified intervention are as follows:

**Lead – Investigations and Care Coordination:** Surveillance figures suggest that the total cost of providing follow-up services to MA-eligible children with BLL group of 15 mcg/dl or higher would be approximately \$2.3 million. At least 50% of this cost, or \$1.15 million, could be saved for the state overall (combined state and local shares) by claiming federal financial participation. The addition of MA reimbursement would represent a significant step in the Department's comprehensive agenda to eliminate childhood lead poisoning in NYS. Both CMS and CDC have provided guidance to states encouraging Medicaid coverage for these services.

**Asthma:** Total Medicaid cost associated with supporting a home environmental assessment and intervention program is estimated at \$6,500,000 annually (20,000 X \$325). Total return on investment is estimated at \$58,675,200 (cost of asthma hospitalizations prevented) and net savings are estimated to total \$52,175,200 annually (the difference between the two). These figures assume approximately 20,000 homes with asthmatics are visited annually at a cost of \$325, and asthma related hospitalizations cost \$12,224 per hospitalization, and are reduced by 24% by the home visit program. Additional savings in reduced emergency room utilization, unscheduled office visits, pharmacy cost, etc. are also anticipated to be reduced but are not factored in to the cost analysis.

- **Automated Blood Pressure Cuffs:** Several short term studies have suggested cost neutrality to payers, based on reduced need for hypertension-based office visits or changes in medication [Shogikan, Med Care 1992; McManus, BMJ 2005] The short term studies do not capture the expected reductions in high-cost cardiovascular events attributable to lower blood pressure. Although long term studies of self-blood pressure monitoring are lacking, it is well established through multiple randomized therapeutic trials that lowering blood pressure in individuals with hypertension reduces high-cost cardiovascular events. [Staessen, Lancet 2001.]



**Health Disparities Impact:** Significant given the disproportionate impact of chronic disease on racial and ethnic minorities in New York State.

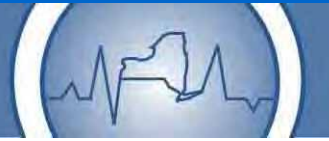
**Benefits of Recommendation:** A 2009 report by the Urban Institute estimates that in 2009, disparities among African Americans, Hispanics, and non-Hispanic whites will cost the health care system \$23.9 billion dollars. Over the 10-year period from 2009 through 2018, the authors estimate that the total cost of these disparities is approximately \$337 billion. With respect to Medicare and Medicaid, the report notes excess costs for both African Americans—more than \$12 billion annually in combined costs—and Hispanics—nearly \$5 billion—as a result of health disparities. As an example, a Medicaid-reimbursed diabetes prevention program will significantly delay and even prevent onset of diabetes, thus improving health outcomes and yielding significant savings to the state. Research published in 2010 found that for middle-age or older adults and for the obese, every screening method evaluated was projected to reduce costs to the healthcare system over a three year span even when factoring in medication costs and false negatives, (*Chatterjee R, et al "Screening for diabetes and pre-diabetes should be cost-saving in high-risk patients" ADA 2010; Abstract 65-LB.*) When averaged across screening tests, the chance to catch cases early and potentially prevent complications actually would shave an estimated 7.3% off the healthcare costs for those with a body mass index of 25 to 35 kg/m<sup>2</sup> and 21.5% for those in the over 35 kg/m<sup>2</sup> range. For the 40- to 55-year-old set, screening would cut costs 8.1%, while the savings were 17.1% for those over 55.

**Concerns with Recommendation:** Current investment required for longer- term savings.

**Impacted Stakeholders:** Persons with pre-diabetes, health care providers, adults and children with asthma, children at risk for lead poisoning, patients with uncontrolled hypertension and Medicaid funded health plans.

Organizations in support include:

- American Diabetes Association
- Alliance of New York State YMCAs
- Center for Independence of the Disabled, NY
- Housing Works
- Medicaid Matters New York
- Medical Society of the State of New York
- New York Chapter, American College of Physicians
- New Yorkers for Accessible Health Coverage
- New York Academy of Medicine
- New York City Department of Health and Mental Hygiene
- New York State Academy of Family Physicians
- New York State Association of County Health Officials
- New York State Dietetic Association
- New York State Healthy Eating and Physical Activity Alliance
- New York State Public Health Association
- The Bronx Health Link



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Streamline and Improve Access to Emergency Medicaid.

**Program Area:** Health Disparities

**Implementation Complexity:** Low

**Implementation Timeline:**

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Healthcare providers are eligible to receive reimbursement for treatment and services provided to undocumented immigrants suffering from emergency medical conditions through the Emergency Medicaid program. However, the current process to obtain reimbursement under the Emergency Medicaid program is burdensome on both providers and patients, leading to delayed or inadequate care and increased cost. Increasing awareness about the program among consumers, providers, and local Social Services districts and streamlining the application process through prequalification and the extension of certification periods for certain medical conditions will enable providers to receive appropriate reimbursement from federal funds and reduce hospital and institutional reliance on state charity care dollars.

The Health Disparities Workgroup recommends the following with respect to Emergency Medicaid:

1. Clarify Emergency Medicaid Application Procedures. The State Department of Health and other relevant agencies are urged to implement outreach initiatives and issue guidance to increase awareness about the availability of the Emergency Medicaid program and the ins-and-outs of its application process among potential consumers, local Social Services districts, and providers. Doing so would help ensure that eligible patients make use of the program and providers and hospitals are able to appropriately tap into available federal funding to cover the costs of providing emergency care to undocumented patients. Disseminating additional clarifying information about the program would also help local Social Services offices correctly identify and efficiently process paperwork for Emergency Medicaid-eligible consumers.





- 2. Prequalify Medicaid Financial Eligibility:** It is recommended that New York State create a limited scope Emergency Medicaid enrollment category code, which would enable local Social Services offices and facilitated enrollers to screen individuals who satisfy financial and other relevant criteria for Medicaid to determine whether they would likely qualify for Emergency Medicaid, should an emergency arise. Several states already implement Medicaid prequalification procedures, including California, Massachusetts, Michigan and Oregon.<sup>16</sup> Advanced screening and prequalification would *not* expand the scope of coverage available to undocumented immigrants in any way. Individuals would still need to suffer from an emergency medical condition as defined by federal and state statutes. Advanced prequalification would flag a patient's eligibility for Emergency Medicaid and eliminate the need for undocumented patients to complete an entire Medicaid application should an emergency medical condition arise. Prequalification would help to streamline the Emergency Medicaid process and ensure that providers and hospitals receive appropriate reimbursement for emergency care provided to undocumented immigrants from available federal funds. In addition, advanced screening may have the added advantage of increasing potential eligible patients' awareness of the availability of the Emergency Medicaid program.
- 3. Implement a 12-month Certification Period for Certain Emergency Medical Conditions.** The MRT health disparities workgroup recommends that New York State extend certification periods for certain emergency medical conditions, such as cancer or renal failure, which help ensure that providers receive appropriate reimbursement for the care and services they provide under the Emergency Medicaid program. With extended one year certification periods for emergency treatment related to certain chronic illnesses, physicians would no longer need to complete and submit additional certification forms every 90 days. Several states, including California, Connecticut, Maine, Virginia and Washington, have adopted extended certification periods for certain medical conditions. Extending certification periods for certain illnesses would reduce paperwork for treating physicians, patients, and staff at local Social Services Offices as well as reduce potential disruptions in coverage and reimbursement.

**Financial Impact:** This proposal is likely to be cost neutral with a slight increase resulting from increased usage, a modest decrease in administrative costs and in utilization of charity care funds.

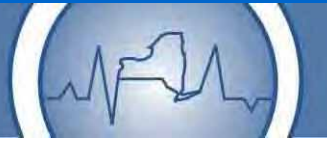
**Health Disparities Impact:** High

**Benefits of Recommendation:** Under the Medicaid program, healthcare providers may receive reimbursement for the treatment of an emergency medical condition provided to undocumented immigrants residing in New York State who otherwise satisfy Medicaid's income and other eligibility criteria.<sup>17</sup> These immigrants are ineligible for full coverage under the Medicaid program due to their immigration status. Emergency Medicaid provides limited coverage to undocumented immigrants in extremely narrow circumstances.

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<sup>16</sup> LEGAL MOMENTUM, EMERGENCY MEDICAID FOR NON-QUALIFIED ALIENS (2007), available at [www.legalmomentum.org/assets/pdfs/4\\_emergency\\_medicaid\\_chart.doc](http://www.legalmomentum.org/assets/pdfs/4_emergency_medicaid_chart.doc).

<sup>17</sup> 42 U.S.C. § 1396b(v)(3); 42 C.F.R § 440.255; N.Y. Soc. Servs. L. § 122(1)(e)(2011)



In order to access Emergency Medicaid coverage and reimbursement, an individual suffering from an emergency medical condition and his or her treating physician must complete three steps. First, the treating physician must certify, using form DOH-4471 “Certification of Treatment of an Emergency Medical Condition”, that the individual suffers from an “emergency medical condition”, which “manifest[s] itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in – (A) placing the person’s health in serious jeopardy, (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part”<sup>18</sup> within thirty days of the emergency.<sup>19</sup> The treating physician must also obtain the patient’s signature on the certification form in order to authorize the release of protected health information. The certification may cover a maximum of 90 days of treatment, with up to 30 days of retroactive coverage and up to 60 days or prospective coverage.<sup>20</sup> If the treating physician anticipates that the patient will need care for more than the maximum 90 day period, the physician must renew the certification by completing additional forms, as needed.<sup>21</sup> Secondly, the patient must complete a full Medicaid application. Lastly, the hospital at which the patient received care or the patient must submit the completed certification form and Medicaid application to a local Medicaid office, which will determine the patient’s eligibility for Emergency Medicaid.

#### **Problems in Current System that will be addressed by this proposal include:**

Lack of awareness among patients: Many individuals suffering from emergency medical conditions are unaware of the existence of Emergency Medicaid. The application process begins only after patients receive emergency treatment. Typically, eligible individuals fail to receive any information from their providers or hospital staff about the availability of Emergency Medicaid. As a result, despite being eligible for the program, many individuals end up receiving large medical bills, which they are unable to pay. In addition, concerns about accumulating additional medical debt prevent many individuals from seeking much-needed follow-up care.

Lack of awareness among social services offices: Community advocates also report that employees at some local social services offices, which process Emergency Medicaid applications, appear unfamiliar with the requirements of the program, rejecting completed Medicaid applications for the patient’s failure to enter a social security number, which is not required for Emergency Medicaid applications, thereby creating additional paperwork burdens and access impediments.

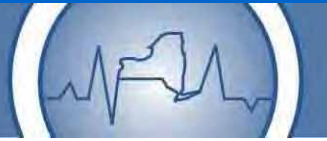
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<sup>18</sup> 42 U.S.C. § 1396b(v)(3); 42 C.F.R § 440.255

<sup>19</sup> Determining whether a particular condition qualifies as an emergency medical condition depends on the facts of each particular case as well as the medical judgment of the patient’s treating physician. *Scottsdale Healthcare Inc. v. Arizona Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 98 (Ariz. 2003) (noting that determining whether a particular condition qualifies as an “emergency medical condition” “should be largely informed by the expertise of the health care providers”). Coverage under Emergency Medicaid is not specific to a particular site or setting; depending on the nature of the emergency medical condition, Emergency Medicaid may cover treatment and services received outside of the in-patient or emergency room setting. *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259, 269 n.15 (quoting *Scottsdale*, 75 P.3d at 98) (noting that “whether a patient suffers from an emergency medical condition does not depend upon the type of bed or facility the patient may be in”).

<sup>20</sup> GIS 10 MA/012

<sup>21</sup> GIS 10 MA/012



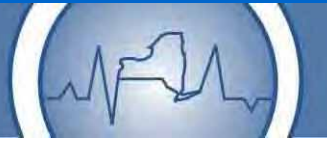
Lack of awareness among health care providers: In addition, advocates report that treating physicians are often unaware of their critical role in certifying a patient's emergency medical condition and may fail to complete and sign the certification form. Patients may subsequently encounter substantial difficulties in tracking down their treating physicians to complete and sign the certification form. Without the certification form, patients either fail to apply for Emergency Medicaid entirely or submit incomplete and ultimately unsuccessful Emergency Medicaid applications.

Failure to capitalize on available reimbursement streams: Lastly, in instances where the hospital has failed to initiate the Emergency Medicaid application process and a patient has unpaid medical bills, the hospital may seek reimbursement for the care provided from state charity care funds or other reimbursement sources, even though federal dollars are available to help defray the costs of providing care to undocumented immigrants.

**Concerns with Recommendation:** New York State Medicaid will need to take concrete actions to conduct outreach and provide education to providers, consumers and advocates who work with this population to ensure full understanding and in turn utilization of this benefit. In addition implement Medicaid prequalification procedures and implementation of a 12-month Certification Period for Certain Emergency Medical Conditions will required specific systemic changes along with education of providers, consumers, facilitated enrollers and managed care plans.

#### **Impacted Stakeholders:**

- Individuals who otherwise have intermittent and/or delayed access to critical health care services.
- Hospitals and other providers who will be able to realize more timely payment for services rendered and reduced reliance on charity care dollars.
- Social Service agency staff who through education about this program will realize reduced paperwork.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Address Disparities in Treatment at Teaching Facilities

**Program Area:** Health Disparities

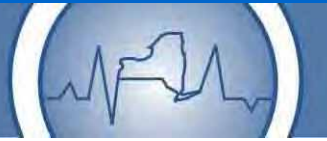
**Implementation Complexity:** Moderate

**Implementation Timeline:**

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

**Proposal Description:** The Health Disparities Workgroup recommends that administrative actions be taken by the New York State Department of Health (Department) to assure that the health care delivered by academic medical teaching facilities to persons who are uninsured, to people covered by Medicaid and to people who are privately insured is comparable and meets the same standards of care. Draft Medicaid Primary Care Standards developed by the Department in 2008 [http://www.health.ny.gov/health\\_care/medicaid/standards/](http://www.health.ny.gov/health_care/medicaid/standards/) that were to apply to all primary care clinicians in all clinical settings and draft Additional Standards for Article 28 Facilities with Training Programs in Internal Medicine, Pediatrics, and/or Family Practice [http://www.health.ny.gov/health\\_care/medicaid/standards/draft\\_standards.htm#additional\\_standards](http://www.health.ny.gov/health_care/medicaid/standards/draft_standards.htm#additional_standards) should be enforced to eliminate disparities in care between clinics and faculty practices and to ensure consistent delivery of high quality care to all individuals regardless of insurance or coverage status.

Workgroup members felt that faculty medical practices and general and specialty teaching hospital outpatient clinics differ in the services offered to patients. Workgroup members noted differences in continuity of care; patient access to physicians; on call after-hours; continuity through hospitalization; communication (reporting) back to referring physicians; access to appointments; and quality of supervision. Workgroup members felt that New York State is unique in the fact that it allows teaching hospitals (those that train residents) to establish two models of care within their walls that provide substantially different levels of quality in the care they deliver. Faculty practices, which may have agreements to use space within state licensed teaching hospitals, provide care to privately insured patients and those covered by Medicare in a setting that the workgroup believes provides better continuity of care with an attending physician, patient access to physicians on-call after-hours, and good communication with referring community providers.



General and specialty teaching hospital clinics, which often provide care for the uninsured, people on Medicaid including those in Medicaid Managed Care, are staffed by rotating residents and fellows and rotating staffs of supervising attending physicians and therefore may provide little to no continuity of care over time, may have inadequate communication with referring community providers and may refer patients to the emergency room if they call after-hours. All providers, regardless of type of practice should be required to comply with a consistent set of standards that guides the quality of care provided to patients.

**Financial Impact:** By requiring a single level of care that affords all patients quality services, after-hours call, effective communication with community providers and comprehensive and coordinated care overall costs to the system will be reduced. New York State has substantially increased payment to these institutions for ambulatory care and may be paying, in some cases, more for people covered by Medicaid than private insurers pay for their enrollees. Despite this, work group members felt these individuals are provided care inferior to that provided in faculty medical practices providing services in the same physical settings. In the long run this inferior care leads to increased costs to the Medicaid system. A lack of communication with referring community providers means that care is duplicated, errors in medication administration are increased and care is often maintained in higher cost hospital settings than in lower- cost community settings. Furthermore, the lack of continuity of care has been shown to reduce the speed at which diagnostic work-ups and therapeutic interventions are completed, leading to adverse outcomes and greater overall costs. Finally, a lack of after-hours coverage for the clinics leads to unnecessary emergency room use and hospitalizations.

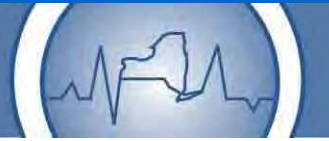
**Health Disparities Impact:** This proposal will improve the quality of care delivered to persons who are uninsured and who are covered by Medicaid including many persons who currently suffer significant health disparities.

**Benefits of Recommendation:** By requiring a single level of care that affords all patients quality services, after-hours call, effective communication with community providers and comprehensive and coordinated care health status will improve for all patients along with reductions in overall systemic costs to the Medicaid system. Metrics to track savings include reduced emergency room visits, reduced hospitalizations and Increased access to timely hospital-based out-patient specialty care.

#### **Concerns with Recommendation:**

- The Primary Care Medical Home (PCMH) waiver program was recently approved by CMS and will be implemented in primary care training sites (Partnership Plan Waiver). The program has the goal of addressing many of the issues related to communication, access, follow up, referral management that are being raised in the proposal without specifically requiring changes in service delivery models.
- There is currently a perception among institutional providers that there are prohibitions regarding use of clinic facilities for faculty medical practices which would need to be clarified and addressed before this recommendation could be fully adopted.
- Department resources and staff would be needed for oversight and enforcement of these standards.

**Impacted Stakeholders:** Teaching hospitals, consumers and the Department of Health



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Enhance Services to Promote Maternal and Child Health

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**

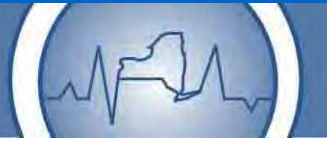
- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends that the following actions be taken as part of a comprehensive initiative to improve maternal and child health in New York State particularly among racial and ethnic minorities:

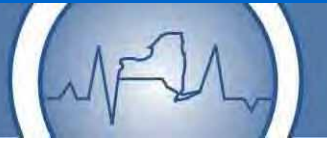
1. Expand access to coverage in the Medicaid Program for contraception and other family planning services to prevent unintended pregnancies
2. Expand Medicaid coverage for inter-conceptional care following an adverse pregnancy
3. Expand Medicaid coverage to include breastfeeding education and lactation counseling during pregnancy and in the postpartum period and provide financial incentives to hospitals to provide breastfeeding support
4. Support initiatives to demonstrate effective and efficient use of HIT technology between hospitals/health care systems and community-based health organizations to improve care delivery for women and infants (quality, timely access, appropriate utilization) to reduce costs while improving health outcomes.

The specifics of each of these proposals follow below. These actions should result in improved maternal and child health and reduced costs to the Medicaid program.

- **Expand financial eligibility for Medicaid coverage for contraceptive and other family planning services from 200% FPL to 300% FPL.** This will require a parallel expansion of criteria for MA coverage for pregnant women. Both are expected to yield overall cost savings through reduced expenses associated with unintended pregnancies and poor birth outcomes.



- **Consider only the income of the applicant in determining Medicaid eligibility for contraceptive and other family planning services for individuals over 21 years.** Under both the current Family Planning Benefit Program and the new State Plan service under development, individuals under age 21 may be considered in this way, but not applicants over age 21. A good cause exception should be established to allow applicants over age 21 to request this consideration, including applicants involved in abusive relationships.
- **Determine Medicaid income eligibility for contraceptive and other family planning services by counting the applicant as a household of two (or more) rather than one.** Currently in NYS, MA eligibility for pregnant women is determined based on counting the applicant as a household of two (or more) rather than one, using this same methodology for determining eligibility for family planning services will increase access and ensure eligibility parity for both pregnant women and women seeking family planning services.
- **Provide Medicaid coverage for contraceptive and other family planning services for undocumented women who are not pregnant.** Currently in NYS undocumented women are eligible for MA during pregnancy and, through the Family Planning Extension Program (FPEP), for MA coverage for Family Planning services for 26 months post-pregnancy, but are not otherwise eligible for MA coverage of family planning services. Coverage for family planning services should be extended to all undocumented women to ensure parity, to be funded at 100% state share, as is currently done for post-pregnant women through FPEP.
- **Provide Medicaid coverage for a dedicated preconception visit for all women and adolescents of reproductive age on Medicaid,** particularly those women and teens with chronic health conditions that have high potential for adverse impact on a pregnancy. Reimbursement for a preconception visit is particularly important for women and teens with chronic health conditions that have high potential for adverse impact on a pregnancy. Encouraging patient visits with an obstetrician prior to conceiving may result in improved prenatal care. This visit can be reimbursed at an enhanced rate to encourage physicians and primary care clinics to provide the service.
- **Provide Medicaid coverage for breastfeeding education and lactation counseling** during pregnancy and in the postpartum period and provide financial incentives to hospitals that provide breastfeeding support (as recommended by the World Health Organization; i.e. have been certified by “Baby Friendly USA, Inc.”). *The Baby-Friendly Hospital Initiative* (BFHI) is a global program to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding.
- **Coordinate service delivery among and between community-based social health organizations (CBHOs) and clinical providers using Health Information Technology (HIT) and uniform screening criteria for perinatal risks.** These risks, if identified and ameliorated in a timely manner can contribute to significant reductions in Medicaid costs due to poor health outcomes with life span consequences.



The steps outlined above, implemented as whole, will significantly reduce barriers and expand access to family planning services to high-need populations. Careful consideration should also be given to replicating the eligibility criteria and determination process used in the California FPACT Program which has been in existence since 1999. This 1115 waiver program was recently approved by CMS as a California State Plan Amendment and has been proven to be highly effective in averting unintended pregnancies. Specifically, FPACT applicants do not need to provide an SSN; may self declare their income and do not need to provide documentation; may self declare the size of their household; and do not need to provide documentation of CA residency. These eligibility criteria have greatly expanded access to family planning services, especially among adolescents.

### Financial Impact:

- Expanded Medicaid coverage. A reduction of only 1% of premature births to MA-enrolled women would result in average annual savings of \$64,384,376. Implementing enhanced case management services for all MA women with adverse pregnancy outcomes and maintaining eligibility of women in the expanded eligibility categories to result in reduced high-risk births is cost-effective. Every dollar invested in helping women avoid pregnancies they did not want to have saves \$4.02 in Medicaid expenditures that otherwise would have been needed for pregnancy-related care (Guttmacher Institute, 2009) According to the March of Dimes, the average cost for management of a premature or low birth-weight baby is \$49,000 in the first year. By comparison, cost of care for a newborn without complications is \$4,551 in the first year, a difference of \$44,449. MA accounts for approximately 50% of births in NYS.
- Breastfeeding Education and Lactation Counseling. Increasing breastfeeding rates can reduce the prevalence of various illnesses and health conditions which will in turn lower health care costs. A recent academic article estimated that if 90% of US families complied with medical recommendations to breastfeed exclusively for 6 months, the health care savings would be \$13 billion per year nationally, and save over 900 deaths per year, almost all exclusively infants. Babies exclusively breastfed in the hospital are 40% more likely to be continue breastfeeding at 6-8 weeks.<sup>22</sup> Assuming that each counseling visit costs \$20, and an average of 3 visits per infant, the proposal would cost \$60 per birth. There were ~250,000 births in New York in 2009.<sup>23</sup> Coverage for all births would cost \$15 million. Savings would be derived in the long term by increasing the rate of exclusively breastfeed infants, improved health and reduced health care costs<sup>24</sup>. Assuming a savings of \$475 per infant who is breastfed, a 15% increase in breastfeeding rate would amount to a net savings of \$2.8 million savings in health care costs.

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<sup>22</sup> New York State Department of Health, unpublished dataset, 2009.

<sup>23</sup> Ibid.

<sup>24</sup> **The Economic Benefits of Breastfeeding: A Review and Analysis.** By Jon Weimer. Food and Rural Economics Division, Economic Research Service, U.S. Department of Agriculture. Food Assistance and Nutrition Research Report No. 13.





- Incentives paid to baby Friendly Hospitals. An \$25 incentive paid to Baby Friendly Hospitals per birth, for 249,970 births translates to \$1.9 million in annual Medicaid costs associated with Breastfeeding support assuming that 25% of births were at hospitals that were Baby Friendly and 25% of mothers took advantage of breastfeeding education/lactation counseling. These costs are balanced against \$475 savings in health care expenses for each infant who exclusively breastfeeds for the first 6 months of life, for a net benefit of \$317 per infant. Thus the potential maximum savings to the state Medicaid program are \$ 29 million (based on 249,970 births in 2009, approximately 50% of which are covered by Medicaid).

**Health Disparities Impact:** Significant benefits would accrue to racial and ethnic minorities who experience significant health disparities in birth outcomes including low birth weight and preterm births in New York State.

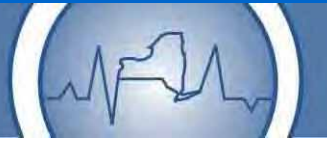
**Benefits of Recommendation:** Although New York has made tremendous strides in improving birth outcomes, key perinatal indicators have remained stagnant or have worsened. These poor outcomes result from complex medical, psychological, social and environmental factors that can present significant public health challenges to a state as diverse as New York. Some of the most significant factors that influence birth outcomes occur before pregnancy, such as nutritional status and other health behaviors.

In 2008, the percent of women giving birth in NYS who received early prenatal care was 66.5%, significantly below the Healthy People 2020 goal of 90%. There has also been little change in low birth weight rates for the past decade. In 2008, the prevalence of low birth weight was 8.2% of all births, higher than the Healthy People 2020 goal of 7.8 % of all births. Data also show that disparities in birth outcomes are often significant. For example, in 2008, 12.5% of black infants were born low birth weight, and black women were more likely to have preterm births than white and Hispanic women.

The 2008 NYS Minority Health Surveillance Report indicated that NYS' infant mortality rate for black babies was 11.3 as compared with 4.4 white deaths for every 1000 live births. African American women are also more likely to experience a miscarriage or an early term delivery than white women. In 2006, 16.8 % of black women went into pre-term labor compared to 10.8% of white women. Observed disparities are not simply the result of differences in income and education: experts note that "black women are more than twice as likely to deliver a baby prematurely." Poverty, chronic diseases, and poor access to health care contribute to the high mortality rates, as well as stress. (**Sources:** New Jersey's Black Infant Mortality Reduction Resource Center (BIMRRC) and The Kaiser Family Foundation).

**Specific benefits of the recommendations offered are as follows:**

1. Ensure access to effective contraception and other family planning services for all women of reproductive age. Access to family planning services including funding for contraceptive services and supplies is one of the most fundamentally cost-effective public health investments. Multiple studies have demonstrated that providing coverage for family planning services results in cost savings, as the cost of providing pregnancy-related care greatly outstrips the cost of providing contraceptive services.



It is estimated that 51% of all pregnancies nationally are unintended and over 50% of women whose pregnancies were unintended were not using contraception at the time they became pregnant. Over 50% of births in NYS are covered by MA.

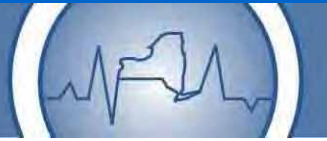
2. Inter-conceptional Care Coverage. Women who experience high-risk pregnancies and/or poor birth outcomes are more likely to experience the same problems in subsequent pregnancies. Effective management of chronic health problems (such as obesity, diabetes, and hypertension) between pregnancies, along with prevention of unintended pregnancies/adequate spacing of repeat pregnancies, has significant potential to reduce the costs of repeated adverse birth outcomes for both mothers and infants. Mothers, who are overweight or obese during pregnancy, as measured by body mass index, are known to be at risk for significant complications. These can include but are not limited to miscarriage, birth defects, hypertension, macrosomia, gestational diabetes, increased rates of Cesarean sections, and in general the morbidity and mortality of these women and children is higher. Many women who become MA eligible as a result of pregnancy status subsequently lose MA eligibility/coverage after birth, thereby increasing the likelihood that chronic health problems will not be optimally managed prior to another pregnancy. Perinatal health outcomes are directly impacted by the health of the woman prior to her pregnancy. Over 50% of pregnancies are unintended, diminishing the opportunity to foster optimal health at the time of conception.

3. Breastfeeding Education and Lactation Counseling. Provide Medicaid coverage of breastfeeding education and lactation counseling during pregnancy and in the postpartum period and financial incentives to hospitals that provide breastfeeding support (as recommended by the World Health Organization; i.e. have been certified by “Baby Friendly USA, Inc.”). These two initiatives are anticipated to result in increased rates of breastfeeding, exclusivity and duration and in turn reduced infant healthcare costs, reduced risk of childhood obesity and asthma, reduced perinatal bleeding and anemia and reduced risk of breast or ovarian cancer (mother). The Workgroup recommends Medicaid reimbursement for breastfeeding support services conducted by a specially trained lactation counselor. Analogous to coverage currently authorized for diabetes education and asthma counseling, this service conducted by a specially trained lactation counselor would be billed to Medicaid under the license of a professional (MD, DO, NP, PA, NMW, RD, RN, other) in New York State. Coverage of breastfeeding support and counseling will be required by insurance exchanges by January 1, 2013.

Increasing the rate of breastfeeding is a cost-effective public health strategy to reduce health care costs associated with infant and childhood illnesses and achieve better health outcomes later in life. Breastfed babies have been found to have fewer episodes of acute respiratory illnesses, ear infections and stomach viruses, as well as reduced incidence of Sudden Infant Death Syndrome, and a decreased risk of asthma later in life. Breastfeeding also benefits mothers by reducing postpartum bleeding and anemia, and decreasing the risk for breast and ovarian cancers. In recognition of the well-documented, scientific evidence of the benefits of breastfeeding, the Surgeon General recently issued a Call to Action<sup>25</sup> to Support Breastfeeding, describing in detail how people and organizations can contribute to the health of mothers and their children in a profound and lasting way.

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<sup>25</sup> U.S. Department of Health and Human Services. *The Surgeon General’s Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011.



The Call to Action includes recommendations for insurance coverage for breastfeeding counseling and support.<sup>26</sup> In addition, recently issued HHS guidelines pertaining to insurance plans offered under the Patient Protection and Affordability Care Act require breastfeeding counseling and support to be covered without a co-pay.

4. Using HIT to coordinate service delivery among and between community-based social health and clinical care providers to enhance the quality of care to underserved populations and to increase the effectiveness of service navigation is recommended to improve overall health outcomes. This proposal recommends beginning with funding for community pilots with hospital and health care systems and community-based health organizations to demonstrate the effectiveness and efficiencies of using HIT technology to coordinate services, reduce fragmentation and redundancy and the associated costs; increase patient's access to health records and care engagement, improve quality and reduce costs. Use of a HealthSmart ID card will assure compliance with several health reform requirements for electronic health records and portability and increase the timely availability of data for community assessments and health planning to more effectively address health disparities.

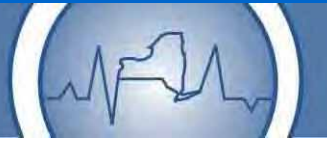
Use of this technology will virtually eliminate redundant tests and procedures as well as medical errors, greatly reduce patient admission times and insure that all caregivers are aware of patient encounters with other caregivers and outcomes. Most of the current demonstration projects in New York, like the Health Homes, are targeted to special populations that do not necessarily include pregnant and parenting women and their families. Yet it has been well-documented that low-income and immigrant women, and particularly those of color, have particular health needs that when ignored/addressed too late create significant health care treatment costs, some covered by Medicaid others borne by service providers as uncompensated care.

Poor perinatal health outcomes are major cost drivers for health care institutions and Medicaid. When high risk perinatal women receive early and comprehensive screening, and timely social and medical interventions to mitigate identified risks, birth and health outcomes are greatly improved. (Stankaitis et. al., 2005) The majority of infant and maternal morbidity and mortality and associated costs are related to women's/ maternal health and prematurity factors, so it is wise for prevention efforts to focus on maternal health supports and early identification and treatment of risks. (Mittal, 2005). This underscores the need for early screening and continuous primary/prenatal care, referral of those at high-risk for poor pregnancy outcomes, good management of chronic conditions such as diabetes, and comprehensive obstetric care and perinatal depression / behavioral health risks, among them.

Two examples of systems that work include the New Jersey State Health Department which has mandated the use of increased screening criteria and data collection processes that have in turn resulted in improved birth outcomes and reduced costs and in Upstate New York, Monroe County (the Monroe Plan for Health (MPH)) which has demonstrated savings on perinatal costs (\$2) saved for every dollar of enhancement spent. (Stankaitis et. al., 2005)

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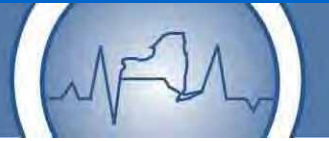
<sup>26</sup> U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011.



**Concerns with Recommendation:** Overall the recommendations suggest significant system changes to enhance initial and ongoing Medicaid coverage to promote maternal and child health. Specific concerns include a limited number of CLC health care professionals to support breastfeeding recommendations. Time will be needed to institute statewide training and certification. With regard to the health IT proposal it will be necessary to engage all parties for effective implementation.

**Impacted Stakeholders:**

- Female Medicaid recipients of child bearing age
- OBGYN Health personnel
- Primary Care Providers
- Hospitals
- Medical societies
- Breastfeeding advocates
- Health care Funders



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Address Disparities through Targeted Training for NYS' Health Care Workforce

**Program Area:** Health Disparities

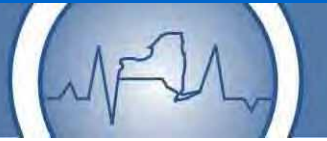
**Implementation Complexity:** Medium

**Implementation Timeline:**

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

**Proposal Description:** The Health Disparities Workgroup recommends that New York mandate training to promote care and reduce disparities experienced by people with disabilities, for Lesbian, Gay, Bisexual and Transgender (LGBT) persons and for persons at risk of suicide. More specifically the workgroup recommends the following:

- Mandated annual training of staff working within OASAS and OMH licensed programs on Sexual Orientation and Gender Identity and Expression to address cultural sensitivity as well as clinical issues that relate to the LGBT experience. Such training should not only take place in multiple settings including OASAS and OMH licensed programs but should target multiple provider specialties including pediatricians, family medicine and internal medicine providers as well as front line staff, family members and social networks to assure comprehensive community-based understanding and support.
- That the State apply for funding under ACA § 5307 Cultural Competency, Prevention, Public Health Proficiency, and Individuals with Disabilities Training for the purpose of developing curricula to address training in cultural competency, prevention, public health proficiency, reducing health disparities, and training for working with disabled individuals. In addition, Section 5403 of the ACA allows for certain health professions training dollars to be used to prepare health professionals for placement in underserved areas and with health disparities populations.
- Provide suicide prevention training material that is germane to various ethnic populations that are at highest risk of suicide attempts.
- That Disability Competency Training for NYS' Health Care Workforce be required to increase access to care and reduce disparities experienced by people with disabilities.



**Financial Impact:** Costs of implementation would be training costs and could be partially offset by ACA funding (is available to NYS).

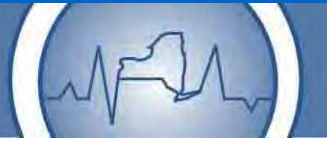
**Health Disparities Impact:** The impact of health disparities will be significant as appropriate training will facilitate enhanced utilization of services by identified populations and more effective engagement and retention in appropriate care and treatment.

**Benefits of Recommendation:** The purpose of this proposal is to reduce barriers to health services for Lesbian, Gay, Bisexual and Transgender persons, persons with disabilities and persons at risk of suicide and in turn result in better engagement and retention of these individuals in health care and treatment services as appropriate.

Persons of LGBT experience have higher levels of addiction and certain mental health problems than the population at large which may be related to the prejudice they experience because of their sexual orientation and/or gender identity and expression. They experience other mental health issues at the same rates as the larger population, but their identification as LGBT makes access to treatment sometimes difficult. Often, even professional staff in mental health services and drug treatment services are uneducated with regard to non-normative sexual orientation and gender identity and expression. This frequently causes insensitivity and even outright discrimination that become barriers to care for people of LGBT experience. This proposal would mandate annual training of staff working within OASAS and OMH licensed facilities on LGBT issues that would address cultural sensitivity as well as clinical issues that relate to LGBT experience.

A potential model is training now required by NYC HHC that is mandatory for all staff and is designed to improve access to healthcare for lesbian, gay, bisexual and transgender (LGBT) New Yorkers. The training focuses on the importance of showing openness, using inclusive language, welcoming and normalizing individuals' disclosure of their sexual orientation and is intended to address the fact that many LGBT individuals are totally turned off by the healthcare system and avoid getting the help they need out of fear of stigma and discrimination. There are serious health disparities in this community, like late cancer diagnoses, high rates of depression, and higher rates of smoking and alcohol use. To help patients to feel welcome and respected HHC now mandates cultural competency for providers as a first step to help providers understand issues of sexual orientation and gender identity.

With regard to persons with Disabilities, a survey of primary care physicians found that almost 20% were unaware of the Americans with Disabilities Act and 45% were not aware of its architectural requirements. Physicians receiving training on disability issues were in the minority. Lack of knowledge or disability-related education is consistent with other reports finding inadequate preparedness to provide health services to people with disabilities. (Michelle A. Larson McNeal, Ph.D.; LeeAnne Carrothers, Ph.D.; Brenda Premo, MA; "Providing



Primary Health Care for People with Physical Disabilities: A Survey of California Physicians,” Center for Disability Issues and the Health Professions, Fall 2002.) Studies related to lack of disability knowledge or education are too numerous to catalogue here.

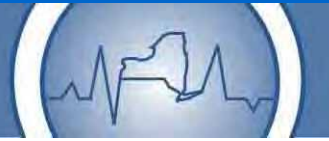
Various sections of the Affordable care Act promote and support training particularly for persons with disabilities as follows:

- ACA § 5307 Cultural Competency, Prevention, Public Health Proficiency, and Individuals with Disabilities Training: Secretary has the authority to award grants, contracts, or cooperative agreements to public and non-profit entities to develop curricula to be used in health professions training programs. The curricula should provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and training for working with disabled individuals.
- Section 5403 of the ACA allows for certain health professions training dollars to be used to prepare health professionals for placement in underserved areas and with health disparities populations.

A potential model is the Kansas “Healthcare Access for Persons with Disabilities” continuing education course which addresses strategies for offering “high quality care to adults and children with physical and sensory disabilities, along with solutions to problems in serving patients with disabilities. By the end of this course providers will: gain a better understanding of health, wellness and care issues concerning people with physical and sensory disabilities, recognize the four barriers to quality healthcare as addressed in the (ADA), identify a minimum of five skills to increase effective communication and problem solving to enhance quality care for people with disabilities. The course should be offered for CME/CNE credit. Another model is the Disability and Public Health Curriculum co-authored by Charles Drum, Gloria Krahn and Hank Bersani – published by APHA 2009.

**Concerns with Recommendation:** Would require the cost of committing staff time to training. New York would have to apply for funding pursuant to Section 5403 of the ACA.

**Impacted Stakeholders:** The LGBT community, persons who have disabilities and persons at risk of suicide and the providers who serve these individuals.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Enhance Services for Youth in Transition with Psychiatric Disabilities

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

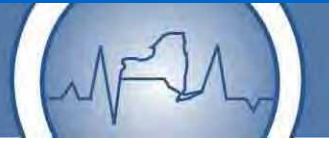
**Proposal Description:** The workgroup recommends that comprehensive programs to serve youth in transition to adulthood with psychiatric disabilities be developed across all systems of care including foster care, school populations that have youth with serious emotional diagnoses (SED) and the juvenile justice population to ensure that youth with psychiatric disabilities who are aging out of these programs do not end up homeless or in the criminal justice system.

More specifically the workgroup recommends that Medicaid (the Medicaid Rehab Option - MRO<sup>27</sup>) be used to support the provision of rehabilitative, community-based services to transitioning youth (ages 16-24 years) with psychiatric and co-occurring psychiatric-substance abuse diagnosis. The MRO services have the advantages of reimbursing services delivered in clients' natural settings as well as in offices. They can be used to ensure coverage of points of intervention for transitioning youth including youth in the educational system with SED that require intervention. Medicaid coverage of services and programs that will assist these youth with successful development through education, employment and community integration will in turn reduce overall health system expenditures. Points of intervention should include youth drop in centers run by peers that integrate employment, education, vocational services, General Educational Development education and other necessary skills that will provide links to the community.

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<sup>27</sup> The Medicaid Rehab Option incorporates rehabilitative, community-based services to persons with psychiatric and co-occurring psychiatric-substance abuse diagnosis. The MRO services have the advantages of being reimbursed for delivery in clients' natural settings as well as in offices. They focus specifically on assisting clients with gaining skills and resources that allow them to live and function as independently as possible.





Provision of these programs will assist clients with gaining skills and resources that allow them to live and function as independently as possible and will pay for supported education, pre-employment training and ADL skill training. It is also recommended that New York better utilize and publicize the Medicaid Buy-In program which offers Medicaid coverage to people with disabilities who are working, and earning more than the allowable limits for regular Medicaid, to insure that when these youth transition to an adult home and are employed, they do not lose benefits.

**Financial Impact:** TBD

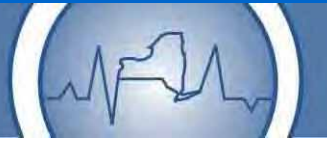
**Health Disparities Impact:** Youth with serious emotional diagnoses are at increased risk of homelessness, poor health, being uninsured and in the criminal justice system. Only 35% of young disabled people are employed full- or part-time, compared to 78% of individuals without disabilities, and they are three times as likely to live in poverty,” Funded interventions will assist these youth and promote health and well being.

**Benefits of Recommendation:** Youth in transition with psychiatric disabilities cross all systems of care including the school system, foster care and juvenile justice. Over 40% of these transitional age youth drop out of high school and end up homeless, in the criminal justice system or in emergency rooms. Points of intervention to insure that these youth receive the services and programs that will assist them in successful development through education, employment and community integration will promote health and reduce overall health costs.

It is estimated that nationally at least 2.4 million young adults aged 18 through 26—or 6.5 percent of the 37 million non-institutionalized young adults in that age range—had a serious mental illness in 2006, and they had lower levels of education on average than other young adults. This estimate of 2.4 million is likely to be low because certain groups that may have high rates of mental illness, such as the institutionalized, were not included in the NCS-R. Nearly 90 percent of young adults with serious mental illness had more than one type of disorder. For example, 32 percent of these young adults had a drug or alcohol-related disorder in addition to another type of mental disorder. In addition, compared to young adults with no mental illness, those with serious mental illness have significantly lower rates of high school graduation (64 versus 83 percent) and continuation into postsecondary education (32 versus 51 percent)

Young adults with serious mental illness face several challenges, including finding services tailored to their specific needs, qualifying for adult programs that provide access to mental health services, and navigating multiple programs and delivery systems. Existing public mental health, employment, and housing programs are not necessarily tailored to their mental disability or age range, which may discourage these young adults from participating.

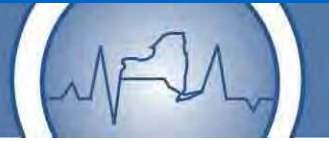
Three states, Maryland, Massachusetts and Mississippi use the Medicaid rehab option to pay for services related to community living, psych rehab programs, symptom management, and counseling and ACT. In Massachusetts rehab option used in Medicaid has helped to fund recovery oriented services for adults with psychiatric disabilities including the acquisition of skills essential for everyday functioning.



A report issued by the State (Massachusetts) recommends that there be better use of the rehab option to pay for services for youth in transition. With appropriate and timely transition planning to connect youth with employment, post-secondary education, and support services, these programs and services will make a positive difference in hundreds of young lives.

**Concerns with Recommendation:** Pending Federal guidance regarding use of this benefit.

**Impacted Stakeholders:** Juveniles with serious emotional diagnoses; schools, juvenile justice and foster care providers.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Effective Use of Charity Care Funds

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

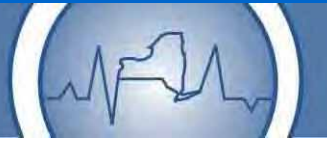
**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the charity care reimbursement system be revised to ensure that charity care funding is transparent and is used to pay for the care of the uninsured. New federal law under the Affordable Care Act (ACA) will use some of the current federal funding under DSH (Disproportionate Share Hospitals) to pay for care of the newly insured. Remaining DSH funding will be distributed to states based on the remaining number of uninsured and that use the money to pay for care of the uninsured and target to hospitals with high Medicaid patients. To continue to receive New York will be required to change the current way that federal matching funds for charity care are distributed to hospitals.

The Workgroup specifically recommends that two principles guide the distribution of charity care funds: (1) Funding should follow the patient – hospitals should be paid from the charity care pool for providing care to uninsured patients; and (2) Payments to hospitals should be progressively increased based on providing a larger proportion of care for the uninsured.

Based on these principles, specific changes in the way the State distributes Charity Care funding were developed and are offered for consideration:

- The first step is to start with a uniform reimbursement, the median statewide Medicaid reimbursement rate, as a leveler for all hospitals in the state.
- The second step is to add to this median rate the regional costs for things like salaries and then to add more for the care of sicker patients.
- The third step is to add more dollars on a progressive scale for hospitals that treat a higher percentage of uninsured patients.



- The final step only occurs if the federal DSH dollars are reduced; in this instance it is proposed that the current pools be combined to fund public and private hospitals. This is very important because the 21 public hospitals in the state provide the lions' share of services for the uninsured.

To ensure that safety-net hospitals that provide a high proportion of care for Medicaid patients but do not provide as much care for the uninsured do not lose money as a result of the charity care recommendations, it is proposed that there be a special increase in the Medicaid reimbursement rate to cover potential funding shortfall. It is also recommended that there be an increase in the dollar amount of the Charity Care pool which funds community health centers for the care of the uninsured.

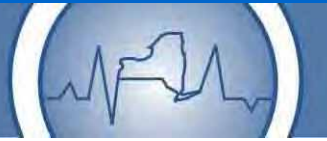
### **Background:**

New York has a long history of using public financing to help hospitals provide care to uninsured and underinsured patients. The State remains committed to supporting those institutions that provide this care. However the formulas that allocate bad debt and charity care funds are not transparent and it is difficult to trace the allocation of fund back to care delivered.

The Commission on the Public's Health System (CPHS), and others, has long advocated for a more transparent system, where money indeed follows the patient.

Over a period of years, the CPHS documented the allocation of public dollars from the State's \$847 million Hospital Indigent Care Pool intended to compensate hospitals for the indigent care they provided. As a result of this effort, CPHS published two reports that showed little or no relationship between the actual dollars received by the hospitals from the hospital Charity Care pool and the amount of health care services they provided to the uninsured. It is interesting to note that there is a separate community health center pool to pay for the care of the uninsured. This pool of dollars is much smaller than the hospital pool and is funding allocated to health centers based on their reporting care that they provide to the uninsured.

Despite recent efforts to change the allocation of charity care dollars, provider resistance has maintained the system almost untouched. There has, however, been movement over the last several years to ensure that they uninsured have access to health services regardless of their ability to pay. The first change was passage of the Hospital Financial Assistance Law (Subdivision 9-a of Section 2807-k of the New York State Public Health Law) – also called Manny's Law. For the first time, the State required that all hospitals develop a charity care sliding scale fee policy for New York residents with incomes at or below 300% of the federal poverty level, post these policies, and notify patients of their right to a sliding fee scale for payments based on income and family size.



The second important change came as the result of a 2008 State Task Force which reviewed the hospital charity care system, and resulted in the requirement that 10% of the total \$847 million in the hospital Charity Care pool be distributed on the strength of the hospital showing it had cared for numbers of uninsured patients. The benefit of this very small movement is that in order to receive a share of the 10%, hospitals have to report all of the care they delivered to people with no health insurance. The reporting has enabled a more in-depth look at what hospitals are doing to provide care and to match that care to the dollars being distributed to these institutions.

**Financial Impact:** The Hospital Indigent Care (Charity Care) Pool has \$847 million annually for distribution to hospitals. The concept here is for redistribution of these funds to ensure that those hospitals providing care for the uninsured are paid for providing this care. This is also a way for encouraging hospitals to meet their obligations under Manny's Law to post and inform patients of a sliding fee scale for uninsured patients with family income under 300% of the federal poverty level. Although this is currently a requirement, it is not at all clear how many hospitals are actually informing patients about charity care at the time that they arrive for services. Funding that would follow the uninsured patient could serve as an important stimulus for hospitals to follow the Manny's Law requirement, and it could result in preventive and primary care patients who now use the Emergency Room. Use of primary and preventive care could mean a reduction in overall cost of care. Another very important consideration is that in the not too distant future there will be a reduction in federal Disproportionate Share Hospital dollars to pay for newly insured patients under the Affordable Care Act (ACA). Federal DSH dollars will be reduced by \$500 million in 2014.

"The HHS Secretary will develop the DSH allotment reduction methodology to apply funding reductions to states. The methodology will be structured to ensure that states using DSH funding appropriately are able to retain such funding. Specifically, the methodology will:

\*apply the largest reductions to states that (i) have the lowest uninsured rates (based on Census data), (ii) have the lowest levels of uncompensated care (excluding bad debts), and (iii) do not target DSH payments to hospitals with high volumes of Medicaid inpatient care..."<sup>28</sup>

If New York State does not make changes in the hospital charity care distribution formula this year, the state stands to lose millions of federal dollars.

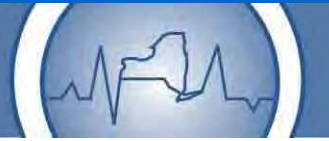
**Health Disparities Impact: High.** Assuring the Charity Care funding is appropriately used to support care and services for the uninsured will primarily benefit New Yorkers who currently experience significant health disparities.

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<sup>28</sup> *Implementing Federal Health Care Reform: A Roadmap for New York State.* Boozang, Patricia, Dutton, Melinda, Lam, Alice and Bachrach, Deborah. August 2010. New York State Health Foundation.

# Redesigning

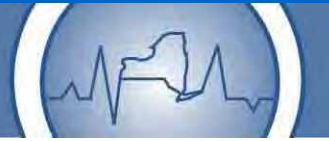
THE MEDICAID PROGRAM



**Benefits of Recommendation:** Reduction in disparities in treatment and improved clinical outcomes

**Concerns with Recommendation:** Implementation would require New York State to revise its payment methodology. There is the potential for unintended consequences for providers who will lose significant funding as a result of the proposal.

**Impacted Stakeholders:** All hospitals and Community Health Centers, Consumers, and the Department of Health.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Hepatitis C Care and Treatment through Service Integration

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

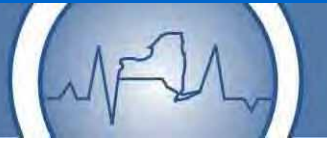
**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities workgroup recommends that steps be taken to integrate Hepatitis C (HCV) care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.

The purpose of this proposal is to create an integrated hepatitis C care model that will ensure comprehensive and coordinated quality care for HCV mono-infected and HIV/HCV co-infected persons, by providing HCV medical management and treatment, mental health and substance use services, care coordination and peer education/support services within primary care environments. While Health Homes are not disease specific, each Health Home will have COBRA providers in their network and those members with Hepatitis C who are eligible for Health Home services will be expected to receive appropriate care management around their needs (physical, behavioral, social).

The integration of such services is designed to: 1) improve the identification of HCV mono-infected individuals; 2) increase their access to and engagement in care; and 3) support adherence to care and improve treatment outcomes while also addressing other health conditions of the client. With recent advances in HCV testing, the number of individuals knowing their HCV status is increasing; at the same time more effective treatments aimed at curing more people with HCV are becoming available. Therefore, the need for timely access to medical care and treatment is crucial. Unlike HIV, HCV can be cured in some cases and treatment is short term. Studies have shown that earlier diagnosis and earlier treatment lead to better treatment outcomes.

**Financial Impact:** Savings associated with reduced health care needs and thus expenditures resulting from enhance care coordination, access and treatment adherence will result. Most of these services are independently covered by Medicaid. Grant funding currently supports infrastructure costs (staff, peer counselors).



**Health Disparities Impact:** High

**Benefits of Recommendation:** Reduction in HCV-related Medicaid expenditures through enhanced coordination, access to and adherence in treatment.

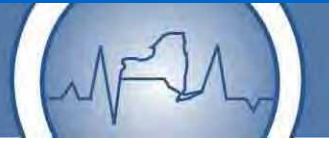
**Concerns with Recommendation:**

- There may be an inadequate number of primary care providers willing and able to treat HCV. However, this proposal could lead to an increase in the number of providers.

**Impacted Stakeholders:**

- Community health centers,
- HIV primary care providers,
- Drug treatment programs.
- Medical providers (health care facilities and practitioners), NYSDOH-authorized syringe exchange programs, addiction treatment providers, pharmacies.





## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Full Access to the Mental Health Medication on the Medicaid Formulary

**Program Area:** Health Disparities

**Implementation Complexity:** Low

**Implementation Timeline:**

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

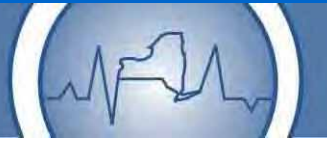
**Proposal Description:** The Health Disparities Workgroup recommends that all Medicaid recipients who are in managed care plans where the pharmacy benefit is no longer carved out continue to have full access to mental health medications under the Medicaid formulary. To assure continued access to ongoing medications the Workgroup recommends that the State Health Department provide written notification to health plans urging that all individuals on existing mental health medications remain on that medication (unless changed by their physician) whether or not the medication is subject to pre-authorization. In addition it is recommended that the Department of Health send a letter to Medicaid recipients that identify medication resources available to them through the State and recourse should they have difficulty accessing medications.

**Financial Impact:** None.

**Health Disparities Impact:** Significant benefits would accrue to persons living with mental illness.

**Benefits of Recommendation:** Recent Medicaid changes eliminated the carve out of all mental health medications. Prior to these changes, there was access to the full array of mental health medications for anti-depressants and atypical antipsychotics. Given the variability in individualized reaction to medications, it is essential to recovery to continue to assure individuals access to the full array of mental health medications.

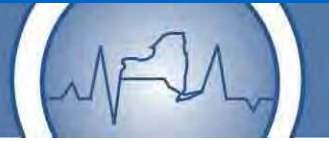
The Department of Health has encouraged health plans to cover the full array of mental health medication in their formularies; most plans have agreed to 'grandfather in' all mental health medications. The Health Disparities Workgroup urges the Department to follow up with a statement (in



writing) to providers and consumers indicating that all individuals on existing mental health medications may remain on that medication (unless changed by their physician) whether or not the medication is subject to pre-authorization. Communication with consumers should also note available recourse if they perceive that a medication has been denied or discontinued. The recent changes and the letters sent to Medicaid recipients have led to a great deal of anxiety regarding mental health medication coverage in each health plan – additional communication should help to relieve that anxiety and assure continued access to needed medications.

**Concerns with Recommendation:** Costs associated with mailings to consumers.

**Impacted Stakeholders:** Health Plans and Medicaid enrollees with mental illness.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Medicaid Support of Water Fluoridation

**Program Area:** Health Disparities

**Implementation Complexity:**

**Implementation Timeline:** SFY 2012

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** Medicaid funds will be used to support costs of community water fluoridation equipment and chemical additives. With this waiver New York proposes to utilize Medicaid dollars to support community water fluoridation equipment, supplies and staff time in population centers (cities of over 50,000) where the majority of Medicaid eligible children reside.

**Financial Impact:** Studies comparing the cost-effectiveness of water fluoridation compared with other strategies for reducing tooth decay always conclude that water fluoridation is the most cost-effective approach. Analysis of dental procedures in predominantly fluoridated community water versus non-fluoridated drinking water communities in New York State suggests savings of \$24 per child<sup>29</sup>. Out of the approximately 2 million children on Medicaid in New York State, about 500,000 live in less fluoridated counties and another 1.5 million live in mostly fluoridated counties. With \$1 million investment, we estimate that the number of children on fluoridated drinking water will increase by 200,000 to 1.7 million children. At a savings of \$24 per child, and a utilization of 35%, we estimate the annual savings to be \$14million. Thus an investment of \$10 million is likely to yield savings of \$140 million to the Medicaid program. This is a conservative estimate, as claims for adjunctive services such as examinations; radiographs and complex treatments; and costs related to transportation, emergency room visits, and lost productivity are not included. Such annual decreases in claims per recipient when applied to lifetime exposure of the whole population have large societal benefits. Barriers to fluoridation of public drinking water include lack of resources for community water systems to purchase equipment and chemical additives to institute fluoridation or to upgrade old equipment.

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<sup>29</sup> Kumar JV, Adekugbe O, Melnik T. Geographic Variation in Medicaid Claims for Dental Procedures in New York State: Role of Fluoridation under Contemporary Conditions. Public Health Reports 2010;125 (Sept-Oct):647-654



**Annual Cost: \$ 1.0 million**

**Annual Net Savings: \$14.28 million**

**Health Disparities Impact:** Significant benefits would accrue to all children covered by Medicaid.

**Benefits of Recommendation:** Even though the Department of Health and Human Services and New York State Department of Health fully support drinking water fluoridation, approximately 30% of all children in New York receive community drinking water that is not fluoridated. Community water fluoridation at current levels results in a 20 to 40 percent reduction in **tooth decay** nationwide.

Assuring fluoride in community drinking water is especially important today because many people cannot afford dental care. Fluoridation of community drinking water helps people of all ages and income groups. Systematic reviews of the scientific evidence have concluded that community water fluoridation is effective in decreasing dental caries prevalence and severity (McDonagh MS, et al, 2000<sup>30</sup>, Truman BI, et al, 2002<sup>31</sup>, Griffin SO, et al, 2007<sup>32</sup>). Effects included significant increases in the proportion of children who were caries-free and significant reductions in the number of teeth or tooth surfaces with caries in both children and adults (McDonagh MS, et al, 2000b, Griffin SO, et al, 2007). When analyses were limited to studies conducted after the introduction of other sources of fluoride, especially fluoride toothpaste, beneficial effects across the lifespan from community water fluoridation were still apparent (McDonagh MS, et al, 2000b; Griffin SO, et al, 2007).

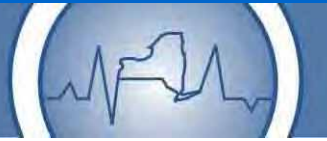
Tooth decay is the most common chronic disease in children accounting for about 30% of all health care expenditures in children. Although dental caries is preventable, many children unnecessarily suffer the consequences because of poor dental care and the inability to access preventive and treatment services in a timely manner. Untreated dental disease in children can lead to chronic pain, medical complications, early tooth loss, impaired speech development, poor nutrition and resultant failure to thrive or impaired growth, inability to concentrate in school and missed school days, and reduced self-esteem. The burden of oral disease is far worse for those who have restricted access to prevention and treatment services. Limited financial resources, lack of dental insurance coverage, and a limited availability of dental care providers all impact access to care and lead to widespread disparities in health.

**Concerns with Recommendation:** Some members of the public are opposed to fluoridation, in part due to concerns about excessive exposure to fluoride. Excessive intake of fluoride during the first 8 years of life leads to changes in the tooth enamel called dental fluorosis. It is a disturbance in the mineralization of enamel. Its manifestation ranges from barely noticeable fine lacy white markings to pitting of surface. A report released late last year by the Centers for Disease Control and Prevention linked fluoride to an increase among children in dental fluorosis. About 40 percent of children ages 12 to 15 had dental

<sup>30</sup> McDonagh MS, Whiting PF, Wilson PM, et al. Systematic review of water fluoridation. *BMJ* 2000;321(7265):855–9.

<sup>31</sup> Truman BI, Gooch BF, Evans CA Jr, editors. The guide to community preventive services: interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. *Am J Prev Med* 2002;23(Suppl 1).

<sup>32</sup> Griffin SO, Regnier E, Griffin PM, Huntley V. Effectiveness of Fluoride in Preventing Cavities in Adults. *J Dent Res* 2007;86(5):410-415.



fluorosis, mostly very mild or mild cases, from 1999 to 2004<sup>33</sup>. That percentage was 22.6 in a 1986-87 study. In fluoridated areas, dental fluorosis is seen mostly in milder forms and therefore, considered as a cosmetic effect and not an adverse functional effect. In fact, studies show that teeth with enamel fluorosis are more resistant to tooth decay.

**Impacted Stakeholders:** All New Yorkers, most notably children will be affected by the lack of access to fluoride. Critical inadequacies in access to oral health care in the U.S., particularly in the low-income population, have been a focus of increasing concern in the health policy community in recent years. *Poor children suffer the most dental disease and are less likely to receive dental care.* The burden of dental disease and conditions is not distributed evenly in children. The Surgeon General's report documented that poor children suffer far more, and more extensive and severe, dental disease than other children; indeed, they are about twice as likely to have untreated caries<sup>34</sup>. Another federal report, by the U.S. General Accountability Office, indicates that 80% of untreated caries in permanent teeth are found in roughly 25% of children who are 5 to 17 years old – mostly from low-income and other vulnerable groups<sup>35</sup>. That report also estimates that poor children suffer nearly 12 times more restricted-activity days, such as missing school, as a result of dental problems, than higher-income children. Because poverty is more prevalent among minority children than among whites, income-related disparities in oral health status can translate also into racial/ethnic disparities. At the same time that poor children have more dental disease than other children, they are less likely to receive dental care.<sup>910</sup> In 2006, nearly a quarter of all children age 2-17 had not had a dental visit in the past year, but poor and low-income children were more likely to lack a recent visit than higher-income children (31% and 33% versus 18%).<sup>36</sup>

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<sup>33</sup> Beltrán-Aguilar ED, Barker L, Dye BA. Prevalence and Severity of Dental Fluorosis in the United States, 1999–2004. NCHS Data Brief No. 53. November 2010.

<sup>34</sup> US Department of Health and Human Services. Oral health in America: A Report of the Surgeon General. Rockville (MD): National Institute of Health; 2000.

<sup>35</sup> GAO, MEDICAID: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

<sup>36</sup> Bloom B and Cohen RA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006. National Center for Health Statistics. Vital Health Stat 10(234). 2007.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Medicaid Coverage of Syringe Access and Harm Reduction Activities

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

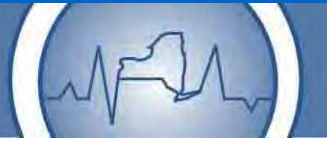
**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends the following three actions to promote and address health care needs of persons with chemical dependency:

- Clarify regulations to allow any medical provider to prescribe syringes to an injection drug use for purposes of preventing disease transmission, paid for by Medicaid. (Currently payment for syringes is only available with ESAP funding).
- Allow OASAS licensed drug treatment providers to be reimbursed for harm reduction counseling.
- Authorize NYS DOH AIDS Institute Syringe Exchange providers (community-based organizations) to be reimbursed by Medicaid for harm reduction/syringe exchange program services provided to Medicaid eligible individuals.

**Financial Impact:** Overall Medicaid costs would be reduced through enhanced engagement and retention of persons with chemical dependency in drug treatment, primary health and mental health services resulting in reduced inpatient hospital, detoxification and rehabilitation costs as well as reduced emergency room visits.

**Health Disparities Impact:** Significant. The services afforded under this proposal will reduce HIV/AIDS transmission. HIV/AIDS has had a devastating impact on minorities in the United States and in New York State. Racial and Ethnic minorities accounted for almost 71 percent of the newly diagnosed cases of HIV and AIDS in 2008. For Hepatitis the story is largely the same with African American men are 80% more likely to have chronic



liver disease than non-Hispanic White men; Asian American women are 2.4 times more likely to die from chronic liver disease, as compared to non-Hispanic Whites; Native Hawaiian/Pacific Islanders are seven times more likely to be diagnosed with chronic liver disease, as compared to non-Hispanic Whites and both Hispanic men and women have a chronic liver disease rate that is twice that of the White population.

**Benefits of Recommendation:** Implementing these proposals would increase the number and availability of harm reduction providers to the state’s injection drug-using population. In addition to retaining current grant funding, a Medicaid reimbursed program would greatly complement the existing structures and support for syringe access. Once linked into this system of care, individuals could more easily be integrated into a range of health care as well as mental health and substance use services. Research has shown that harm reduction and access to sterile syringes promotes entry to and retention in drug treatment, health care, and other social services and leads to reductions in and even cessation of injecting behaviors among program participants. Addiction treatment results in other outcomes such as reductions in use of and expenditures for emergency departments and outpatient and inpatient detoxification services, and also results in a reduction in transmission of HIV, hepatitis, and other blood-borne infections. (Addiction treatment has also been shown to result in reduced crime and increased employment.) Evidence of the benefits of harm reduction has supported the lifting of the ban on the use of federal funds to support programs such as syringe exchange. In addition, the Surgeon-General has determined that syringe services are effective in reducing drug abuse and HIV transmission, thus meeting the statutory requirement permitting the expenditure of Substance Abuse Prevention and Treatment (SAPT) block grant to pay for such services.

#### **Concerns with Recommendation:**

- Would require a redirection of OASAS resources.
- For clinicians who are not currently registered as providers in the Department’s Expanded Syringe Access Program (ESAP), writing prescriptions for syringes for purposes of injecting drugs may not be a common practice. Implementation will require an educational effort.
- The Federal Government may ban the use of federal funds for syringe exchange.

#### **Impacted Stakeholders:**

- Persons who are chemically dependent,
- Syringe Exchange and Harm Reduction Programs,
- OASAS-licensed drug treatment providers.
- Medical providers (health care facilities and practitioners), NYSDOH-authorized syringe exchange programs, addiction treatment providers, pharmacies

**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Basic Benefit Review Work Group

**FINAL RECOMMENDATIONS**





## **Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011**

### **Work Group Charge:**

- Conduct a thorough examination of the current list of covered benefits in the New York State Medicaid program.
- Extend the examination beyond the list of covered services to current copay, coinsurance and premium levels.
- Examine the latest cost-effectiveness research and value-based benefit design initiatives to see what lessons can be gleaned for New York State Medicaid.
- Develop a series of recommendations for modifications to the Medicaid benefit package and cost-sharing policies that will both improve health care quality and lower costs in the program.
- Focus on ways to monitor the impact of changes enacted in the budget regarding access to care and services.

The members determined that a full review of all benefit changes which could possibly be of value could not be conducted in the short period the group would exist. It was determined that it would be of more lasting value to develop guidance for not only the Group's current review of Medicaid benefits but for on-going benefit design. The Group adopted the following additional charges:

- Develop a recommendation regarding guiding principles which apply to any future reviews of benefit changes.
- Develop a recommendation regarding a process New York State Medicaid can follow in making future and on-going benefit decisions in response to new codes, new procedures, new technologies, and other advances in medical/behavioral knowledge regarding effectiveness and costs within the parameter of available resources in the Medicaid program.



**Work Group Membership:**

**CO-CHAIR: Frank Branchini**, President and CEO, EmblemHealth

**CO-CHAIR: Nirav Shah, MD, MPH**, New York State Commissioner of Health

**Elisabeth R. Benjamin**, Vice President of Health Initiatives, Community Service Society

**R. Scott Braithwaite, MD, MMSc**, Associate Professor of Internal Medicine, New York University School of Medicine

**Kate Breslin**, President/CEO, Schuyler Center for Analysis and Advocacy

**Basit Chaudhry, M.D., PhD**, Senior Researcher, Healthcare Analytics, IBM Research

**Henry Chung, MD**, Vice President and Chief Medical Officer, CMO Care Management Company, Montefiore

**Robert M. Corwin, MD, FAAP**, Pediatrician, former district chair, American Academy of Pediatrics

**Douglas DeLong, MD, FACP**, Governor-elect, NY American College of Physicians

**Mark Gibson**, Director, Center for Evidence-based Policy, Oregon Health & Science University

**Eugene Heslin, MD**, NYS Academy of Family Physicians

**Paloma Izquierdo-Hernandez MS, MPH**, President and CEO, Urban Health Plan, Inc

**Ira B. Lamster, DDS, MMSc**, Dean, Columbia University College of Dental Medicine

**Eliot J. Lazar, MD, MBA**, SVP & Chief Quality & Patient Safety Officer, NY-Presbyterian

**David Lehmann, MD, PharmD**, SUNY Upstate Medical University

**Peter Newell**, Director, United Hospital Fund's Health Insurance Project

**Arnold Saperstein, MD**, President/CEO, Metro Plus Health Plan

**Kathleen Shure**, Senior Vice President, Managed Care and Insurance Expansion, Greater NY Hospital Association

**Joseph Stankaitis, MD, MPH**, Medical Director, Excellus/Monroe Health Plan

**Albert George Thomas, MD**, Associate Professor of Obstetrics and Gynecology, Mount Sinai School of Medicine



## Meeting Dates and Focus:

**August 31, 2011** – The first meeting of the Work Group reviewed the group’s mission, vision, guiding principles, and charge. The Department of Health provided an overview of the Medicaid program including information regarding mandated and optional services, co-payments, federal requirements, primary care enhancements, enacted MRT reforms, population specific benefits and waiver services. The Department also provided an overview of the way in which new technology is currently evaluated to determine whether or not it will be covered by New York State Medicaid. The processes other states follow in making determinations were also discussed. Some specific areas for potential benefit reform were reviewed. The group was asked to establish a process for on-going assessment of benefits against evidence going forward.

**September 14, 2011** – The second meeting of the Work Group more closely examined the Group’s charge and expected output. Plans to produce specific recommendations to the MRT which are budget neutral, evidence-informed and cost-effective were reviewed. Additionally, the Group planned to establish a process to do an on-going assessment of benefits against evidence. A draft of the Group’s guiding principles was shared. Additionally, an overview of the benefit change research process was provided along with a discussion of the hierarchy of evidence. Examples of the ways in which other states use evidence were provided. Specific NYS benefits were examined as potential areas for reform.

**October 4, 2011** – The Work Group reviewed and finalized the guiding principles and the benefit review process documents. The remainder of the meeting was spent reviewing specific benefit reforms for consideration in the final package of proposals.

**October 19, 2011** – Final drafts of the principles and process documents were briefly reviewed and approved by all present group members. The remainder of the meeting was spent discussing the ten proposals for specific reforms to the Medicaid benefit package in detail. All of the Work Group members who were present at this meeting were in favor of advancing these recommendations with some suggested modifications and caveats to the MRT.



### **Outside Experts Consulted with:**

The group was aided by a presentation by the Oregon Health & Science University (OHSU) with input from the State University of New York on the research process, the use of evidence, and the way in which other states use evidence in benefit design. OHSU also provided several examples of benefits which have recently been reviewed and/or considered across the nation by public and private payers.

Additionally, Edward L. Hannan, Ph.D., M.S., M.S., F.A.C.C., Professor of Health Policy, Management and Behavior at the SUNY at Albany School of Public Health, shared his expertise on Percutaneous Coronary Intervention (angioplasty) with the Work Group. Dr. Hannan has expertise in health services research; evidence-based medicine; outcomes research; cardiac surgery; angioplasty, trauma systems; carotid endarterectomy; volume-outcome relationships in health care; medical decision-making; risk-adjustment; medical errors; and patient safety.

### **Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report:**

One of the Work Group's charges was to examine current co-pay, coinsurance and premium levels. The Group determined after discussion of possible co-payment changes there was significant concern, based on the literature, that even small incremental changes in co-payments can have unintended consequences in low income populations such as reducing utilization of important treatments and services. Also, since co-payments must be waived by providers if necessary, they are often an unintended 'tax' or reduction in payment to providers. It was decided to pend any co-pay change recommendation until a fuller analysis of positive and negative co-pays could be conducted.

Fiscal Note: In addition, because the Medicaid program is operating under a global cap, any benefit changes must be cap neutral.

Suggestions for specific benefit redesign came from the public, Work Group members, DOH contractors, NYC Department of Health and Mental Hygiene, and DOH staff from the Office of Health Insurance Programs (OHIP) and the Office of Public Health (OPH).



## Summary Listing of Recommendations

- A. *Benefit Review Principles*** – The set of principles carefully crafted by the Work Group highlights the use of evidence and the value in prioritizing benefits based on population impact and overall value to the program.
- B. *Benefit Review Process*** – A detailed process which addresses the criteria used to determine if the benefit should be reviewed, the evidence to be considered, the clinical as well as financial review, and the final approval authority. Additionally, an expert advisory panel is recommended to provide consultation as needed.
- C. *Specific Benefit Reforms*** –The Work Group have made specific recommendations in the following areas:
- 1) *Podiatry for Diabetics*
  - 2) *Knee Arthroscopy*
  - 3) *Back Pain Treatments*
  - 4) *Breastfeeding Support*
  - 5) *PCI (Angioplasty)*
  - 6) *Obesity Treatment*
  - 7) *Elective Delivery (C-sections and inductions) < 39 Weeks Gestation without Medical Indication*
  - 8) *Growth Hormone*
  - 9) *Tobacco Cessation Counseling by Dentists*
  - 10) *Nurse Family Partnership (NFP)*



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation: (A)**

**Recommendation Short Name: Guiding Principles for Benefit Design**

**Program Area: OHIP**

**Implementation Complexity: Low**

**Implementation Timeline: Short Term**

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

**Proposal Description:** The Work Group took considerable time and care in crafting the following set of guiding principles which were applied when developing their specific redesign recommendations and when conducting benefit reviews going forward.

The **guiding principles** recommended by the Work Group are as follows:

- 1) All Medicaid members will be treated equitably without discrimination so that they may attain the highest level of health.
- 2) If Medicaid budgets are insufficient to support all potential services, then priorities must be set by the program among services to be provided based on evidence and effectiveness.
- 3) Priorities in benefit design must maximize the health of the population served by the program and be based on an assessment of benefits, harms, and costs.
- 4) When assessing benefits, harms and costs, empirical evidence (when available and of high quality) will be critically appraised to determine its appropriateness for policy application and will be given more weight than subjective or expert opinion. The hierarchy of evidence used for coverage decisions includes:
  - Type I (highest): meta-analysis or systematic review of multiple well designed randomized controlled trials.
  - Type II: one or more well designed randomized controlled trials.



- Type III: well designed studies which could include nonrandomized controlled, pre-post, cohort, case-control, cross-sectional, observational studies.
  - Type IV: expert panel opinion/ high quality professional guidelines.
  - Type V (lowest): single expert, case report.
- 5) Criteria to be considered for evaluation of specific services and benefits follow those of evidence-based health care, and include:
- Evidence that it is better than receiving no service for the specific clinical condition(s) or populations.
  - The added benefit per added cost compares favorably to other treatments for the same condition.
  - Evidence that access to less expensive interventions does not create undue burden for individuals.
  - Evidence that benefits outweigh harms in improving health.
  - The burden of presenting evidence for the above criteria lies with those advocating the use of the service.
  - Level of evidence will be specified in accord with typology described above and reassessed when sufficient new evidence would suggest a possible change in benefit coverage.
- 6) Considering cost and value as well as cost control through benefit design are legitimate as they support the ability of the state to provide the maximum number of services that are effective in improving the health of the population. This approach will make the most efficient use possible of available resources and maximize the public good. Criteria for excluding or limiting benefits should focus on those services in which:
- Costs are high and evidence for clinical effectiveness is highly variable or low, or (the clinical intervention (product or service) is overused compared to evidence-based appropriateness criteria.
  - Evidence of additional value (benefits to cost) compared to other treatments for the same condition is low.
- 7) A highly limited number of benefit decisions may require an individualized approach including those pertaining to rare or emerging clinical conditions for which a high level of evidence is not realistic, certain experimental treatments where no 'standard of care' exists, and/or complex emergency circumstances.



- 8) In the evaluation of services and benefit design the outcomes of interest should include the preferences of patients, individual autonomy, and those outcomes generally of high value to patients such as survival, function, symptoms and quality of life.
- 9) Evaluation of benefit decisions on utilization, costs, and health outcomes (where feasible) should follow any 'major' benefit decisions in order to assess impact post-coverage decisions.
- 10) Every attempt should be made to eliminate any conflict of interest in the use of clinical experts.

Nothing in the benefit review principles or the process shall limit in any way the existing role or responsibility of the New York State legislature with regard to statutory authority over the NYS Medicaid program.

**Financial Impact:** A primary focus of the principles is to allow for cost control measures with the intent of ensuring funding is available to provide the appropriate level of necessary services to the maximum number of beneficiaries.

**Health Disparities Impact:** The principles are designed to ensure that Medicaid beneficiaries are treated equitably.

**Benefits of Recommendation:** Currently, the Medicaid program does not have a written set of principles to refer to when making decisions regarding benefit design. The consistent application of clear and relevant principles will serve to assist in the creation of an improved Medicaid program.

**Concerns with Recommendation:** None

**Impacted Stakeholders:** Providers, Health Plans, and Members





## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (B)

**Recommendation Short Name:** The Benefit Review Process

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** Short Term

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

**Proposal Description:** The Group also spent a great deal of time designing a detailed process for all benefit reviews. The process addresses the criteria used to determine if the benefit should be reviewed, the evidence to be considered, the clinical as well as financial aspects of the review, and the final approval authority. Additionally, it is recommended that an expert advisory panel be established to provide as needed guidance to the Medicaid program in regard to ongoing benefit design. There was a discussion regarding consumer/member input to the benefit process. The group agreed on the importance of this, but chose to use the general language of 'expert panel' which was intended to include consumers/members as well as others.

One aspect of the process which was considered by the group is the importance of evidence in the initial evaluation of benefits and the challenge of translating the evidence into specific benefit design.

The benefit review process recommended by the Work Group is as follows:

OHIP clinicians, consultants, and finance staff will perform a two-step review of Medicaid benefits beginning with a clinical review followed by a financial impact evaluation. Benefits or services to be reviewed will include existing or new technology with significant costs or utilization or health impact(s), requests external to the department, proposed new codes for services (CPT and HCPCS) and any new federal or state statute/regulatory changes that mandate review. Depth and breadth of reviews will be proportional to expense and/or potential health impact on population health.



- Most CPT and HCPCS reviews will not be given comprehensive reviews in situations of:
  - Low programmatic cost (considering both price and utilization);
  - Clear and known benefit;
  - Code clarification or update.
- Providers and manufacturers requesting coverage will be asked to assist OHIP in its process of understanding the safety and effectiveness of the proposed benefit by completing a standardized template of questions which describe the technology/service/device, its uses and health benefits, federal agency approvals (if any) such as the Food and Drug Administration (FDA), and a description and evaluation of the quality of the evidence base
- Review decisions for pharmaceuticals would remain within the authority of the Pharmacy and Therapeutics (P&T) Committee unless otherwise delegated to this process
- Experimental/Investigational requests would require humanitarian device exemption from the FDA and/or a local institutional review board protocol
- Reviews of existing benefits will occur on a regular and recurrent basis based on those services with high programmatic costs, high utilization, or new or emerging evidence

In the first step OHIP clinical staff will use the best evidence available to determine clinical effectiveness of the service/benefit proposed for review. Reviews may include (where available):

- Primary source documents;
- Clinical studies;
- Meta analyses;
- Coverage guidelines of major insurers (including Medicare);
- Clinical practice guidelines;
- Consensus panel or expert opinion statements;
- Academic consultants; and
- Current payment rules (APG logic).

Following review, recommendations from OHIP clinical staff may include:

- No coverage;
- Limited coverage (based on patient population, conditions, frequency/amount, indications, etc. and may be either prospective (prior authorization) or retrospective);
- Covered without limitations; or
- Deferred due to insufficient information.



For the second step, recommendations by OHIP clinicians that result in new benefits or services will be forwarded to finance staff to project anticipated costs (including any possible offsets through elimination or reductions in the need for other services) for Medicaid, including both FFS costs and impacts on health plan premiums. The clinical group will forward any information that may assist the finance staff in making their determinations.

Final determinations by OHIP regarding coverage will integrate clinical effectiveness results with impact on cost and cost effectiveness. Decisions that would result in an increase in annual Medicaid costs above \$1 million will be reviewed by the State Medicaid Director for final approval.

Final determinations, along with the rationale for decisions (for or against coverage) will be made publicly available.

An external expert group on benefits will be created as an advisory group to Medicaid. The Medicaid advisory group will consist of an external group of experts that provides overall guidance to the review process as needed, reviews benefit design in light of policy and program goals, and provides specific input into benefit reviews that are particularly challenging, high potential impact, or controversial. This group would meet quarterly, agenda would be posted to Department's website in advance and meetings will be open to the public.

Individual denials of coverage based on medical necessity (including denials based on experimental/investigational determinations) will continue to be eligible for statutory based appeals processes which may include 'internal' appeals, access to the state external appeal process, and/or fair hearing reviews.

All meetings of the expert advisory committee on Medicaid benefit review shall be open and public.

**Financial Impact:** There will be some costs to implement the process but many required staff and resources are already in place. Details regarding funding for the external expert group have not yet been determined. This process should return savings to the Medicaid program by focusing benefit decisions toward evidence driven policy.

**Health Disparities Impact:** Neutral

**Benefits of Recommendation:** This formalized, documented process for benefit review will be beneficial in many ways. A uniform fiscal analysis process along with a more structured review of evidence will allow for more informed decision-making.

**Concerns with Recommendation:** None

**Impacted Stakeholders:** Providers, Health Plans, and Members



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 2, 2011

**Recommendation: (C-1)**

**Recommendation Short Name:** Podiatry for Diabetics

**Recommendation Long Name:** Expand coverage of podiatry services to include private office podiatrists for adults with diabetes mellitus

**Premise:** Medicaid should cover this evidence based, cost effective service in all settings to improve access and reduce complications of diabetes, including amputations.

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** July 1, 2012

**Required Approvals:**

<input type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input checked="" type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

**Proposal Description:** Currently, MA covers the services of private practicing podiatrists only for children up to age 21 and for Medicare/Medicaid dually eligible recipients. Adults (age 21+) may obtain podiatry services in Article 28 hospital outpatient departments and free-standing clinics. Under this proposal, Medicaid will permit adult MA recipients who have a diagnosis of Diabetes Mellitus to obtain care from a private practicing podiatrist.

**Financial Impact:** In CY 2010, there were 58,000 Medicaid recipients (fee-for-service non duals) with a diagnosis of diabetes. Those recipients had 444 hospital admissions for lower limb amputations which cost the Medicaid program \$10.6 million. Routine preventive foot care can reduce the number of amputations by 50%<sup>1</sup> and therefore yield savings of \$5.3 million. The average payment for a routine podiatry visit is \$38.97 (E&M at \$30.97 and nail debridement at \$8.00). Based on an average of 2 visits annually/diabetic patient for 20 percent of this population (20% of 58,000), total Medicaid fee-for-service costs are \$0.9 million dollars. Based on this analysis, the net savings would be \$4.4 million.

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<sup>1</sup> Rogers, Lee C., DPM, Lavery, Lawrence A., DPM, and Armstrong, David G., Ph.D., (2008). The right to bear legs – an amendment to healthcare: How preventing amputations can save billions for the US health-care system. Journal of the American Podiatric Medical Association, Volume 98, No. 2, 166-168.



Note: Above fiscal does not include managed care or Medicare/Medicaid dually eligible enrollees; managed care plans presently cover all podiatry, and Medicaid fee-for-service covers deductible/coinsurance for dually eligible enrollees.

**Health Disparities Impact:** Type 2 diabetes is highly prevalent in certain Medicaid populations. Expanding Medicaid payment to private practicing podiatrists for the adult diabetic population will help to improve health outcomes for those populations where there is a higher incidence of adult onset diabetes.

**Benefits of Recommendation:** Studies show that routine foot care/examination in diabetic patients can identify risk factors predictive of diabetic complications, such as lower extremity ulcers, infections and amputations. Expanding podiatry coverage for adult diabetics will result in cost saving to Medicaid by decreasing the diabetic complications mentioned above. The American Diabetes Association recommends an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. Note: Medicare covers routine foot care performed by podiatrists in the presence of a qualifying diagnosis, of which Diabetes is one.

**Concerns with Recommendation:** Overutilization may be a concern. Appropriate payment edits will need to be put into place.

**Impacted Stakeholders:** Podiatrists, patients with diabetes, hospitals (lower amputation rates).



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-2)

**Recommendation Short Name:** Knee Arthroscopy

**Recommendation Long Name:** Eliminate coverage of arthroscopy of the knee for osteoarthritis

**Premise:** Medicaid should not cover the costs of knee arthroscopy for osteoarthritis because there is no evidence of benefit.

**Program Area:** OHIP

**Implementation Complexity:** Low

**Implementation Timeline:** April 1, 2012

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

**Proposal Description:** This proposal would limit coverage for arthroscopic knee surgery when primary diagnosis is osteoarthritis of the knee (without mechanical destruction of the knee).

The American Academy of Orthopedic Surgeons (AAOS) Board of Directors adopted The Clinical Practice Guideline for the Treatment of Osteoarthritis of the Knee (Non-Arthroplasty) in December 2008. This evidence-based guideline recommends against performing arthroscopy with a primary diagnosis of OA of the knee.<sup>2</sup> There is evidence that arthroscopic surgery for removal of loose debris, cartilage flaps, torn meniscal fragments, and inflammatory enzymes results in minimal pain relief and no functional benefit in patients that have joint space narrowing on standing radiographs.<sup>3</sup>

Many patients with joint space narrowing are older with multiple medical comorbidities. Such patients are more prone to complications and, consistent with the recommendations of the AAOS, there is no proven clinical benefit to arthroscopy of the knee for osteoarthritis (in the absence of mechanical

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<sup>2</sup> <http://www.aaos.org/news/aaosnow/feb09/cover1.asp>

<sup>3</sup> Howell, Stephen M., MD (2010). The role of arthroscopy in treating osteoarthritis of the knee in the older patient. *Orthopedics*, 33(9): 652.



destruction of the knee joint). Howell (2010) indicates that arthroscopic debridement of the osteoarthritic knee is no more effective than sham surgery and physical and medical therapy.<sup>4</sup>

**Financial Impact:** In CY 2010, Medicaid paid approximately \$400,000 for the knee arthroscopy provided to patients with a diagnosis of osteoarthritis. Elimination of this service will result in modest cost savings to the Program. The State is exploring whether any savings might accrue for Medicare-enrolled patients for whom the State is paying coinsurance.

**Health Disparities Impact:** Neutral

**Benefits of Recommendation:**

- Savings created by limiting arthroscopies to only those patients for whom there is medical necessity and anticipated benefit post-procedure.
- Reduce medically unnecessary surgeries and potential for complications in medically complex patients.

**Concerns with Recommendation:**

- Although a patient's primary diagnosis is osteoarthritis, there may be comorbid conditions that are not evident on exam and that would warrant performance of this procedure.

**Impacted Stakeholders:** Physicians, patients with OA of the knee, hospitals, managed care plans

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<sup>4</sup> Ibid.



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-3)

**Recommendation Short Name:** Back Pain Treatments

**Recommendation Long Name:** Eliminate payment for treatments for low back pain where evidence suggests no benefit or there is no evidence for benefit

**Premise:** Medicaid should end reimbursement for low back pain treatments that have no credible evidence of producing more benefit than harm.

**Program Area:** OHIP

**Implementation Complexity:** Low to Moderate

**Implementation Timeline:** April 1, 2012

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** This proposal would limit/exclude coverage of prolotherapy (see Note 1), intradiscal steroid injections, facet joint steroid injections, systemic corticosteroids and traction (continuous or intermittent) (see Note 2). Based on the current literature, intradiscal steroids offer limited clinical improvement in pain or function for patients with discogenic low back pain. Controlled trials have revealed minimal if any benefit.

Note 1: Prolotherapy is “natural” technique that claims to stimulate the body to repair a painful area. A sugar- based solution is injected into the affected ligaments or tendons, which leads to local inflammation. A wound healing cascade is purportedly triggered, resulting in the deposition of new collagen. New collagen shrinks as it matures and tightens/strengthens the ligament that was injected. Prolotherapy is not covered as a separate procedure (inactive code on eMedNY).

Note 2: Traction procedure codes are not active on eMedNY; however, traction may be provided in conjunction with physical therapy rehabilitation services.





**Financial Impact:** In CY 2010, Medicaid paid approximately \$7.7 million dollars for the identified medical procedures to treat low back pain. Eliminating coverage will result in considerable savings to the Program. If Medicare Part B coinsurance is not covered, then an additional \$378,000 in Medicaid savings would result.

**Health Disparities Impact:** Neutral

**Benefits of Recommendation:**

- Increased savings by limiting coverage of non-evidence based treatments for low back pain.
- Improved patient safety by limiting exposure to invasive procedures which can cause infections, steroid-related problems, and stretch injuries among others.

**Concerns with Recommendation:**

- Anecdotally, patients report temporary relief of back pain after steroid injections.
- Increased referrals for physical therapy (note: physical therapy is presently limited to 20 visits in a 12 month period).
- Potential co-insurance reductions would require further exploration and discussion.

**Impacted Stakeholders:** Physicians, patients, hospitals, Medicaid managed care plans



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-4)

**Recommendation Short Name:** Breastfeeding Support

**Recommendation Long Name:** Payment for specially trained lactation counselors

**Premise:** Medicaid should cover this USPSTF 'B' rated preventive service, which improves the health of infants, reduces short term health care costs, and can contribute to reductions in obesity.

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** September 1, 2012

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Provide Medicaid reimbursement for International Board Certified Lactation Consultant (IBCLC) services for eligible pregnant women. The United States Preventive Services Task Force (USPSTF) recommends interventions during pregnancy and after birth to promote and support breastfeeding (Grade B - there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial). Additionally, ACOG guidelines promote exclusive breastfeeding for the first six months of life. In accordance with ACOG, practitioners are directed to provide counseling and education regarding infant feeding choices with the woman during prenatal visits and immediately postpartum.

**Financial Impact:** The NYS DOH Office of Public Health estimates that cost savings realized from breastfeeding are approximately \$532 per infant per year due to lower incidences of treatment for otitis media, gastroenteritis, and necrotizing enterocolitis. Medicaid lactation counseling costs are estimated at \$240 per birth (based on 115,311 Medicaid births annually at an average of three visits with an IBCLC - current private pay rates range from \$50 to \$110/hour).



New York State currently has 627 International Board Certified Lactation Consultants (IBCLCs). Of these, 70% also hold a NYS professional license (i.e., 394 RN, 3 RNC, 35 NP, 7 LPN, and 11 CNM).<sup>5</sup> In addition, there are 1,900 Certified Lactation Consultants (CLCs) in New York.<sup>6</sup> To assure access to this service, consideration may need to be given to approving trained registered nurses that are not certified, perhaps at a lower rate than that paid to IBCLCs.

Projected fiscal impact (at \$240/birth for 115,311 births):

- 100% utilization - \$27.67 million dollars gross.
- 50% utilization - \$13.84 million dollars gross.
- 25% utilization - \$6.92 million dollars gross.

\*Net savings per infant/year (\$532 savings/infant - \$240 lactation counseling costs/infant):

- \$33.67 million for 100% utilization.
- \$16.84 million for 50% utilization.
- \$8.42 million for 25% utilization.

**Health Disparities Impact:** 2007 CDC breastfeeding rates are significantly lower for African-American babies compared to the rates for the total population. Additional utilization of covered services or coverage for IBCLC could increase the numbers of African-American babies that are breastfed.

#### **Benefits of Recommendation:**

- Improved health outcomes for breast-fed babies (lower rates of acute and chronic diseases such as otitis media, atopic dermatitis, gastrointestinal infections, lower respiratory infections, asthma, overweight, type 1 and type 2 diabetes and childhood leukemia).
- Improved outcomes for the mother (reduced risk of ovarian and breast cancers, diabetes, metabolic disease, and heart disease).

**Concerns with Recommendation:** Care will need to be taken to ensure there is no duplication of effort and careful integration with Medicaid and other state/federal funded programs. For example, the WIC program is charged with the responsibility of providing nutrition and lactation counseling to all participants. Similarly, local county health departments that provide postpartum home visits do offer assistance with lactation counseling.

**Impacted Stakeholders:** Pregnant women, prenatal care providers (hospital outpatient departments, free-standing clinics, physicians, licensed midwives, nurse practitioners), and CHHA/LHCSA.

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<sup>5</sup> Marsha Walker, RN, IBCLC, Director Public Policy, US Lactation Consultant Association. Personal communication, 10/07/11.

<sup>6</sup> The Center for Breastfeeding, Certified Lactation Counselor® (CLC) Training; Healthy Children Project, East Sandwich, MA 02537. Personal communication, 10/07/11.



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-5)

**Recommendation Short Name:** PCI

**Recommendation Long Name:** Eliminate coverage of Percutaneous Coronary Intervention (PCI) in circumstance of no clear benefit

**Premise:** Medicaid should not pay for expensive cardiac invasive services when evidence and professional recommendations do not support benefit over less expensive, less invasive, medical therapies. Medicaid should support the collection of this information through the cardiac registries, which improves quality, safety, and costs for Medicaid members and others.

**Program Area:** OHIP

**Implementation Complexity:** High

**Implementation Timeline:** September 1, 2012

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Limit coverage for PCI to only those patients who are not inappropriate for the procedure based on ACC/AHA appropriateness criteria. PCI is very effective for evolving heart attacks, but its value is less certain for patients with stable coronary artery disease (no recent heart attack or unstable angina). Studies have shown that for many people with stable coronary artery disease, coronary angioplasty is no better than optimal medical therapy at preventing future heart attacks or strokes, nor does it extend life.

**Financial Impact:** In CY 2010, there were 1874 Medicaid claims for PCI without a recent heart attack or unstable angina with enough information to obtain an appropriateness rating. A total of 206 of these patients (11.0%) were inappropriate for the procedure based on ACC/AHA criteria. The total average cost per Medicaid patient for patients without a heart attack was \$14,066. Applying this cost to the inappropriate procedures yields an annual cost savings of 2.9 million dollars.

Savings from this proposal will be used first to directly support the cardiac services registry with additional savings to return to the overall Medicaid budget.



**Health Disparities Impact:** Neutral

**Benefits of Recommendation:** Increased savings and decreased risk of complications by limiting coronary angioplasty to only those patients for whom there is clearly established medical necessity based on national guidelines.

**Concerns with Recommendation:** It will be necessary to develop a prior authorization process to ensure that quality care and patient safety issues are appropriately addressed.

**Impacted Stakeholders:** Physicians, patients, hospitals, Medicaid managed care plans.



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-6)

**Recommendation Short Name:** Obesity Treatment

**Recommendation Long Name:** Coverage of intensive behavioral therapy (IBT) for obesity

**Premise:** Medicaid should cover this USPSTF 'B' rated treatment for this major public health epidemic.

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** October 1, 2012

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

**Proposal Description:** Medicaid will cover intensive behavioral therapy for treatment of obesity. The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen all adults and children age 6 or older for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obesity. This proposal would incorporate recommendations of the USPSTF Grade B for children and adults (Grade B - there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial).

Criteria for coverage of Intensive behavioral therapy (IBT) for obesity in adults is a BMI > or = to 30kg/m<sup>2</sup> and overweight is 25-29.9 kg/m<sup>2</sup>. Obesity among children is defined as a BMI at or above the 95<sup>th</sup> percentile of the sex-specific BMI-for-age growth charts.



## Financial Impact:

### ADULTS:

As of August 2011, there were 2,564,654 adults <65 years enrolled in NYS Medicaid. From the NYS Behavioral Risk Factor Surveillance System (BRFSS) (2006), the prevalence of obesity is 30%, making 769,396 eligible for participation in an intensive counseling and behavioral intervention as a reimbursable service through Medicaid. A projected 5% of eligible **beneficiaries** (38,470) will enroll in the first full year.

### PROJECTED COSTS FOR THE NEW YORK MEDICAID PROGRAM

**The projected annual cumulative costs of intensive behavioral counseling are \$61.5 million.**

- Assumes \$80 per patient per visit x 20 visits = \$1,600.
- \$1,600 x 38,470 enrollees (5% of eligible) = **\$61.5 million.**
- Economic impact may vary depending on eligibility criteria, rates of participation and drop-out, in addition to potential differences in intervention delivery and effectiveness.

Note 1: Savings may be longer term based on fewer chronic conditions (e.g., diabetes, heart disease, or hypertension) and related office visits, hospitalizations, etc. associated with obesity.

Note 2: Consideration may need to be given to visit limits. As an example, under preventive services, Medicare covers medically necessary nutrition services for people with specific conditions. . A physician's referral is required to access these services initially and yearly if treatment continues into another calendar year. Coverage includes three hours of one-on-one counseling services the first year and two hours each year after that, with the potential for additional hours with a doctor's referral.<sup>7</sup>

### CHILDREN:

As of April 2008, there were 1,241,000 children and adolescents enrolled in Medicaid Managed Care (MMC) in New York State and In CY 2010, there were 819,000 children and adolescents (ages 6 to 19 y.o.) enrolled in Fee for Service Medicaid for an approximate total of 2,060,000 children. Estimates of obesity prevalence indicate that at least 17% of child and adolescent enrollees have a BMI percentile at or above the 95<sup>th</sup> percentile and that 58% of obese children have at least one co-morbid condition (adverse levels of lipids, blood pressure or insulin), making 203,116 eligible to enroll in comprehensive interventions as a reimbursable service through Medicaid. A projected 5% of eligible beneficiaries (10,155) will enroll in the first year.

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<sup>7</sup> <http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf>



The projected annual medical costs of Comprehensive Multidisciplinary Interventions are \$19,577,600.

- Assumes \$200 per patient per visit with the obesity care team x 16 visits = \$3,200.
- \$3,200 X 10,155 enrollees (5% eligible population) = \$32,496,000.
- Economic impact may vary depending on eligibility criteria, rates of participation and drop-out, in addition to potential differences in intervention delivery and effectiveness.

**Health Disparities Impact:** Clinicians will need to consider cultural norms when counseling patients.

**Benefits of Recommendation:** Intensive counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies with the goal of producing sustained weight loss will lessen the risk for developing diabetes, high blood pressure, coronary heart disease (CHD), hypertension, and stroke; type 2 diabetes; several types of cancer, including those of the colon, kidney, gallbladder, breast, and endometrium; sleep apnea; gall bladder disease; and certain musculoskeletal disorders, such as knee osteoarthritis. In addition, obesity is associated with decreased quality of life, including diminished mobility and social stigmatization.

**Concerns with Recommendation:**

- Competing demands affecting both clinicians and patients may get in the way of obesity counseling.
- Rates of patient non-compliance with plan of care.

**Impacted Stakeholders:** Providers, Managed Care Organizations, and Medicaid Recipients.





## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation: (C-7)**

**Recommendation Short Name:** Elective delivery (C-sections and inductions) < 39 weeks without medical indication

**Recommendation Long Name:** Reduce payments for elective Cesarean sections and inductions performed < 39 weeks without medical indication.

**Premise:** Medicaid should discourage this practice, which has compelling evidence of harm and is inconsistent with professional society recommendations.

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** September 1, 2012

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Do not cover elective C-section deliveries or elective induction of labor less than 39 weeks unless a documented medical indication is present. Infants delivered prior to 39 weeks have an increased chance of complications and double the mortality rate of infants delivered at full-term. Babies born by C-section are at greater risk for respiratory problems, compared with those born vaginally, even at full term. Further, maternal concerns include an increased risk of infection, injury to other organs, and infertility, as well as anesthesia complications, and difficulty with breast-feeding. Life-threatening risks such as serious bleeding and blood clots or the need for an emergency hysterectomy are increased in cesarean section deliveries. In certain limited situations, C-sections or inductions may be appropriate even without a medical indication. Special consideration will need to be given to address this.

**Financial Impact:** In CY 2009, there were 121,533 Medicaid births. Of these, 26,101 (21%) were 36-38 weeks in estimated gestation age. 13,411 (51%) were delivered spontaneously; 8,147 (31%) were delivered by induction and/or C-section with indication; 4,543 (17%) were induced or C-section without indication.



If there is a 2% reduction in NICU stays related to avoiding induction or C-Section without indication (270 stays avoided against 13,450 NICU stays in 2007) at an average cost of \$18,400 for a NICU stay, the savings would be almost \$5M per year. Savings could be even greater if more NICU stays are avoided as has been the case in States like Ohio that implemented a very successful program to reduce the number of pre-term births. All State savings should come from reduced NICU admissions and reductions in other adverse events. Consideration will be given to either prospective prior authorization or retrospective review against approved criteria.

\*Note: Data for C-sections and elective inductions are combined and the net effect is on reducing NICU admissions related to both interventions.

**Health Disparities Impact:** Neutral

**Benefits of Recommendation:**

- Avoidance of a pre-term delivery if due date calculation is inaccurate.
- Avoidance of health risks to mother and newborn.
- Reduction of NICU admissions.
- Reduced length of hospital stays.
- Reduced risk of neonatal respiratory problems.
- Decreased incidence of primary C-section rates will result in a decrease in repeat C-section (and associated costs).

**Concerns with Recommendation:** The reasons for increased C-section rates include: maternal preferences and characteristics, provider preferences and practice patterns, institutional factors, ambiguous indications and guidelines for C-section, and fear of litigation. Altering these attitudes and practice patterns will take considerable effort.

**Impacted Stakeholders:** Hospitals, physicians and other providers, managed care organizations, billing contractors, and Medicaid recipients.



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation:** (C-8)

**Recommendation Short Name:** Growth Hormone

**Recommendation Long Name:** Eliminate coverage for treatment of Idiopathic Short Stature (ISS) with growth hormone

**Premise:** Coverage for ISS is not medically necessary but cosmetic in purpose and does not treat a medical condition defined by growth hormone deficiency.

**Program Area:** OHIP

**Implementation Complexity:** Medium

**Implementation Timeline:** July 1, 2012

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

**Proposal Description:** Limit coverage of growth hormone injections for idiopathic short stature in children. Idiopathic Short Stature (ISS) is not considered to be a disease, but a term used to describe children two or more standard deviations below the mean for their age and gender and for who no alternate diagnosis can be made to account for this height. Insurance plans exclude coverage of growth hormones for short stature caused by heredity and not caused by a diagnosed medical condition. Coverage will remain available in cases of documented growth hormone deficiency (GHD) defined as a GH response of  $\leq 20$  mU/L confirmed by two growth hormone stimulation tests in children.<sup>8</sup>

Consensus guidelines published by the American Association of Clinical Endocrinologists (AACE) and the Growth Hormone Research Society (GRS) Consensus Committee state that the diagnostic test of choice for adults is the insulin intolerance test: a peak serum GH response less than 5 ug/L to insulin-induced hypoglycemia indicates GH deficiency.<sup>9</sup>

<sup>8</sup> \_\_\_\_\_. Author. (2003). Recombinant Growth Hormone Treatment in Children. <https://www.hayesinc.com/subscribers>

<sup>9</sup> \_\_\_\_\_. Author. (2002). Recombinant Growth Hormone Treatment in Growth Hormone-Deficient Adults. <https://www.hayesinc.com/subscribers/displanSubscriberArticle.do?articleId=2185>



**Financial Impact:** In CY 2010, 2,593 Medicaid children received growth hormone therapy. Fee-for-service program cost was \$40 million dollars. There was a limited number of Medicaid managed care claims - growth hormone drugs are normally dispensed by a pharmacy and pharmacy drugs have been carved out of the managed care benefit. Note: pharmacy has been carved back into the managed care benefit effective October 1, 2011. If limiting coverage results in a 25% utilization decrease (one NYS managed care plan found 30 percent of the children using growth hormone were diagnosed with ISS), fiscal savings will be \$10 million dollars gross.

Lee, et al. (2006) showed that for children, the estimated incremental cost-effectiveness ratio of GH treatment for ISS was \$52,634 per inch (per 2.54 cm), with an incremental height gain of 1.9 in (4.8 cm) during 5 years at an incremental cost per child of \$99,959. Alternate treatment strategies such as increased duration of GH treatment and high pubertal dosing of GH did not substantially improve the cost-effectiveness ratio.<sup>10</sup> Allen (2006) also indicates that use of growth hormone for ISS without evidence of underlying disease or growth hormone deficiency has uncertain benefits and significant costs.<sup>11</sup> Deodati and Cianfarani (2011) reviewed studies on use of growth hormone for ISS. The conclusions from this meta-analysis were that there is no study to date that has fulfilled the evidence-based medicine criteria for high quality evidence and a strong recommendation for use of GH for ISS.<sup>12</sup> Further, Deodati and Cianfarani (2011) found that the individual response to this therapy is highly variable and recommended further study to identify the responders. Cohen et al. (2008) concluded that further clinical research and development is warranted to ensure optimal management of children with ISS and to ensure that treatments are safe and beneficial.<sup>13</sup>

**Health Disparities Impact:** Neutral

**Benefits of Recommendation:** Considerable Medicaid cost savings will be realized and Medicaid policy will mirror that employed by other payers.

**Concerns with Recommendation:** Attention will have to be paid to assure that providers don't miscode claims to improperly indicate a growth hormone deficiency diagnosis in an effort to circumvent the new coverage policy.

**Impacted Stakeholders:** Primary care physicians, pediatricians, clinical endocrinologists, and Medicaid enrollees.

<sup>10</sup> Lee J, Davis M, Clark S. Estimated cost-effectiveness of growth hormone therapy for idiopathic short stature. *Arch Pediatr. Adolesc. Med.* 2006;160:263-269.

<sup>11</sup> Allen, David B. (2006). Growth hormone therapy for short stature: Is the benefit worth the burden? *Pediatrics*, Vol 118, 343-348.

<sup>12</sup> Deodati, Annalisa and Cianfarano, Stefano (2010). Impact of growth hormone therapy on adult height of children with idiopathic short stature: Systematic review. *BMJ* 2011; 342:c7157.

<sup>13</sup> Cohen, P., Rogol, A.D., Deal, C.L., Saenger, P., Reiter, E.O., Ross, J.L., Chernausek, S.D., Savage, M.O., and Wit, J.M. on behalf of 2007 ISS Consensus Workshop Participants (2008). Consensus statement on the diagnosis and treatment of children with idiopathic short stature: A summary of the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop. *J. Clin. Endocrinol Metab.* 93(11): 4210-4217.



## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation: (C-9)**

**Recommendation Short Name:** Tobacco Cessation Counseling by Dentists

**Recommendation Long Name:** Expansion of providers who can bill Medicaid for tobacco cessation counseling to dentists

**Precedent:** Medicaid should expand access to this evidence based, USPSTF 'A' rated, cost effective service which contributes to reductions in tobacco use.

**Program Area:** OHIP

**Implementation Complexity:** High

**Implementation Timeline:** October 1, 2012

**Required Approvals:**

<input checked="" type="checkbox"/>	<b>Administrative Action</b>	<input type="checkbox"/>	<b>Statutory Change</b>
<input checked="" type="checkbox"/>	<b>State Plan Amendment</b>	<input type="checkbox"/>	<b>Federal Waiver</b>

**Proposal Description:** Effective April 1, 2011, Medicaid expanded coverage of smoking cessation counseling (SCC) to all Medicaid beneficiaries. Each Medicaid beneficiary is allowed six counseling sessions during any 12 continuous months which must be provided face-to-face by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife either with or without an Evaluation and Management procedure code. SCC complements the use of prescription and non-prescription smoking cessation products. These products are also covered by Medicaid.

This proposal will enable dentists to be reimbursed by Medicaid for delivering smoking cessation counseling for an addiction that disproportionately affects Medicaid patients and is associated substantial healthcare costs.

Tobacco use is the leading cause of disease and premature death in New York State, responsible for more than 25,000 deaths annually. In 2010, personal health care expenditures attributable to smoking in New York totaled \$8.2 billion including \$3.3 billion in Medicaid expenses. The current adult smoking rate in New York is 15.5%. From 2003 to 2010, the prevalence of smoking declined faster in New York (29% decline) than in the United States as a whole (9% decline). While this overall decrease is significant, not every population group benefitted equally. Over the last decade, the prevalence of smoking has remained virtually unchanged for adults with lower levels of income and education.



Compared to the general population, smoking rates are considerably higher among those with less than a high school education (24.0%), those with household incomes less than \$15,000 (22.6%), and those who report poorer mental health (30.9%). Smoking prevalence among Medicaid enrollees in New York State (NYS) has decreased from 39% in 2003 to 31% in 2010, but Medicaid prevalence is still much higher than the private health insurance population (10.8%). These large disparities argue clearly for further expansion of Medicaid's smoking cessation benefit so that greater reductions in smoking can be attained. Smokers who are covered by Medicaid are just as likely to make quit attempts, but less than half as likely to quit successfully when compared to those covered by private insurance. One way to broaden delivery mechanisms is to ensure that more healthcare providers offer pharmacotherapy and counseling, the two components of effective smoking cessation treatment.

The *2008 U.S. Public Health Service Guidelines* report that the combination of pharmacotherapy and counseling doubles a smoker's chances of quitting, and that pharmacotherapy and cessation counseling are more effective than either approach independently.

In 2010, New York State Medicaid Managed Care reported that only half of Medicaid Managed Care enrollees in New York State discussed smoking cessation medications and strategies with their doctors. Additionally, a national survey found that less than one-fourth of Medicaid smokers received a prescription from their providers for smoking cessation aids.

## DENTISTS

New York State Education Law (§6604-a) requires dentists to receive ongoing training and coursework regarding tobacco, including recognition and treatment of the oral health effects of tobacco usage. Specifically, the continuing education requirements for dentists include at least two hours of training on tobacco use and dependence. As such, dentists are the only clinicians in New York State who have a training requirement specifically related to tobacco.

A study funded by the Robert Wood Johnson Foundation to evaluate a tobacco-use cessation program delivered via public health dental practitioners illustrates the potential of reimbursing dentists for smoking cessation counseling. Two public health dental clinics participated in this quasi-experimental design study. First, all patients in one clinic who used tobacco ( $n = 178$ ) received usual care. Next, the authors trained all practitioners to conduct a tobacco-use assessment and provide a brief cessation intervention. Subsequently, all patients in both clinics who used tobacco ( $N = 190$ ) received the intervention. All enrolled patients had an income at or below the federal poverty level. The authors conducted follow-up assessments at six weeks and three and six months after enrollment. Differences in self-reported quitting by condition between participants in the two groups were significant across all endpoints. Patients in the intervention group were more likely to quit than those receiving usual care (15.5 versus 4.3 percent) and after 12 months (18.8 versus 4.6 percent). Controlling for enrollment differences between patients in the two groups (age, race/ethnicity, time to first cigarette after waking), the authors found that differences between groups were significant for quitting at three and six months.



The results of this study suggest the viability and effectiveness of delivering a tobacco intervention to low-income smokers via public dental practitioners.

A more recent and larger study sought to compare the effectiveness of a dental practitioner advice and brief counseling intervention to quit tobacco use versus usual care for patients in community health centers on tobacco cessation, reduction in tobacco use, number of quit attempts, and change in readiness to quit. Fourteen federally funded community health center dental clinics that serve diverse racial/ethnic groups in 3 states (Mississippi, New York, and Oregon) were randomly assigned to the intervention (brief advice and assistance, including nicotine replacement therapy) or usual care group. The study enrolled 2549 smokers. Participants in the intervention group reported significantly higher abstinence rates at the 7.5-month follow-up, for both point prevalence and prolonged abstinence than did those in the usual care group. The results of this study also suggest the viability and effectiveness of tobacco cessation services delivered to low-income smokers via their dental health care practitioner in community health centers.

A dental survey conducted by Medicaid managed care indicate that Medicaid enrollees regularly see the dentist; among about 1,000 adult Medicaid Managed Care enrollees in NYS, 71% had visited a dentist at least once in the past 12 months, and 60% reported having a dentist that they see on a regular basis. Integrating tobacco treatment within dental care will enable a greater number of Medicaid enrollees to receive smoking cessation services.

**Financial Impact:** It has been suggested that New York State could possibly incur \$18.5 million in savings over a two year period if the utilization rate of Medicaid smoking cessation pharmacotherapy benefit rises to 40%. Forty percent was the benefit utilization rate achieved by the Massachusetts Medicaid program. These savings are based on avoidance of hospitalizations for acute myocardial infarctions and coronary atherosclerosis using 2009 Medicaid data.

A further breakdown of potential savings could yield the following: By increasing pharmacotherapy tobacco use by 20%, the projected two year cost savings would be \$9,257,863; a 10% usage would be \$4,628,932; and a 5% usage would be a \$2,314,466 possible savings.

These cost-savings are based upon a recently published journal article by Tom Land et al. that detected an association between use of a comprehensive tobacco cessation pharmacotherapy benefit among Massachusetts Medicaid enrollees, and significant decreases in claims for hospitalizations for acute myocardial infarction and coronary atherosclerosis.

Costs for smoking cessation for dentists is still being developed but at \$20 a session and two sessions per year the per person cost would be \$40 for counseling. The Medicaid average cost per person for nicotine replacement therapy is approximately \$300 per person for three month course of treatment. At a combined annual cost per person of \$340 for counseling and medication the total impact to treat 25,000 patients annually under this proposal would be \$8.5 million dollars.



**Health Disparities Impact:** Neutral

**Benefits of Recommendation:** This expanded service can provide greater access to effective, high quality smoking cessation treatment among Medicaid enrollees. Various meta-analyses have found that smoking-interventions delivered by non-physician clinicians are effective in increasing abstinence rates among smokers. Increased abstinence rates are associated with better health and lower cost.

**Concerns with Recommendation:**

- Replicating effects of the studies may be uncertain without proper training and outreach to dentists as well as enrollees.
- Potential scope of practice issues may need to be addressed.
- It is not clear if providing this service through dentists will increase the number of patients that access smoking cessation interventions.

**Impacted Stakeholders:** Medicaid members who smoke, dentists, managed care plans





## Medicaid Redesign Team Basic Benefit Review Work Group Final Recommendations – November 1, 2011

**Recommendation: (C-10)**

**Recommendation Short Name:** Nurse Family Partnership (NFP)

**Recommendation Long Name:** Statewide expansion of intensive nurse home visits for first-time mothers and infants

**Premise:** Medicaid should expand its support for this evidence based model to improve care for high risk mothers and infants, which has a documented return on investment (based on health, welfare, education, and criminal justice outcomes), and full support of CMS and HRSA.

**Program Area:** OHIP

**Implementation Complexity:** High

**Implementation Timeline:** Partial implementation – 1 year

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Nurse Family Partnership (NFP) is a nurse home-visiting program in which registered nurses visit low-income pregnant women in their homes during the pregnancy and up to the second birthday of the child. It is nationally recognized as a cost effective means of achieving improved health outcomes, self-sufficiency and parenting skills. The program currently operates in two counties – NYC and Monroe. Medicaid presently covers only the targeted case management component of the program. While it was initially believed that this coverage would support 40% of program costs, this has not proven to be the case. Medicaid payment represents approximately only 15% to 20% of the total program costs. This proposal will expand Medicaid coverage for all services under the NFP, and will additionally expand coverage to the entire State, thereby offering all Medicaid pregnant women access to improved pregnancy outcomes.



## Financial Impact:

Based on a 12% statewide patient enrollment, totaling 5,867 enrolled first-time mothers at an average cost/patient of \$6,594 annually:

- \$38.7 million dollars, and a five year cost of \$193.4 million dollars (gross).

NFP has proven nationally to save \$5.70 for every \$1.00 invested.<sup>1</sup> However, these dollars are not all Medicaid dollars and are not realized for as many as 15 years.

**Health Disparities Impact:** As a visiting nurse program, NFP allows for a first-hand look at an expectant mothers total environment. These home visits provide a working knowledge of an expectant mothers access to and utilization of health care, as well as their educational, social and, economic needs. Improved bidirectional communication and education helps pave the way for a mom's partnership with the healthcare delivery system and thereby raises the bar on clinical outcomes for each first-time mother and her newborn.

**Benefits of Recommendation:** NFP reports evidence of improved pregnancy outcomes, reduction in childhood injuries/emergency room use, child abuse/neglect, reduction in childhood emotional, behavioral and cognitive problems, increased spacing between pregnancies, and reductions in arrest of the mother. In addition, there is evidence of reduced reliance on TANF, Food Stamps, and Medicaid and other social service programs. A reduced use of alcohol, cigarette, and marijuana use has been recorded for enrolled mothers and children, and increased father presence in the household.

Nationally, Nurse Family Partnership (NFP) has consistently evidenced its ability to achieve the following outcomes:

Improvements in pregnancy outcomes (including a 79% reduction in preterm births among women who smoke and 35% fewer hypertensive disorders during pregnancy);<sup>2-4</sup>

- Reductions in early childhood injuries (including 39% fewer injuries among children, and a 56% reduction in emergency room visits for accidents);<sup>5-7</sup>
- Reductions in child abuse and neglect by 48%;<sup>8</sup>
- Reductions in childhood emotional, behavioral and cognitive problems (including 50% reduction in language delays of child age 21 months, and a 67% reduction in behavioral and intellectual problems at child age 6);<sup>9-11</sup>
- Increased spacing between pregnancies for Medicaid-eligible women (including a 28-month greater interval between the first and second child, 31% fewer closely spaced subsequent pregnancies, and a 32% reduction in subsequent pregnancies);<sup>12-16</sup>



- Other achievements worth noting are:
  - Reductions in arrests of the mother by 61%;<sup>17</sup>
  - Reductions in criminal convictions for the mother by 72%;<sup>18</sup> and
  - Increases in father presence in household by 42%.<sup>19</sup>

New York City's NFP (First-time Mothers/Newborns (F/TMN) Program) has achieved the following outcomes as shown by data collected through June 2011:

- 91.2% of mothers initiated breastfeeding (vs. 87% citywide),<sup>20</sup>
- 41.6% of mothers were still exclusively breastfeeding at 2-months postpartum (vs. 33% citywide),<sup>21</sup>.
- By four months of age, 80.8% of NFP infants received an ASQ assessment,<sup>22</sup>
- At 6-months postpartum, 87% of mothers use contraception (vs. 74% citywide),<sup>23</sup>
- At 18-months postpartum, 83% of mothers had no subsequent pregnancies (vs. 73% nationwide),<sup>24</sup>
- By program completion (24 months postpartum), 93.2% of infants were up-to-date with their immunizations (vs. 77% citywide),<sup>25</sup>
- 65.5% of 17-19 year old mothers completed their HS degree or GED (vs. 59% citywide),<sup>26</sup> and
- 52% of non-resident fathers were moderately to highly involved in their children's lives at 12-months postpartum (vs. 37% nationwide).<sup>27</sup>

The data from national studies of NFP and from New York City's F/TMN program all demonstrate similar and significant improvements in health outcomes for mothers and their children. Expansion of F/TMN to all of New York State will give all Medicaid-eligible first-time mothers the opportunity for improved pregnancy outcomes. Further exploration of implementation specifics will be needed.

**Concerns with Recommendation:** It is anticipated there may be difficulties finding enough registered nurses to meet the demand of the program. This may preclude implementation in all counties. Benefits, both financial and societal, may not be realized for many years. Some of these services are being provided by Medicaid managed care plans already.

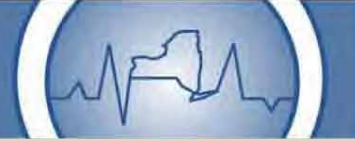
**Impacted Stakeholders:** Prenatal care providers, and Planned Parenthood (assist with Medicaid enrollments and may do referrals to FTM/N), Medicaid recipients, child abuse services, emergency rooms, domestic violence services, juvenile justice and correctional services, the state TANF system and the Medicaid program including Managed Care Plans.



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27. i National Survey of Family Growth, 2006: [Among fathers with children under age 5 who did not reside with children and who had earned a high school diploma/GED or less. Moderate to high level of father involvement was defined as having bathed, diapered, or dressed his child anywhere from once a week to a daily basis within a 4 week period].

**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Workforce Flexibility and  
Scope of Practice Work Group

**FINAL RECOMMENDATIONS**



**Medicaid Redesign Team**  
**Workforce Flexibility / Scope of Practice Workgroup**  
**Final Recommendations – November 21, 2011**

**Work Group Charge:**

The **Workforce Flexibility / Scope of Practice Workgroup** will develop a multi-year strategy to redefine and develop the workforce, to ensure that the comprehensive health care needs of New York's population are met in the future.

The proposed strategy will include redefining the roles of certain types of providers and aligning training and certification requirements with workforce development goals. The objective will be to formulate consensus recommendations and identify areas in statute, regulation and policy that would require changes in order to implement them.

The work group will consider proposals for implementation in FY 2012-2013 that would increase workforce flexibility, including those outlined in MRT 200.

The goal should be to create a consensus product that both builds and redefines the workforce to allow New York to ensure that the comprehensive health care needs of our population are met in the future.

The work group will discuss changes in health care settings outside the long term care sector, as well as changes to the scope of practice of advanced practice clinicians in all settings.

This work is related to MRT recommendation #200, Change in Scope of Practice for Mid-level Providers to Promote Efficiency and Lower Medicaid Costs.

Work group membership will include representatives of the State Education Department, New York State Nurses Association and other interested stakeholders.

Smaller groups within this work group will focus on several issues:

- Permit nurses (under their scope of practice exemption) to orient/direct home health aides (HHAs) and personal care workers to provide nursing care as is currently allowed in the consumer-directed personal assistance program;
- Allow licensed practical nurses (LPs) to complete assessments in long-term care settings;
- Extend the use of medication aides into nursing homes;
- Extend the scope of practice of HHAs to include the administration of pre-poured medications to both self-directed and non-self-directing individuals; and
- Expand the scope of practice to allow dental hygienists to address the need for services in underserved areas.



**WORK GROUP MEMBERSHIP:**

- **Co-chair:** William Ebenstein, Ph.D., University Dean for Health and Human Services, City University of New York
- **Co-chair:** George Gresham, President, 1199 SEIU United Healthcare Workers East
- Penny B. Abulencia, RN, MSN, Vice President, Loretto
- Karen Coleman, Acting Deputy Commissioner, Workforce Development, New York State Department of Labor<sup>1</sup>
- Tom Curran, DDS, Member, Chemung County Board of Health
- Moira Dolan, Senior Assistant Director, Research and Negotiations Department, District Council 37
- Joy Elwell, DNP, FNP, Chairperson, The Nurse Practitioner Association of New York State
- Deborah Elliott, MBA, RN, Deputy Executive Officer, New York State Nurses Association<sup>2</sup>
- Valerie Grey, Executive Deputy Commissioner, New York State Education Department<sup>3</sup>
- Kathryn Haslanger, JD, MCRP, Vice President, Community Benefit and External Affairs, Visiting Nurse Service of New York
- Jean Heady, Chair, NYS Rural Health Council
- Frederick Heigel, Vice President, Regulatory Affairs, Rural Health and Workforce, Healthcare Association of New York State
- Robert Hughes, MD, FACS, President-Elect, Medical Society of the State of New York
- David I. Jackson, MPAS, RPA-C, Past President, New York State Society of Physician Assistants
- Lauren Johnston, Senior Assistant Vice President, Chief Nursing Officer, New York City Health and Hospitals Corporation
- Tim Johnson, Executive Director, GNYHA Foundation, Center for Graduate Medical Education and Workforce Studies
- Deborah King, Executive Director, 1199 SEIU Training and Employment Funds
- Stephen Knight, Chief Executive Officer, United Helpers
- Bruce McIver, President, League of Voluntary Hospitals and Homes of New York

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<sup>1</sup> Not a voting member of the MRT Workforce Flexibility Workgroup.

<sup>2</sup> Tina Gerardi, MS, RN, CAE, Chief Executive Officer, New York State Nurses Association had been the originally appointed representative to this Workgroup.

<sup>3</sup> Not a voting member of the MRT Workforce Flexibility Workgroup.



- Jean Moore, Director, Center for Health Work Force Studies
- Bryan O'Malley, Executive Director, Consumer Directed Personal Assistance Association of New York State
- Peggy Powell, National Director, Curriculum and Workforce Development, Paraprofessional Healthcare Institute
- Kathleen Preston, Vice Chancellor for Financial Services and Health Affairs, State University of New York
- Bill Stackhouse, PhD, Director of Workforce Development, Community Health Care Association of New York State
- Audrey Weiner, DSW, MPH, President and CEO, Jewish Home Lifecare
- Douglas Wissmann, CFO, Hillside Manor Rehabilitation and Extended Care
- Mary Ellen Yankosky, RDH, BS, Director, Policy and Advocacy, Dental Hygienists' Association of the State of New York





## MEETING DATES AND FOCUS

**Monday, October 3, 2011: 10:00 a.m. to 3:30 p.m.** - The first meeting focused on providing background information to ensure that the Workforce Flexibility/Scope of Practice Work Group targeted its work from a common knowledge base. Department of Health(DOH) staff provided presentations on various topics including current practice parameters for RNs, LPNs, HHAs, PCAs and CNAs, emerging care structures such as health and medical homes and related efforts such as the President’s Job Council and the Department of Labor’s (DOL’s) federal planning grant. Understanding these new structures, as well as developing new practice and service modalities to accommodate them, are now more critical than ever, especially in light of the expansion of coverage, beginning in 2014, under the federal Patient Protection and Affordable Care Act (ACA). The ACA’s overarching goals are to expand health insurance for 32 million uninsured Americans and to achieve delivery system reform that would both promote quality and bring healthcare costs under control (to help finance health insurance expansion). As a result of federal healthcare reform, 2 million New Yorkers are expected to obtain health insurance. About one million uninsured New Yorkers are expected to obtain health coverage through the health insurance exchange, with an additional one million becoming insured under New York’s Medicaid program.<sup>4</sup>

Workgroup members then held a brainstorming session and proposed strategies to increase workforce flexibility and to expand the scope of practice for several types of health care providers, including changing the roles associated with specific health care professions and adjusting training and certification requirements. Incongruities between stakeholders’ positions on these issues were highlighted for future discussion. Members were asked to develop and refine the ideas they proposed during the brainstorming session and also submit additional proposals at their discretion. The co-chairs asked that these be submitted to DOH electronically by October 4. DOH staff compiled the proposals in a spreadsheet and tentatively classified them by sector, targeted profession, occupation and licensed worker, unlicensed worker or “other.”

### Activity between October 3 and October 27 Workgroup Meetings

Members and the public submitted, via an electronic email inbox ([mrtworkforce@health.state.ny.us](mailto:mrtworkforce@health.state.ny.us)), a total of 87 proposals. These proposals were shared with the co-chairs and members. The co-chairs directed the formation of two sub-workgroups to explore the proposals and to assemble supplemental information needed by the full workgroup at the October 27 meeting. One sub-workgroup, headed by MRT Workforce Workgroup Co-Chair George Gresham (assisted by Helen Schaub) was responsible for reviewing 26 proposals that targeted non-licensed workers. Another sub-workgroup, headed by MRT Workforce Workgroup Co-Chair Bill Ebenstein, was responsible for reviewing 31 proposals that targeted licensed workers. These sub-workgroups met twice each. They consolidated closely related proposals, attempted to distinguish short term from longer term proposals, and researched the efficacy of each proposal or grouping of proposals. DOH staff researched the approximately 30 “other” proposals not fitting into either of the licensed or non-licensed worker category.

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<sup>4</sup> New York State Department of Health, Office of Health Insurance Programs.



The goal of these sub-workgroups was to identify priority proposals that could be acted upon by the main workgroup, and possibly advanced to the full MRT.

**Thursday, October 27, 2011: 10:00 a.m. to 3:30 p.m.** – At the second meeting, following a review of the charge issued to the Work Group by the MRT, members approved its adoption with one modification (see Work Group charge on page 1). The reference to the expectation that the Work Group would discuss the consequences of implementing recommendations was modified to a discussion of changes that could result from implementation.

Each sub-workgroup group chair, with the assistance of sub-workgroup members reported out the results of their respective deliberations. Members discussed the history of some of the proposals that had been debated for several years as well as the various research that had been conducted on them.

DOH staff presented a summary of the proposals not fitting into the categories of licensed or non-licensed workers. Several of these “Other” proposals were referred back to the exiting sub groups. Many dealt with reimbursement issues, basic benefits, provider incentives or GME and are being referred to the appropriate entities that handle these issues. Others were either too general or missing the level of specificity needed to classify and were referred for further study.

DOH then presented a newly developed proposal for an ongoing process and structure for the objective assessment of future changes in workforce flexibility and changes in scope of practice. The idea was originally proposed by the Center for Health Workforce Studies (at SUNY Albany), and is consistent with the emerging shift to evidence-based decision making. A similar proposal had been submitted by the Medical Society of the State of NY (MSSNY). Ideas from MSSNY were incorporated into the proposal.

DOH also presented a proposal, based on a proposal advanced by the Healthcare Association of New York State (HANYS) to create a Primary Care Service Corps that would provide loan repayment for non-physician clinicians in exchange for a service obligation in a medically underserved area. State funding would be matched dollar-for-dollar by federal State Loan Repayment Program funds.

DOH staff introduced a survey tool that was to be used to help the Work Group make better informed decisions regarding the relative priority of the proposals under consideration. The process, successfully used by the full MRT and other MRT Work Groups, employed a quantitative technique to assess the degree to which each proposal could address goals of Medicaid Reform, i.e. cost, quality, efficiency, and overall impact on the Medicaid program.

### **Activity between October 27 and November 7 Workgroup Meetings**

DOH developed the survey instrument for preliminary prioritization of 17 finalized proposals and sent it to workgroup members on October 28. Members were asked to complete the survey and return it to DOH by November 1. DOH analyzed the results and distributed them to the workgroup co-chairs for presentation and discussion at the November 7 meeting.

### **Monday, November 7, 10:00am to 3:30pm**

This third and final meeting began with a report by State Education Department (SED) Deputy Commissioner Douglas Lentivech (representing MRT Workgroup member Valerie Grey) of SED’s methods for the consideration of proposed changes in the scope of practice for health professions. The avoidance of unintended consequences was highlighted as a major concern. Mr. Lentivech stated that



SED welcomed input and is committed to addressing changes and working with stakeholders in an open and collaborative manner.

MRT Workgroup member Jean Moore presented a revised proposal to establish an advisory committee to SED that would support inter-agency and stakeholder review of proposals to develop expand or modify scope of practice for health care professionals and/or assistive personnel. This proposal would help meet the MRT's charge to develop a multi-year strategy to address workforce flexibility and scope of practice changes.

The co-chairs reviewed the results of the preliminary priority scoring process for the full set of 17 proposals under consideration. Revisions to individual proposals were presented. After considerable discussion and a vote, the group decided to advance 12 of the highest scoring proposals. The group also decided to have Jean Moore revise the advisory committee proposal and take a vote by November 14, 2011 on the revised proposal (#13, page 10). If approved by a super-majority (i.e., 2/3 of Workforce Flexibility Workgroup members), it would be advanced with the 12.

Proposals not being advanced at this time could be submitted to the SED advisory committee as priority items for analysis and possible implementation over a longer term. These included the 4 of the 17 proposals not selected for advancement to the MRT as part of the 13 Final Recommendations, 2 proposals recommended by the Co-Chairs, including a proposal to study

the community health worker/care management field and make specific recommendations for implementation in Fall 2012 regarding training, certification and career pathways for community health workers and related titles; a study of the training and roles of other direct care workers across long term care settings; and additional proposals that were submitted by the MRT Workforce Workgroup and the public both during and after the period in which the Workgroup was convened.

#### **Activity between November 7 Meeting And Preparation of Final Report**

On November 14, 2011, the group voted overwhelmingly to approve the proposal to develop an SED advisory committee. This proposal is attached as MRT Workforce Recommendation 13 (Exhibit A, page 10).

#### **Outside Experts Consulted with: None**

#### **Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report**

The Work Group began by listening to a number of presentations by various Department of Health staff on: current practice parameters for several licensed and unlicensed health care occupations; the significance of emerging care structures such as health and medical homes; and related efforts that are currently underway, such as the President's Job Council and Department of Labor federal planning grant, which seek to develop new strategies to address, among other strategies, the expansion of health care coverage, beginning in 2014 under the ACA.

The Work Group spent a significant portion of their first two meetings brainstorming ideas and strategies which would increase workforce flexibility, expand the scope of practice for health care clinicians and assistive personnel and lead to improved efficiencies in the Medicaid program or improved access to health care. The Co-chairs and members decided the best way to review the myriad proposals put forth was to break into two sub-workgroups. One group would review all proposals that targeted licensed workers. The other sub-workgroup reviewed and analyzed proposals that targeted



unlicensed workers. DOH staff to the Workgroup vetted 30 “other” proposals that did not relate to licensed or un-licensed worker issues. The disposition of these proposals is as described on page 4 (above).

During the course of its deliberations, several members of the group voiced their concerns that workforce scope of practice issues were complex, often had significant impacts on patient care, and decision-making on scope of practice matters was somewhat fragmented. In response to this concern - and consistent with several recommendations from members and the public -, the workgroup adopted an overarching proposal to develop an ongoing process and structure for the objective assessment of future changes in workforce flexibility and changes in scope of practice. The concept that was eventually developed, in consultation with the Department of Education, was to empanel an advisory committee to SED that would use an evidence-based

process to advise and inform SED on emerging scope of practice issues. The advisory group concept allowed the workgroup to, in part, address that specific part of the initial charge to develop a multi-year strategy to redefine and develop the workforce. This recommendation also addressed the workgroup’s recognition that the time frame in which the workgroup meetings were held, i.e., between October 3 and November 7, 2011 was too short a period to realistically assess, no less attempt to address, the myriad scope of practice issues that were raised during the brainstorming session.

A second overarching theme related to, but separate from, the above (identified during the workgroup meetings and also suggested in several proposals) was that decision-makers often lack objective data to make informed decisions on scope of practice issues. Even when data or studies are available, often the study results are either unclear or contradictory. It is anticipated that the proposed SED advisory committee will help to address this lack of data and objectivity with the development of a data-driven, objective process.

The process used to develop a final list of 12 recommendations was fairly straightforward. The sub-workgroups, through 4 face-to-face and conference call meetings, reduced the larger listing of 87 proposals to 17. These 17 were subjected to a prioritization ranking exercise. During the third and final workgroup meeting, after additional discussion and limited debate, workgroup members voted to forward the top 12 proposals to the full MRT for consideration. They also agreed, via a separate vote within about a week after the final meeting to also forward the SED advisory committee recommendation (#13) to the full MRT.

The twelve recommendations (page 8) and SED advisory committee proposal (Appendix A, page 10) mostly address the home care and hospital sectors and increased access to primary care and oral health services. The tight timeframe did not allow the workgroup to adequately debate or begin to address many potentially worthwhile proposals submitted by both workgroup members and the public.

A third and final overarching theme is the need to continue the workgroup’s work either via the SED advisory committee (MRT Workforce #13) or via another group that has the time and resources to take up this mission. These recommendations are listed in rank order as determined by the prioritization exercise utilized by the workgroup.



**Summary Listing of 12 Final Recommendations: (by priority order, old and revised proposal number, and short name; supplemental information is provided on recommendation forms as Exhibit B below)**

Rank (Priority)	MRT Proposal Number	Original Proposal Number	Page #	Proposal Description
1	1	PIR 4 NL 27,40,66	14	Permit Advanced Aides, with supervision and training by a registered nurse, to assist self-directing and non-self-directing consumers with routine pre-poured medications.
2	2	PIR 1 NL 1,64,12,28,67	17	Creating an advanced home care aide certification and expanding the ability of registered nurses to assign tasks to such aides.
3	3	PIR 9 L 39,44	19	Enable use of standing orders/physician practice protocols to improve quality of care.
4	4	PIR 12 L 46,47	23	Remove the requirement that certified Nurse Practitioners enter into a written collaborative practice agreement with a licensed physician (see A5308/S3289)
5	5	PIR 15 L 18	26	Collaborative Practice of Dental Hygienists and Redefining the Definition of Dental Hygiene
6	6	PIR 2 NL 2	30	Stackable certification and credentials for direct care workers
7	7	PIR 8 L 38	32	Enable physician home visits
8	8	PIR 7 O 37	34	New York State Primary Care Service Corps (PCSC)
9	9	PIR 16 L 84	41	Reform NYS social worker licensing laws to address independent practice standards that inappropriately substitute an independent practice model that limits access to outpatient behavioral health care in underserved areas where no independent clinicians exist
10	10	PIR 10 L 45	67	Removal of physician supervisory ratio of physician assistants

# Redesigning THE MEDICAID PROGRAM



Rank (Priority)	MRT Proposal Number	Original Proposal Number	Page #	Proposal Description
11	11	PIR 3 NL 14	72	Promote underutilized programs such as the Consumer Directed Personal Assistance Program that are cost-effective and build on consumers strengths
12	12	PIR 11 L 16	76	Children's health dental certificate
<b>Not ranked</b>	13	PIR 6 O 8	10	Establish an Advisory Committee to the Office of the Professions of the State Education Department



**Exhibit A: Long-term MRT Workforce Flexibility Workgroup proposal: Develop an Workforce Advisory Committee to the New York State Education Department**

**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number:** 13 (Formerly PIR 6 O 8)

**Recommendation Short Name:** Establish an Advisory Committee to the Office of the Professions of the State Education Department.

**Program Area:** General health workforce

**Implementation Complexity:** Moderate

**Implementation Timeline:** Could be included in a program bill for 2012-13. It could take between 6 and 12 months to implement, depending on how members were appointed or recommended.

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

**Proposal Description:**

Establish an Advisory Committee to the Office of the Professions of the State Education Department that supports collaborative, comprehensive and systematic assessments of proposals designed to improve health workforce flexibility in the state, including, but not limited to proposals to develop, expand or modify scopes of practice for health care professionals and/or scopes of services for assistive health personnel. The standing members of the committee will include state agencies, such as DOH, OMH, OASAS, DOL, SUNY, CUNY; state legislative staff; professional associations, representing nurses, physicians, nurse practitioners, physician assistants, etc.; provider associations representing hospitals, nursing homes, home care agencies, health centers, etc.; health worker unions such as 1199; the Center for Health Workforce Studies (CHWS), and other relevant organizations such as the Paraprofessional Healthcare institute (PHI), the New York State Area Health Education Center and consumer groups.

At SED's request for review of a proposal to improve workforce flexibility, a small workgroup will be convened, drawn from the standing membership of the Advisory Committee as well as relevant SED staff. The workgroup will consist of no more than ten members, including one member representing the health profession seeking change, one member of the health profession affected by the proposed change, one member representing an affected provider group, and others potentially impacted by the proposed change including state agencies, labor unions and consumers.



Where indicated, workgroups of the Advisory Committee may recommend time-limited health workforce demonstrations to test the effectiveness of new approaches to the provision of health service delivery. Such demonstrations would require authorization by the state Legislature, or relevant state agency such as SED or DOH. In addition, workgroups may recommend an evaluation (process and/or outcome) of any change to law, regulation or rules that result in enhancements in health workforce flexibility. All evaluations will, to the extent possible, measure impacts of change in workforce flexibility on safety, cost, quality and access to health services.

CHWS, with expertise in health workforce research, will serve as staff to the committee, convening workgroups and preparing reports that summarize findings of analyses of all relevant data, research and information available to effectively review proposals.

All proposals will be submitted to the Office of the Professions of the State Education Department and include the following information:

- A description of the proposed change to enhance health workforce flexibility (including whether a change to law, regulations, and/or rules is required);
- Statement of the problem;
- Alternatives considered and rationale for selecting the proposed action;
- Impacts on the public that identifies potential benefits and harms, related to safety, quality of care and access to care;
- Implications for education and training;
- Economic implications to the state and the general public;
- A list of all states where the proposed change is currently allowed;
- Known support and opposition to the proposal;
- As applicable, references for all research that has been conducted to measure impacts of proposed change on cost, quality and access to care.

The purpose of the Advisory Committee is to:

- Provide input from a broad array of stakeholders on any proposals designed to increase health workforce flexibility in the state.
- Enhance efforts to use objective, evidence-based data and research to inform decision-making related to workforce flexibility.
- Support efforts to evaluate impacts of changes designed to increased health workforce flexibility on cost, quality and access to health services.





**Financial Impact:** The development of a structure and process will require an initial additional expenditure of \$175,000 in each of the next 2 fiscal years. Some changes to increase health workforce flexibility could result in lower Medicaid costs by appropriately allowing lower level health care workers to perform tasks previously provided by higher level staff.

**Health Disparities Impact:** The workgroup did not discuss the impact of this recommendation on health disparities. However, the structure and process that is established will be cognizant of, and informed by the new team based approaches that are being developed to promote the delivery of health care services to medically underserved areas and disenfranchised patients.

**Benefits of Recommendation:** New York's health care delivery system is facing many challenges including a misdistribution of primary care providers and assistive personnel, limited access to needed health care services for nearly 3 million residents of the state, significant concerns about the rising costs of health care and declines in the quality of care. There is growing recognition by providers of the need to increase use of a team based approaches in the delivery of health care services, such as the patient-centered medical home. These approaches require that members of health care teams work to the full extent of their scopes of practice.

An inter-agency advisory committee can assist SED in the effective review of scope of practice and/or scope of services proposals and support the development of a standardized process to assess these proposals based on the best available information and research. This can provide legislators; policy makers, licensing boards, industry representatives and others with objective, data-driven assessments that support better informed decisions on scope of practice issues.

This proposal is designed to support SED in the timely review of scope of practice and/or scope of services changes. It is not meant to prolong or delay action on requests for changes.

The proposed Advisory Committee would work in collaboration with the State Education Department and support a comprehensive and systematic review of proposals aimed at increasing health workforce flexibility in the state, including proposals to develop, expand or modify of scopes of practice for health care professionals and/or scopes of services for assistive health personnel. The committee will support and enhance SED's efforts to use objective, evidence-based data and research to inform decision-making. The Advisory Committee membership would include representatives from the state agencies, the legislature, professional associations and provider associations, among others. The Center for Health Workforce Studies would serve as staff to the Committee, identifying, analyzing and sharing the relevant data and information necessary to effectively review proposals, convening meetings of workgroups and assisting with the design and implementation of evaluations to measure impacts of increased workforce flexibility on cost, quality and access to care.

The State Education Department would work with Advisory Committee to objectively evaluate proposed changes to health care scope of practice laws, regulations or rules. The committee would only act in an advisory capacity and would in no way usurp the authority currently maintained by the State Education Department, the New York State Board of Regents, the various boards which oversee and have jurisdiction over professional licensing and scope of practice issues, or the New York State Legislature. The committee is



designed to help inform decisions by SED in favor of or opposed to proposals to increase health workforce flexibility. SED, in collaboration with the committee, may also use the option of time-limited demonstration projects to test the effectiveness of new approaches to provision of health service delivery. Such demonstrations would require authorization by the state Legislature, and/or relevant state agencies such as SED or DOH. In addition, to the extent possible, changes designed to enhance health workforce flexibility, will be evaluated to measure impacts on cost, quality and access to health services.

**Concerns with Recommendation:** Care must be taken to not impinge upon the authority or territory of the State Legislature, the Department of Education, the State Board for Nursing or others Boards or agencies that currently have purview over Scope of Practice issues. Given the fact that scope of practice issues can have a significant impact on patient safety and quality of care, clinical professionals must have input into proposals to increase health workforce flexibility.

**Impacted Stakeholders:** SED, other state agencies; state legislative staff; professional associations representing nurses, physicians, nurse practitioners, physician assistants, etc.; provider associations, representing hospitals, nursing homes, home care agencies, health centers, etc.; health worker unions such as 1199; the Center for Health Workforce Studies (CHWS), and other relevant organizations such as the Paraprofessional Healthcare institute (PHI), the New York State Area Health Education Center and consumer groups.



**Exhibit B: Proposal Information for 12 Proposals Recommended To Be Advanced to Full MRT**

**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number:** 1 (Formerly PIR 4 NL 27,40,66)

**Recommendation Short Name:** Permit Advanced Aides, with supervision and training by a registered nurse, to assist self-directing and non-self-directing consumers with routine pre-poured medications.

**Program Area:** Home Health Care

**Implementation Complexity:** Not very complex. Will require development of training, supervision, competency testing and quality outcome measurement protocols. Experience from other states can be instructive in developing these tools.

**Implementation Timeline:** Three months to design, including stakeholder process; three months to implement.

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

**Proposal Description:** Permit home care providers, including LHCSAs, CHHAs, LTHHCPS, MLTCPs, and home hospices to identify non-self-directing consumers who can be safely assisted by an Advanced Aide to take routine pre-poured medications, including routine pre-filled injections of insulin, as is currently permitted for self-directing individuals under “special circumstances”. The Advanced Aide would be permitted to provide this assistance only in cases where the registered nurse has determined the case to be appropriate, the Aide receives specific training from a registered nurse on the individual consumer’s medications and circumstances, demonstrates ongoing competency following this training, and then the registered nurse provides ongoing supervision. The training, supervision, and Advanced Aide competency evaluation requirements must follow protocols to be approved by the Department of Health. These protocols and administrative directives would be developed through a stakeholder process and would articulate the factors required to safely provide this assistance, including provisions for comprehensive RN supervision and RN involvement at any change in a patient’s condition, medication regimen or treatment. Factors for the Department to consider in the development of protocols and administrative directives should include, but not be limited to, the measurement of quality outcomes for this subset of consumers, the appropriate time interval between pre-pouring of medications for non-self-directing consumers (currently 2 weeks for self-directing consumers), the ongoing educational requirements of the Advanced Aide and the number of Advanced Aides who are assisting non-self-directing consumers with medications that an RN would be responsible for supervising. The Department may wish to consider this proposal as a demonstration pilot that would be subject to sunset, thorough evaluation and re-authorization.



**Financial Impact:** The consumer-specific training and RN supervision that aides must receive will add modestly to service cost. This increase will be offset by reductions in nursing visits for consumers currently requiring this assistance and receiving it through the formal system. In addition, Medicaid may realize additional offsets as consumers follow medication regimens with greater consistency.

**Health Disparities Impact:**

**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	x		
Female	x		
People with a primary language other than English	x		
People of Hispanic, Latino, or Spanish origin	x		
People who identify as:			
White	x		
Black or African American	x		
American Indian or Alaska Native	x		
Asian <sup>i</sup>	x		
Native Hawaiian or Other Pacific Islander <sup>ii</sup>	x		
People with a disability <sup>iii</sup>	x		
People who identify as transgender <sup>iv</sup>	x		
People who identify as lesbian, gay, bisexual, or questioning	x		

**Additional comments:**

Because current rules/policies allow family-employed substitutes to assist non-self-directing clients with medication, this means that only those who can pay privately to purchase the medication support in the home can avail themselves of this option. The likely impact is to create disparities among beneficiaries who can pay versus those who can't. The proposal would address this disparity by making this assistance available through Medicaid-funded services.

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders?** No

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities?** No



**Benefits of Recommendation:** Improve quality and consistency of care for non-self-directing home care consumers; reduce strain for already-burdened informal caregivers; increase flexibility of home care providers to meet consumer needs; ensure no gap in services from other cost-saving measures.

**Concerns with Recommendation:** Concerns may be raised that the proposal will create risks for patients. Pilot programs in two states found no adverse outcomes. Concerns about patient selection criteria as well as aide training and supervision can be addressed in a consultative process that includes all key stakeholders to develop program standards.

**Impacted Stakeholders:** Home care consumers and home care providers.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number: 2 (Formerly PIR 1 NL #1,64,12,28,67).**

**Recommendation Short Name:** Create an advanced home care aide certification and expanding the ability of registered nurses to assign tasks to such aides.

**Program Area:** Home Care

**Implementation Complexity:** Not very complex, as the framework for delegation of tasks under special circumstances already exists.

**Implementation Timeline:** Three months to design, three months to implement

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

**Proposal Description:** This proposal would direct the Department to create an advanced home care aide certification and outline the minimum training and qualifications required. The training would focus not on specific tasks but on accurate reporting, communication skills and problem solving. The proposal would then permit Registered Nurses, based on their assessment of the advanced home care aide, the self-directing resident and the home care environment, to assign an expanded range of tasks to Advanced Aides, under the same requirements and restrictions currently outlined for tasks which can be assigned to home health aides in "special circumstances." The expanded range of tasks would be determined through a stakeholder process directed by the Department. This proposal is not intended to alter nursing scopes of practice (RN or LPN), but rather, to facilitate the development of a home healthcare team which includes paraprofessionals.

**Financial Impact:** The advanced aide training can be implemented through existing home health aide training programs. While there will be costs associated with providing the training, this is not expected to add to overall Medicaid costs as managed long term care programs will have an incentive to invest in the additional training in order to gain greater efficiency.

**Health Disparities Impact:**

**1. Did the Work Group discuss this proposal's potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)



	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	X		
Female	X		
People with a primary language other than English	X		
People of Hispanic, Latino, or Spanish origin	X		
People who identify as:			
White	X		
Black or African American	X		
American Indian or Alaska Native	X		
Asian <sup>i</sup>	X		
Native Hawaiian or Other Pacific Islander <sup>ii</sup>	X		
People with a disability <sup>iii</sup>	X		
People who identify as transgender <sup>v</sup>	X		
People who identify as lesbian, gay, bisexual, or questioning	X		

Additional comments: This proposal has the potential to reduce disparities for all Medicaid consumers of home and community based services, including those in the above groups, by increasing quality of care and access to a broader range of services.

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders?** No

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities?** No

**Benefits of Recommendation:** Improve quality of care for home care consumers; increase consistency of services across Medicaid programs; increase flexibility of home care providers to meet consumer needs; ensure no gap in services results from implementation of cost-saving measures, without significantly increasing costs.

**Concerns with Recommendation:** None specified.

**Impacted Stakeholders:** Improve quality of care and increase access to services for home care consumers; increase flexibility of home care providers to meet consumer needs.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number: 3 (Formerly PIR 9L, #39 and #44)**

**Recommendation Short Name:** Enable use of standing orders/physician practice protocols to improve quality of care

**Program Area:** Acute care

**Implementation Complexity:** Low

**Implementation Timeline:** Short term

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

**Proposal Description:** Except for limited immunizations specifically allowed by statute, nurses are prohibited from initiating treatments without patient specific medical orders. This ruling delays mandatory and emergency treatment. CMS has recently proposed a change in federal standards to enable the use nationally of standing orders/treatment protocols intending to reduce unnecessary delays and to improve quality. NYS must modernize its standards to come into alignment with prevailing and evolving national standards. Medicaid patients continue to depend heavily on hospital emergency departments for their care and treatment. The use of standing orders, particularly in busy, urban, emergency departments will speed up treatment and improve the care provided to patients, for example-a pediatric patient arriving at a busy ED in the midst of an asthma attack would receive care immediately.

To improve the quality and efficiency of care delivery, the use of practice protocols, or “standing orders” must be enabled in defined situations. Specific examples include the mandatory administration of newborn prophylaxis, and other immunizations, in EDs for certain conditions such as acute asthma, acute MI and stroke in order to more rapidly respond to needs of emergency cases. This proposal is consistent with recently announced CMS rule changes/prevaling national standards intended to improve the quality of care and efficiency of delivery. Standing orders would only be used as part of an emergency response or as part of an evidenced based treatment regimen where it is not practicable for a nurse to obtain the order and authentication prior to the provision of care. CMS would expect hospitals to have specific criteria for a nurse to initiate the execution of a particular standing order clearly identified in the protocol for the order, for example, the specific clinical situations, patient conditions, or diagnosis by which initiation of the order would be justified. CMS believes the use of standing orders will improve the quality of care in hospitals by speeding response in emergency situations and improving immunization rates.

The SED has worked to resolve limitations included in the Nurse Practice Act in the context of uses of standing orders. Nurses are restricted from making diagnoses. The proposed new construction of the federal rules





would not require nurses to make diagnoses. The circumstances under which standing orders can be used are determined by the hospital’s medical staff. The creation of a national standard for the use of standing orders, under limited and well defined circumstances, should assist SED in addressing this issue in the future.

**Financial Impact:** The federal government is in the process of enabling the use of standing orders by hospitals through changes in the Medicare Conditions of Participation (Cops). This change is included among several proposed regulatory changes projected to save the health care delivery system approximately \$1.1 billion per year (see attached press release). These savings cannot be fully realized unless states also adopt the new standards. This proposal will also increase physician efficiency and improve throughputs.

**Health Disparities Impact:**

**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		
	reduce disparities for this population	increase disparities for this population	
Male	x		The legitimization of standing orders will enable all populations to have more efficient delivery of health care
Female	x		See above
People with a primary language other than English	x		See above
People of Hispanic, Latino, or Spanish origin	x		See above
People who identify as:	x		See above
White	x		See above
Black or African American	x		See above
American Indian or Alaska Native	x		See above
Asian	x		See above



Native Hawaiian or Other Pacific Islander	x		See above
People with a disability	x		See above
People who identify as transgender	x		See above
People who identify as lesbian, gay, bisexual, or questioning	x		See above

Additional comments:

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders?** No

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities?** No

**Benefits of Recommendation:** Will improve quality by not delaying needed care and treatment while awaiting the issuance of a patient specific medical order. Each facility will design and implement these standing orders, based on medical staff involvement in the process.

In addition to cost saving, the use of standing orders will improve care and treatment of patients, both in emergency circumstances and with respect to provision of immunizations. The use of standing orders will be allowed only in limited and controlled circumstances. The new federal provision will allow the use of standing orders only if the hospital:

- Establishes that such orders and protocols have been reviewed and approved by the medical staff in consultation with the hospitals’ nursing and pharmacy leadership;
- Demonstrates that such orders and protocols are consistent with nationally recognized and evidence based guidelines;
- Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff, in consultation with the hospital’s nursing and pharmacy leadership, to determine the continuing usefulness and safety of such orders and protocols; and
- Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient’s medical record by the practitioner responsible for the care of the patient.

**Concerns with Recommendation:** SED has been working to resolve limitations included in the Nurse Practice Act.

**Impacted Stakeholders:** Hospitals.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
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**Recommendation Number: 4 (Formerly PIR 12L 46, 47)**

**Recommendation Short Name:** Remove collaboration practice agreement requirement for Certified Nurse Practitioners

**Program Area:** All health care

**Implementation Complexity:** There are no anticipated barriers to implementation of this proposal once the statutory change is made.

**Implementation Timeline:** Immediately

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

**Proposal Description:** Nurse Practitioners (“NPs”) are autonomous health care practitioners who are authorized to: diagnose illness and physical conditions and perform therapeutic and corrective measures, order tests, prescribe medications, devices and immunizing agents, and, when appropriate, refer patients to other healthcare providers, without supervision.<sup>5</sup> Numerous studies show that NPs deliver high-quality, cost-effective, safe health care to diverse populations. They are highly trained and experienced individuals who exercise independent judgment, and collaborate with multiple specialists and healthcare practitioners every day, much like physicians and other healthcare providers. Despite this independence and training, New York law constrains NPs practice, and limits patients from accessing NP services by requiring that NPs enter into a collaborative practice agreement with physicians.<sup>6</sup> This statutory requirement creates a barrier to practice and is an impediment to the expansion of needed primary care capacity in New York. It also adds excess costs to the system when NPs and/or health facilities are forced to reimburse collaborating physicians for this service. Notably, NPs are experiencing difficulty in identifying physicians who are willing to sign such an agreement. This restricts access to primary healthcare for New York’s diverse populations, especially individuals and families in urban and rural underserved areas of the state. 19 other states, including the District of Columbia, already allow nurse practitioners to practice without any written collaborative agreement requirement.

This Proposal would remove the requirements for written collaboration agreements and written practice protocols between nurse practitioners and physicians.

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<sup>5</sup> N.Y. Education Law § 6902

<sup>6</sup> *Id.*



**Financial Impact:** Medicaid costs will be reduced based several factors. More patients will have access to low cost, high quality care. According to numerous studies, and specifically to the independent study, conducted by Rand Health (cited below), utilizing Nurse Practitioners will lower costs to Medicaid in several ways. First, NPs are paid less. Second, increasing access to primary care results in lower incidence of hospital Emergency Room visits, hospital admissions, readmissions, improved screening rates, prevention, and earlier detection rates of illness, with improved outcomes, necessitating fewer high-cost interventions. This proposal will increase efficiencies and access to services.

**Health Disparities Impact:** This proposal will result in greater access to healthcare, which should result in a reduction in health disparities. NPs already provide services to a disproportionate number of Medicaid patients.

**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	X		
Female	X		
People with a primary language other than English	X		
People of Hispanic, Latino, or Spanish origin	X		
People who identify as:			
White	X		
Black or African American	X		
American Indian or Alaska Native	X		
Asian	X		
Native Hawaiian or Other Pacific Islander	X		
People with a disability	X		
People who identify as transgender	X		
People who identify as lesbian, gay, bisexual, or questioning	X		



Additional comments:

**2. Did the Work Group discuss this proposal's potential impact on disparities with key stakeholders?** Yes

**3. Did the Work Group discuss an approach to monitoring this proposal's effect on disparities?** Yes

If Yes, please describe conclusions:

Conclusions cannot be made at this point. Monitoring of health care outcomes in quality health care statistics can be monitored as it is happening in the 19 states where Nurse Practitioners presently enjoy full autonomous practice.

**Benefits of Recommendation:** Eliminating this barrier will increase access to quality healthcare for Medicaid recipients, while reducing costs to the system. NPs are proven in numerous quality studies to have low hospital admissions and readmission rates, higher immunization rates, and improved compliance rates to health regimens.<sup>7</sup> NPs provide access to both urban and rural populations, and are often the only primary care providers to Medicaid recipients in those areas. They provide care to high volume of patients in the State government programs (Medicaid Managed Care, Child Health Plus and Family Health Plus), which is even more critical in order to ensure appropriate access consistent with the implementation of federal healthcare reform.

**Concerns with Recommendation:** The Medical Society of the State of New York has written a letter of opposition to this proposal, citing concerns of safety, cost, and quality. However, it should be noted that in over 40 years of research, there is no study concluding that NPs are anything less than high-quality, safe, cost-effective health care providers. Further, licensed physicians in New York have voiced disagreement with MSSNY's position (letters can be furnished upon request from The Nurse Practitioner Association). Finally, it should be noted that in every state where NPs have achieved autonomous practice, state medical societies have opposed this type of initiative.

**Impacted Stakeholders:** Medicaid recipients, the NP community, physicians, hospitals, and tax payers will all benefit from this proposal. NPs will be able to better serve the public, and healthcare consumers will have more quality healthcare providers to choose from. Physicians will benefit as there will no longer be a need for these doctors to engage in the administrative obligations that come a long with entering into a written collaboration agreement with NPs. Taxpayers will see savings associated with lower hospital admission and readmission rates, improved immunization rates, and improved compliance rates. Finally, hospitals will benefit by fewer inappropriate Emergency Room visits for non-emergency diagnoses.

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<sup>7</sup> See, e.g., *The Future of Nursing: Leading Change, Advancing Health*, Institute of Medicine, Washington, DC: The National Academies Press (2011); *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, National Council of State Boards of Nursing (NCSBN), APRN Joint Dialogue Group Report (2008); *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, *Nursing Economics*, Vol. 29, No. 5 (2011); *Help Wanted: New York's Physician Shortage Continues to Worsen*, Healthcare Association of NYS (2011).



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number:** 5 (Formerly PIR 15 L 18);

**Recommendation Short Name:** Collaborative Practice of Dental Hygienists and Redefining the Definition of Dental Hygiene

**Program Area:** Oral health

**Implementation Complexity:** Low

**Implementation Timeline:** Upon enactment of statute and promulgation of regulations

**Required Approvals:**  **Administrative Action**<sup>8</sup>       **Statutory Change**<sup>9</sup>  
 **State Plan Amendment**       **Federal Waiver**

**Proposal Description:** Amend Title VIII of Education Law, Section § 6606 - Definition of practice of dental hygiene to allow for Collaborative Practice in Dental Hygiene and a redefinition of the practice of the profession. This proposal seeks to amend statute and regulation to allow for the practice of dental hygiene under a collaborative practice agreement rather than under the supervision of a licensed dentist and redefine the practice of dental hygiene, bringing it in line with the 21<sup>st</sup> century and in accordance with the dental hygiene process of care as defined below. These two changes will allow for the maximum utilization of the dental hygienists in New York State, in keeping with their education, training and expertise as oral health prevention specialists and will serve to improve the oral health status of New Yorkers as well as move towards prevention of disease and promotion of health.

Dental caries continues to be ***the most prevalent childhood disease***. Tooth decay is the most common childhood chronic disease, affecting five times more children than asthma.<sup>10</sup> 38.4% of Medicaid children in New York State accessed NO dental services in 2009.<sup>11</sup> Children visiting emergency departments and ambulatory surgery facilities for treatment of early childhood caries and related pulpal diseases in New York State reached 5,683 encounters, a far cry from the target of 1,500 encounters.<sup>12</sup> A Duke University study (July, 2011) finds that older blacks and Mexican-Americans are more likely to have decayed and missing teeth than are non-Hispanic white individuals. They are also less likely to visit the dentist for checkups.

<sup>8</sup> Amend Title VIII, Article 133, Section § 6606. Definition of practice of dental hygiene (both for collaborative practice and redefining the practice).

<sup>9</sup> Amend §61.9 Practice of dental hygiene. The practice of dental hygiene, in accordance with section 6606 of the Education Law, shall be performed under the supervision of a licensed dentist. Will need to amend to include RDH-CP and note the practice of such must be within a collaborative agreement rather than under supervision.

<sup>10</sup> *Oral Health in America: A Report of the Surgeon General*, National Institute of Dental and Craniofacial Research, National Institutes of Health, U.S. Dept. of Health and Human Services, 2000

<sup>11</sup> Source: Centers for Medicare and Medicaid Services. CMS-416

<sup>12</sup> SPARCS: 2004 - 2008



This is the latest study to conclude that oral health disparities persist among racial and ethnic groups in the US and **that multiple clinical approaches are required to reduce these disparities.**<sup>13</sup> Disparities among Black, Hispanic and those children living in low socio-economic households are undeniable. The National Health and Nutrition Examination Survey (NHANES 1999 - 2004) reports the highest rates of disease prevalence; unmet need (unfilled teeth) and severity of disease, both in primary and permanent teeth among our most disparate children. According to the Department of Health's Oral Health Plan for New York State (2005), approximately 50% of children in New York experience tooth decay by the third grade and about 18% of New Yorkers 65 years and older have lost all their teeth. These numbers are even higher among low-income and minority populations. These are disease statistics about a disease that is entirely preventable! Dental hygiene in collaborative practice, with a redefinition of its practice and the ability to maximize this particular oral health provider isn't going to cure all of these ills – but, it would allow NYS to begin to address the issues of preventing disease rather than continuing to attempt to drill and fill its way out of this quagmire.

Dental disease impacts every single chronic disease in one way or another. Persons with diabetes need preventive dental hygiene services if they are going to control their blood sugar levels. Pregnant women and persons with heart disease need preventive dental hygiene services to control complications caused by periodontal disease.

Dental hygiene is the 11th oldest licensed profession in New York State. It was first licensed in 1917 and was done so to accommodate the first class of dental hygienists' graduating from the Eastman Dental Dispensary that same year whose primary responsibility at that time was to work in the public school districts and PREVENT dental disease in Rochester, NY's children.

Current practice is under general supervision. One of the key changes in practice over the last decade has been the addition of the delivery of local anesthesia and nitrous oxide analgesia. Additional "tasks" have been relegated to the profession over the years and it is time now to make the changes necessary to bring NYS dental hygiene practice in line with numerous other states (27 and growing each day) to begin to address unmet need in NYS.

**Financial Impact:** Short term savings in the provision of dental sealants, a primary preventive intervention for children. A pilot program funded by HRSA, using "remote supervision" of dental hygienists currently in operation in the W. VA Mountains has placed 3,186 dental sealants on permanent molars in one school year. On average the cost per sealant under general supervision was \$24.10 per sealant. Under remote supervision (akin to collaborative practice), the cost per sealant has been determined to be \$19.26, an overall savings of \$15,420.24 or nearly \$5.00 per sealant.<sup>14</sup>

New York State's experience may be different, however. Under the current NYS Medicaid fee schedule, the DOH Bureau of Dental Health does not anticipate cost savings because there is no separate Medicaid fee schedule for dental hygiene services.<sup>15</sup> Therefore, a dental hygienist performing dental sealant placement would receive the same Medicaid rate as a dentist doing similar work.

<sup>13</sup> Wu, B., Liang, J., Plassman, B. L., Remle, R. C. and Bai, L. (2011), Oral health among white, black, and Mexican-American elders: an examination of edentulism and dental caries. *Journal of Public Health Dentistry*. doi: 10.1111/j.1752-7325.2011.00273.x

<sup>14</sup> Virginia Department of Health Dental Hygiene Pilot, Karen Day, DDS, MS, MPH, Dental Health Programs Manager, Virginia Department of Health, Principal Investigator; Sarah Riskin, MPH, Doctoral Candidate, Research Assistant.

<sup>15</sup> Conversation and email from Jayanth Kumar, DDS, Director, NYS DOH Bureau of Dental Health.



However, if a separate fee schedule is developed for reimbursing dental hygienists working in a collaborative practice then there is the potential for cost savings.

**Health Disparities Impact:** The Workgroup did not consider impact on disparities.

**Benefits of Recommendation:**

- a. **Collaborative Practice:** Successful achievement of improved oral health for New York residents will require multiple solutions with a diverse array of engaged partners and acceptance of diversification of the workforce and in the practice of the professions.
  - \* Moving to this model of practice will allow for an ongoing, systemic professional relationship between the dental hygienist and collaborating dentist, each having some degree of authority to independently provide health care services within his or her legal scope of practice.
  - \* The fundamental feature of collaborative practice is always the commitment by the collaborating providers to work in concert to provide the best comprehensive care for their patients while respecting, recognizing, and building on each other's strengths and talents.
  - \* Restrictive supervision of the practice of dental hygiene adds to the inability of qualified, educated, licensed dental hygienists to provide services to those not served by the current oral health care delivery system.
- b. **Redefining Practice:** Dental hygiene has long been dependent (>40 years) on an arbitrary laundry list of services in defining the scope of practice.
  - \* In the midst of growing technology and an oral health crisis, this rigid and arbitrary list serves to unnecessarily restrict the provision of basic preventive, educational and therapeutic services. It does not provide dental hygienists the flexibility to utilize new techniques or perform tasks that are within their training and expertise but fail to appear on the list.

The redefinition proposed is in keeping with the didactic and clinical academic programs and with the standards of education of the Commission on Dental Accreditation, the accrediting body for all dental, dental hygiene, and dental assistant programs in NYS, and follows the "Process of Care" recognized as parameters for dental hygiene practice which include:

- \* **Assessment:** The systematic collection of information about the patient's general health, oral health, behavioral patterns, environment, culture and other pertinent data from the patient and/or the patient's family in order to identify the patient's oral health problems, oral health needs, and the ability to participate in the plan of care.
- \* **Diagnosis:** A formal summary statement of the patient's actual and potential oral health problems and/or deficits that can be treated through dental hygiene care.





- \* **Planning:** Identification of dental hygiene procedures and patient activities needed to resolve dental hygiene problems and/or deficits or to prevent the development of oral health problems. The dental hygienist and the patient participate in setting goals, establishing priorities and identifying interventions and outcome measures.
- \* **Implementation:** The process of carrying out the plan designed to meet the actual and potential needs of the patient.
- \* **Evaluation:** Determination of the extent to which the goals specified in the plan have been met and the need for modification of the plan to provide continuous care for maintaining and/or improving oral health of the patient.

**Concerns with Recommendation:** Opposition by organized dentistry; unsubstantiated claims of inferior delivery of services since it is unsupervised; unsubstantiated claims of no impact on access to care nor on improved oral health status. Perceived loss of revenue by dentists in private practice.

#### **Impacted Stakeholders:**

- \* Long term Medicaid savings realized through direct access to preventive dental hygiene services and basic therapeutic oral health services under collaborative practice.
- \* Short term savings in the provision of dental sealants, a primary preventive intervention for children. A pilot program funded by HRSA, using “remote supervision” of dental hygienists currently in operation in the W. VA Mountains has placed 3,186 dental sealants on permanent molars in one school year. On average the cost per sealant under general supervision was \$24.10 per sealant. **Under remote supervision (akin to collaborative practice), the cost per sealant has been determined to be \$19.26, an overall savings of \$15, 420.24 or nearly \$5.00 per sealant.**<sup>16</sup>
- \* Operational savings by facilities and community-based programs who now must hire a supervising dentist if they choose to employ a dental hygienist. Or worse yet, **pay a dentist to perform dental hygiene services** because there isn’t adequate treatment rooms to allow both dental hygienist and dentist to work on the same day.
- \* Dental hygienists in collaborative practice could move into practice settings such as homebound and institutionalized elderly care settings; developmentally disabled and residential care homes; migrant farm workers and families; pregnant women and their children (WIC, Well baby); congregate sites for elders where access is an issue in both rural and urban areas and provide less costly preventive and basic therapeutic as well as educational services where none are being provided right now.

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<sup>16</sup> Virginia Department of Health Dental Hygiene Pilot, Karen Day, DDS, MS, MPH, Dental Health Programs Manager  
Virginia Department of Health, Principal Investigator; Sarah Riskin, MPH, Doctoral Candidate, Research Assistant.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
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**Recommendation Number:** 6 (formerly PIR 2 NL 2)

**Recommendation Short Name:** Stackable certification and credentials for direct care workers

**Program Area:** Long Term Care

**Implementation Complexity:** Relatively simple since there is already of matrix of tasks and skills outlined.

**Implementation Timeline:** Three months to design, three months to implement.

**Required Approvals:**       **Administrative Action**<sup>17</sup>       **Statutory Change**  
    **State Plan Amendment**       **Federal Waiver**

**Proposal Description:** Articulate training from PCA to HHA to CNA in order to avoid repeating training already received and demonstrated. Direct care workers (personal care aides, home health aides, and certified nursing assistants), are often forced to take the entire training for an additional certificate or credential despite the fact that they could simply add on the additional skills and hours needed to achieve an additional level. For example there are 35 additional hours to move from personal care aide to home health aide and 25 hours to move from home health aide to certified nursing assistant. These workers should be able to add the necessary hours through a standardized process to facilitate ease of transition to other jobs and work environments.

**Financial Impact:** Makes more efficient use of limited dollars for training.

**Health Disparities Impact:**

1. Did the Work Group discuss this proposal's potential effect on disparities in access to care and disease incidence?

- No, the Workgroup did not consider impact on disparities.
- Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

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<sup>17</sup> Requires support from DOH staff)



	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	✓		
Female	✓		
People with a primary language other than English	✓		
People of Hispanic, Latino, or Spanish origin	✓		
People who identify as:			
White	✓		
Black or African American	✓		
American Indian or Alaska Native			✓
Asian			✓
Native Hawaiian or Other Pacific Islander			✓
People with a disability	✓		
People who identify as transgender			✓
People who identify as lesbian, gay, bisexual, or questioning			✓

**Additional comments:** Although we do not know the exact impact of this proposal on populations who identify as transgender, lesbian, gay, bisexual or questioning, there is curriculum to sensitize CNAs and other nursing home workers to the needs of these populations, and components of that curriculum could be added through in-services for the direct care workers.

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders? No** (insufficient time, will be done in the future)

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities? No**

**Benefits of Recommendation:** Builds workforce capacity, is more efficient for the worker and the system, minimizes training costs.

**Concerns with Recommendation:** Some training programs require trainees to take the entire course depending upon screening or testing at the beginning of the training. Every effort should be made to assist the worker in the process while minimizing the amount of repetition.

**Impacted Stakeholders:** As the Medicaid program shifts through increased emphasis on care coordination and management, there will be changes in the available job opportunities for direct care workers. By making the credentials “stackable,” the workers will be able to move more easily into jobs for which there are openings.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number:** 7 (Formerly PIR 8L 38)

**Recommendation Short Name:** Enable physician home visits

**Program Area:** Acute care

**Implementation Complexity:** In light of the FQHC (Article 28 licensed D&TC) and Article 31 OMH licensed clinic precedents, it would be reasonable, and likely accomplished through Medicaid reimbursement policy amendment, to allow all Article 28 licensed hospitals and D&TCs to provide practitioner home visits services to chronically ill, homebound Medicaid patients.

**Implementation Timeline:** Short term

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

**Proposal Description:** Physicians employed by Article 28 licensed hospitals are prohibited from providing services to patients in their homes (including those residing in a nursing home) because of facility licensure restrictions, Medicaid payment rules, and potential malpractice coverage issues that result.

As more physicians, PAs and NPs out of necessity become employed at Article 28 facilities, a mechanism needs to be developed to allow them to treat patients in the patients' homes, including patients who live in nursing homes. These are not home health services but are akin to physician office visits conducted where the patient lives in order to avoid costly ambulance, ED expenses, and inpatient admission expenses. Federally Qualified Health Centers (FQHCs) are licensed as Article 28 facilities and are permitted to provide home visits to their patients. The mechanism that was used to allow for this should be applied to allow other Article 28s the same capability. FQHC patient populations are a very high proportion of Medicaid patients, including many chronically ill and some homebound patients. Article 28 hospitals and diagnostic and treatment centers also treat a high proportion of Medicaid patients with the same characteristics as those served by FQHCs, but are presently precluded from providing practitioner home visits services. As more physicians in community practice become employed by Article 28 facilities, home visits cease. As a result, homebound chronically ill Medicaid patients must be transported to certified Article 28 locations for care. This is both a hardship to the patient and an expense to Medicaid, but more importantly, appointments are not kept resulting in an increase in ambulance transports to EDs and inpatient admissions, as patient conditions worsen. These circumstances are particularly true in rural and underserved urban areas, where access is limited to a few providers who care for Medicaid patients. In further support, clinics licensed by the State Office of Mental Health (OMH) pursuant to Article 31 of the Mental Hygiene Law have recently been authorized to conduct practitioner home visits.



**Financial Impact:** While difficult to quantify a savings amount associated with authorizing practitioner home visits to chronically ill, homebound Medicaid patients, there is clear savings by encouraging and reimbursing such visits compared to ambulance transport, ED visits, and inpatient hospital admissions paid for by Medicaid. In fact, even at a lesser magnitude, there are savings compared to transporting Medicaid patients to and from clinic visits. Once authorized, and as the practice of conducting home visits grows, the savings to Medicaid will increase. A rate would need to be built for this service. The concept has a high potential for savings.

**Health Disparities Impact:** The Workgroup did not consider impact on disparities.

**Benefits of Recommendation:** To keep patients healthier, reduce patient transportation expenses, reduce the costs of unnecessary ED visits, inpatient hospitalizations, and prevent readmissions.

**Concerns with Recommendation:** Would need to deal with possible facility licensure issues and build a rate for these visits.

**Impacted Stakeholders:** To provide homebound chronically ill Medicaid patients with health care services without the need to transport them to Article 28 facilities. Patients will miss fewer appointments and receive better care resulting in less ED visits and fewer hospitalizations.



**Medicaid Redesign Team**  
**Workforce Flexibility / Scope of Practice Workgroup**  
**Final Recommendations - 11/21/11**

**Recommendation Number: 8** (Formerly PIR 7 O 37)

**Recommendation Short Name:** New York State Primary Care Service Corps (PCSC)

**Program Area:** Primary Care

**Implementation Complexity:** Low

**Implementation Timeline:** Proposal enacted in 2012-13 budget; contracts with PCSC candidates begun by October 2012.

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

**Proposal Description:** New York State is committed to transforming the health care system to better address the needs of its residents. To that end, a strong, vibrant and accessible primary care workforce is essential to both promoting, preserving and protecting the health of New Yorkers as well as reducing health care costs for its taxpayers, especially in light of the new requirement under the federal ACA for states to develop new “health insurance exchanges” and provide consumers, many of whom are currently uninsured, with information to enable them to choose among different health plans and with premium and cost-sharing subsidies to make coverage more affordable. As a result of federal healthcare reform, 2 million New Yorkers are expected to obtain health insurance. About one million uninsured New Yorkers are expected to obtain health coverage through the health insurance exchange, with an additional one million becoming insured under New York’s Medicaid program.<sup>18</sup>

As more of the uninsured population becomes insured, the demand for primary healthcare services will surely increase, especially in underserved areas. Financial incentives aimed at students, faculty, colleges and training sites for service in a primary care or allied health profession may be a means to bolster New York’s healthcare network to support this increased demand.

The NYS PCSC is a service-obligated loan repayment program to be administered by NYS Department of Health. Its purpose would be to increase the supply of midwives, nurse practitioners and physician assistants and others who practice in underserved communities. Eligible clinicians would receive loan repayment funding in return for a commitment to practice in an underserved area. Awards would be the same as those awarded by the National Health Service Corps (NHSC) based on the amount of each individual’s qualifying educational debt, but not to exceed the maximum amounts as follows:

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<sup>18</sup> New York State Department of Health, Office of Health Insurance Programs.



Years 1 and 2: Up to \$60,000 for the first 2 years of service (\$30,000 for a part-time commitment); Additional Years: \$35,000 for years 3 and 4; then \$25,000 for any additional years for which qualifying educational loan amounts still exist and the obligated service is still eligible for awards.

**Financial Impact:** Initial state additional spending of \$500,000 will occur to '12-'13 budget. Over the long term, greater access to primary care will likely reduce ER visits, thus lowering overall Medicaid costs below the proposed \$1 million annual budget for the program.

**Health Disparities Impact:** The Workgroup did not consider impact on disparities.

**Benefits of Recommendation:**

- May result in greater penetration of non-physician clinicians in underserved areas;
- State gets 50% match from federal dollars;
- May ease burden to primary care physicians in underserved areas (“multiplier effect”)
- Because a greater percentage (compared to physicians) of non-physician clinicians who graduate from New York schools remain in state and their educational debt levels are lower than those of physicians, extending loan repayment eligibility to non-physician primary care clinicians may be both cost-effective and conducive to the retention of health care personnel in underserved areas.

**Concerns with Recommendation:**

- State dollars are limited; could divert resources from other provider incentive programs such as the Doctors Across New York loan repayment and practice support programs;
- Not clear if the incentives would work in getting additional practitioners to work in underserved areas.<sup>19</sup>
- SRLP participation for matching dollars is uncertain; timing for the grant funding may be challenging.
- NHSC funding, which currently covers 56 nurse practitioners, 39 midwives and 70 physician assistants, is slated to increase, obviating the need for state-financed incentives.

**Impacted Stakeholders:** Non-physician clinicians; primary care sites; Medicaid and other low-income patients in underserved areas.

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<sup>19</sup> According to the February 2010 DOH report, *Increasing the supply of dentists, midwives, physician assistants, and nurse practitioners in underserved areas through Doctors Across New York physician loan repayment program incentives*, There is limited data on the demographics and practice characteristics of NPs, MWs and PAs, so it is difficult to gauge the extent to which these practitioners would respond to incentives such as those provided by the DANY Loan Repayment Program and serve in underserved areas.



**ADDITIONAL INFORMATION:**

***MRT proposal #37 Detail***

*New York State Primary Care Service Corps*

Background

New York State is committed to transforming the health care system to better address the needs of its residents. To that end, a strong, vibrant and accessible primary care workforce is essential to both promoting, preserving and protecting the health of New Yorkers as well as reducing health care costs for its taxpayers, especially in light of the new requirement under the federal ACA for states to develop new “health insurance exchanges” and provide consumers, many of whom are currently uninsured, with information to enable them to choose among different health plans and with premium and cost-sharing subsidies to make coverage more affordable. As a result of federal healthcare reform, 2 million New Yorkers are expected to obtain health insurance. About one million uninsured New Yorkers are expected to obtain health coverage through the health insurance exchange, with an additional one million becoming insured under New York’s Medicaid program.<sup>20</sup>

As a result, as more of the uninsured population becomes insured, the demand for primary healthcare services will surely increase, especially in underserved areas. Financial incentives aimed at clinicians for service in a primary care or allied health profession may be a means to bolster New York’s healthcare network to support this increased demand.

Currently, New York State sponsors or coordinates several obligated clinician service programs aimed at increasing the supply of primary care practitioners. These are illustrated in Table 1 below.

**Table 1. Current Obligated Clinician Service Programs in NYS**

<b>Program</b>	<b>Description</b>	<b>Number of obligated clinicians</b>
Doctors Across New York Physician Loan Repayment Program	A 5-year program that provides up to \$150,000 in loan repayment funding to physicians in return for a 5-year obligation serving full-time in an underserved area of NYS.	41 (27 primary care); 41 additional expected by 3/31/12.
Doctors Across New York Physician Practice Support Program	Provides up to \$100,000 to physicians who agree to practice in an underserved community for at least two years. Funding is available to: (1) physicians to establish or join a practice; or (2) hospitals and other health care providers to help recruit new physicians. All funding must be provided directly to physicians through sign-on bonuses, income guarantees, loan repayment or other financial incentives.	68 physicians were recruited. (50 are primary care). Additional awards anticipated by 2012.

<sup>20</sup> New York State Department of Health, Office of Health Insurance Programs.



# Redesigning THE MEDICAID PROGRAM



Program	Description	Number of obligated clinicians
Conrad “State 30” Program	Authorized under the federal “Conrad 30” legislation, the NYSDOH is deemed an “interested government agency” to recommend up to 30 non-U.S. physicians of any specialty annually for a 3-year placement in, or serving, federally-designated areas of NYS. In return, the physicians receive from the U.S. Department of Homeland Security a waiver of their J-1 visa home residency requirement, allowing them to pursue “green card” status upon completing their 3-year obligations.	30 per year; 150 total currently serving
National Health Service Corps (NHSC) Scholarship/Loan Repayment Program	A federal program, NHSC places primary care, dental and mental health clinicians in federally-designated shortage areas for a minimum of 2 years, serving full- or part-time, in return for up to \$50,000 in loan repayment over those 2 years. Clinicians may re-enroll for additional years and funding beyond the first 2-year obligation.	Approximately 456 NYS clinicians currently serving.
Limited Medical and Dental License Program	DOH coordinates with the NY State Education Department (NYSED) the issuance of medical and dental licenses to non-U.S. clinicians by assuring that the clinicians’ service is limited to eligible shortage areas specified by the New York State Board of Regents.	667 physicians (including specialists); 42 dentists currently serving.
Appalachian Regional Commission (ARC) Waiver Program	Like DOH, the ARC is deemed an “interested government agency” to recommend non-U.S. primary care physicians for a 3-year placement in federally-designated areas within the Appalachian region. <sup>21</sup> In return, the physicians receive from the U.S. Department of Homeland Security a waiver of their J-1 visa home residency requirement, allowing them to pursue “green card” status upon completing their 3-year obligations. DOH coordinates this effort with the NYS Department of State.	Approximately 17 primary care physicians currently serving.

As Table 1 illustrates, with the exception of the NHSC, all the current obligated service programs are geared toward physician or dental clinicians. According to the National Center for Health Statistics, about 55.4% of primary care doctors worked with at least one nurse practitioner (NP), physician assistant (PA) or certified nurse midwife (CNM), but this was true for only 45.9% of surgical specialists and 40.8% of medical specialists, according to the NCHS report. Thus, as the pool of primary care physicians expands, so too will the pool of non-physician primary care clinicians.

<sup>21</sup> In NYS, this area consists of the counties of Allegany, Broome, Cattaraugus, Chautauqua, Chemung, Chenango, Cortland, Delaware, Otsego, Schoharie, Schuyler, Steuben, Tioga, and Tompkins.



In addition, the jobs outlook for primary care non-physician clinicians is strong. For example, according to the NYS Labor Department, PA jobs are projected to grow another 39% in the next decade, among the fastest growing jobs in the state. This is a welcome sign, as long as New York State can distribute the supply to meet the coming demand – especially in underserved areas of the State.

### The New York State Primary Care Service Corps (PCSC)

The NYS PCSC is a service-obligated scholarship program to be administered by the NYS Department of Health. Its purpose would be to increase the supply of midwives, nurse practitioners, physician assistants and others who practice in underserved communities. Eligible clinicians would receive loan repayment funding in return for a commitment to practice in an underserved area. Awards would be the same as those awarded by the National Health Service Corps (NHSC) based on the amount of each individual's qualifying educational debt, but not to exceed the maximum amounts as follows:

Years 1 and 2: Up to \$60,000 for the first 2 years of service (\$30,000 for a part-time commitment)

Additional Years: \$35,000 for years 3 and 4; then up to \$25,000 for any additional years for which qualifying educational loan amounts still exist and the obligated service is still eligible for awards.

To be eligible for loan repayment, all applicants must:

- Be a U.S. citizen (either U.S. born or naturalized) or U.S. National; AND
- Participate or be eligible to participate as a provider in the Medicare, Medicaid, and Children's Health Insurance Programs, as appropriate; AND
- Not have any outstanding service obligation for health professional service to the Federal government (e.g., an active military obligation, an NHSC Scholarship Program obligation or a Nursing Education Loan Repayment Program obligation) or a State (e.g., a State Loan Repayment Program obligation) or other entity (e.g., a recruitment bonus that obligates you to remain employed at a certain site), unless the obligation would be completed prior to receipt of the PCSC award; AND
- Not be in breach of a health professional service obligation to the Federal, State or local government; AND
- Not have any judgment liens arising from Federal or NYS debt; AND
- Not be excluded, debarred, suspended, or disqualified by a Federal or NYS agency.
- Practice as a primary care physician assistant, nurse practitioner, certified nurse midwife, health service psychologist, licensed clinical social worker (LCSW), psychiatric nurse specialist (PNSs), marriage and family therapist, or licensed professional counselor; AND
- Practice in an approved facility in a federally-designated primary care or mental health professional shortage area (HPSA), as appropriate.

The term of the obligation will be 2 years (initially), then the contract may be re-negotiated for additional one-year terms as needed, provided funding is available. Those who do not complete their obligations would be subject to the same default requirements as pertain to clinicians under the National Health Service Corps and DANY Cycle II.

Recommended funding level is \$1 million annually. About 50% of the funding can be derived from federal matching State Loan Repayment Program (SLRP) dollars; thus \$500,000 state dollars and \$500,000 in federal dollars. Assuming the payment terms above, this would add up to 33 obligated non-physician clinicians serving in HPSAs in New York State.



## **Pros and Cons of Program**

### **PROS:**

- May result in greater penetration of non-physician clinicians in underserved areas;
- State gets 50% match from federal dollars;
- May ease burden to primary care physicians in underserved areas (“multiplier effect”)
- Because a greater percentage (compared to physicians) of non-physician clinicians who graduate from New York schools remain in state and their educational debt levels are lower than those of physicians, extending loan repayment eligibility to non-physician primary care clinicians may be both cost-effective and conducive to the retention of health care personnel in underserved areas.

### **CONS:**

- State dollars are limited; could divert resources from DANY programs;
- Not clear if the incentives would work in getting additional practitioners to work in underserved areas.<sup>22</sup>
- SRLP participation for matching dollars is uncertain; timing for the grant funding may be challenging.
- NHSC funding, which currently covers 56 nurse practitioners, 39 midwives and 70 physician assistants, is slated to increase, obviating the need for state-financed incentives.

## **Recommendation**

DOH recommends that the PCSC program be initiated on a pilot basis, with a strong component on assessing the effectiveness of additional incentives on the recruitment and retention of non-physician primary care clinicians in underserved areas.

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<sup>22</sup> According to the February 2010 DOH report, *Increasing the supply of dentists, midwives, physician assistants, and nurse practitioners in underserved areas through Doctors Across New York physician loan repayment program incentives*, There is limited data on the demographics and practice characteristics of NPs, MWs and PAs, so it is difficult to gauge the extent to which these practitioners would respond to incentives such as those provided by the DANY Loan Repayment Program and serve in underserved areas.



**Medicaid Redesign Team**  
**Workforce Flexibility / Scope of Practice Workgroup**  
**Final Recommendations - 11/21/11**

**Recommendation Number:** 9 (Formerly PIR 16 L 84)

**Recommendation Short Name:** Extend authorization to July 1, 2016 in the Education Law that currently permits the activities or services on the part of specific titles in the employ of a program or service operated, regulated, funded, or approved by New York State Agencies to continue to serve without licenses in their current capacities.

**Program Area:** New York State corrections, mental health and other State behavioral health facilities

**Implementation Complexity:** Actionable

**Implementation Timeline:** Legislation must be introduced to establish a 3-year extension of the exemption during the 2012 Legislative Session, prior to the July 1, 2013 sunset. New York State Board of Regents and State Education Department have yet to make a recommendation & will be briefed early 2012.

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

**Proposal Description:** This proposal would affect additional programs licensed, funded or regulated by other State agencies such as: OASAS, OPWDD, OCFS, OASAS, Corrections and others. Sunset of SED Title VII Social Work Law Article 154, Psychology Law Article 153 and Mental Health Practitioners Law Article 163 which exempts programs licensed, regulated or funded by the Office of Mental Health from the Social Work Psychology & Mental Health Practitioners Law will increase costs to replace unlicensed, supervised staff with licensed staff.

This proposal would extend authorization in the Education Law to July 1, 2016 that currently permits the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the Department of Mental Hygiene, the Office of Children and Family Services, the Department of Correctional Services, the State Office for the Aging, the Department of Health, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law and require a report from the Commissioners of the Offices within the Department of Mental Hygiene, the Office of Children and Family Services, the Department of Correctional Services, the State Office for the Aging, the Department of Health by no later than January 2016 concerning the continuing need for any extension of the exemption beyond July 2016. Occupations in OMH programs include but are not limited to Case Managers in Targeted Case Management Programs (ICM & SCM etc.), Psychologist (not licensed), CASAC, Social Worker (not licensed), Certified Rehabilitation Counselor, Vocational Counselor, Recreation Therapist (not licensed), Mental Health Therapy Aide, Case Worker, Service Coordinator, Social Work Case Manager and Peer Specialist.

This proposal would also require the appropriate agency heads to report by January 1 2016 on any continuing need for the exemption beyond July 1, 2016.



**The following refers to the provisions in current social work law (Article 154 of the Education Law). Identical provisions are contained in Article 153 (Psychology) & Article 163 (Mental Health Practitioner):**

Note: Sunset provision for individuals employed by certain programs:

Section 9 of chapter 420 of the Laws of 2002, as amended by section 1 of chapter 433 of the Laws of 2004, as amended by chapter 132 of the laws of 2010 provides:

*Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of correctional services, the state office for the aging, the department of health, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except as otherwise provided by such articles, except that this section shall be deemed repealed on July 1, 2013. (Similar exemptions apply to Article 153 (Psychology) & Article 163 (Mental Health Practitioner).*

**Financial Impact:** Medicaid rates would need to be increased substantially and unnecessarily to comply with the sunset of this law.

**Health Disparities Impact:**

**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male			X
Female			X
People with a primary language other than English	X		
People of Hispanic, Latino, or Spanish origin	X		
People who identify as:			X
White			X
Black or African American	X		
American Indian or Alaska Native			X
Asian <sup>i</sup>			X
Native Hawaiian or Other Pacific Islander <sup>ii</sup>			X
People with a disability <sup>iii</sup>	X		
People who identify as transgender <sup>iv</sup>			X
People who identify as lesbian, gay, bisexual, or questioning			X



**2. Did the Work Group discuss this proposal's potential impact on disparities with key stakeholders?** Yes

Compliance and full implementation of the applicable Education Law with loss of the exemption for OMH regulated and funded providers would dramatically increase the demand for Title VII licensed individuals throughout the State. The impact is that there are insufficient Title VII licensed practitioners to fill the vacancies or meet the need in private settings. Minority populations and rural areas would especially be adversely impacted. Large numbers of public & private sector employees who currently provide effective services with comparable safeguards to licensed practitioners would be displaced with insufficient or nonexistent replacements to serve primarily economically distressed & minority communities. Increased costs & restrictions on currently authorized staff especially providing case management services will negatively compromise MRT's Health Home rollout which otherwise would be expected favorably impact the high cost/co-morbidity Medicaid population.

**3. Did the Work Group discuss an approach to monitoring this proposal's effect on disparities?** No

Additional Information:

**Benefits of Recommendation:** There are insufficient licensed practitioners to replace the current unlicensed workforce that primarily serves the needs of a poor & Medicaid eligible population. The current workforce provides high quality services comparable to licensed practitioners because of the regulatory & contractual responsibility of the impacted state agencies. At the very least, the extension will permit large numbers individuals in need of care to continue to be served cost effectively. Moreover Medicaid savings in the range of \$50 - 90 million annually in Mental Health alone (See attached analysis) would result. OASAS reported between \$36 and \$73 Million dollars in additional costs while OPWDD \$114 Million dollars in additional costs for an overall three agency **savings of between \$200 to \$277 Million** which would be borne by the State & Medicaid program should the exemption not be extended. This proposal supports and insures the viability of the approved MRT Health Home proposal which otherwise would be compromised & likely undermined if the case management workforce was disenfranchised through the sunset of the current exemption. Additionally this proposal compliments and supports the approved MRT proposal establishing Behavioral Health Homes as the current fee for service Behavioral Health benefit transitions to managed care.

**Concerns with Recommendation:** Possible opposition from Social Work, Psychology & Mental Health Practitioner professional Associations and private practitioners.

**Impacted Stakeholders:** Extending the current exemption three years will avoid the adverse impact on the MRT Health Home initiative and especially any disruption on the case management workforce which would be in jeopardy if the Education Law corporate practice restrictions became applicable and large numbers of unlicensed practitioners were required to be replaced. It would prevent an estimated 5,000 staff layoffs and increased costs in the mental health system alone without any demonstrated improvement in clinical outcomes. OMH's regulatory processes have comparable quality and safety standards to services provided by licensed professionals under Title VII. The extension period would also parallel the MRTs Behavioral Health Organization time frame envisioned for the movement of the Behavioral Health care system from a Medicaid Fee for Service modal to a Managed care model. That transition period will provide policy makers with real data on the quality & quantity of resources required to deliver high quality, cost effective services.



**ADDITIONAL INFORMATION:**

**Office of Mental Health**  
**SED Workforce Survey Report**  
**Submitted September 16, 2011**  
**Overview**

The New York State Office of Mental Health (OMH) provides the following assessment of the legislatively-required survey of the Behavioral Health Community regulated by OMH (see §§ 13 and 14 of Chapter 130 of the Laws of 2010, as amended by §§ 3 and 4 of Chapter 132 of the Laws of 2010). The survey is intended to identify those functions, tasks and activities which are performed by staff in programs regulated by the OMH, in order to determine the use of licensed professionals and other staff to deliver restricted and unrestricted services. In addition, OMH provides its recommendation to make permanent the existing exemption from the “scope of practice” provisions for programs operating under the jurisdiction of OMH while continuing to provide high quality and cost effective behavioral health services under the contractual and regulatory oversight of OMH.

**Executive Summary**

OMH and other affected agencies encouraged providers to participate in the survey, developed and circulated by the State Education Department (SED) earlier this year. Of the 426 mental health survey responders this sample represented a mix of residential and outpatient providers, comprising approximately sixteen percent of impacted programs and services operated under the jurisdiction of OMH. The majority of those responding operate mental health programs that provide assessment, diagnosis, assessment based treatment planning, psychotherapy, and other services such as case management to a large cohort of individuals throughout the State.

The respondents to the survey identified 2,523 unlicensed individuals who provided one or more of the services that were defined as “restricted” in the survey instrument. Although the survey, on face value, shows an overlap of licensed and unlicensed staff performing the same functions, in reality, OMH programs perform “restricted” activities predominately in licensed programs under professional supervision, usually within the context of a treatment team approach consisting of multiple licensed professionals, and with multiple layers of programmatic oversight.

If the present statutory exemption were to lapse, the increased cost to replace unlicensed staff with licensed individuals is approximately \$23,302,482 annually for the providers who participated in the survey. Extrapolated to include local providers and impacted staff (see attachment #4) the total annual cost would be approximately \$46,604,964, based on a total from CFR data of non-hospital based programs and including state operated programs (table #3) the total could grow as high as \$85,894,993. Moreover, there are not adequate numbers of licensed individuals to fill these positions. We are also unaware of any evidence that would support better client outcomes with increased licensed staff given the multiple layers of protections that exist in OMH licensed and contracted programs. We see the value of maintaining culturally competent unlicensed staff working to reintegrate individuals with serious mental illness back into their communities.



In addition, we believe that some of the respondents may have misinterpreted some of their activities as constituting the five restricted services, such as: confusing observation of symptoms with diagnosis, psycho-social or rehabilitation assessment with assessment based treatment planning or counseling, and advice giving and support with psychotherapy.

State operated programs were under represented in this survey. In previous analysis OMH identified 4,254 individuals in various titles that could be impacted. (See attachment #3)

The survey also did not assess the quality of the services, although the services provided were consistent with the Education Law and the Mental Hygiene Law.

OMH has a sophisticated regulatory apparatus that has been found to provide cost effective quality Behavioral Health Services prior and subsequent to the enactment of the current exemption. (See Sections VI-X for greater detail and explanation.)

If the results from the responders to the survey were to be extrapolated to all providers, excluding hospital based programs that employ licensed individuals, operating under the jurisdiction of OMH, the system wide salary increase to replace non-licensed individuals in OMH regulated programs is approximately \$46,604,964. If we take into consideration impacted State staff the total could reach \$85,894,993. The additional cost of delivering the services by practitioners licensed under Title VII of the Education Law would be borne by New York State and the Federal government as the overwhelming reimbursement for these services includes Medicaid, Medicare, and State deficit financing.

There is no evidence to suggest that recipients of services provided by entities under the jurisdiction of the OMH are inferior in quality or sub-standard to those provided exclusively by practitioners licensed pursuant to Title VII of the Education Law. In fact, a good portion of individuals seeking licensure gain their clinical experience in OMH programs.

## I. Introduction

OMH submits this report after receiving the summaries of the SED survey of the field, as required by Chapters 130 and 132 of the Laws of 2010. The SED summary response sheets provide insight into the delivery of services that have historically been competently and effectively delivered by OMH entities covered by the “scope of practice” exemption in the behavioral health licensing statutes enacted and renewed several times since 2002.

The OMH survey responders constituted **426** programs for purpose of this analysis or 16 percent of the **6,759** programs in the OMH service delivery system (see Attachment #1). The survey results corroborate and confirm information OMH previously supplied concerning the quality and cost effectiveness of the exemption that currently exists in law. Indeed, given the continued efficacy of the exemption, the enormity of the increased costs and onerous fiscal impact on the State resources should the exemption be eliminated, and the potential to undermine the strategic plan to redesign the Medicaid program, the exemption should be extended and made permanent.





The SED survey data indicate that if the exemption is eliminated, the cost to replace unlicensed practitioners would be at least \$23 million. This is consistent with previous estimates provided by OMH in 2008-09 in the amount of \$22.5 million to come into compliance in the first year and \$13 million thereafter. If this is a representative sample of providers, with clinic programs comprising the majority of the responders, the extrapolated cost increase for the system would be **\$46,604,964** million. This amount is based on a CFR total of 11,000 – 12,000 FTEs (see attachment #4) using the rate of penetration in the SED survey of non-licensed individuals. Overwhelmingly, the financial resources to deliver the surveyed services are State resources paid through Medicaid, deficit financing from the State, and in Legislative member items. Without any evidence of improved services or outcomes in this period of fiscal austerity, the wisdom of eliminating a cost effective exemption is questionable. To put this in perspective, for programs operated under the jurisdiction of OMH the additional expense in the first year alone would completely eliminate the anticipated annual savings anticipated in fiscal year 2011-12 for the Medicaid Health Home initiative.

In addition to the likely increased personnel cost to both the provider community that is likely to be either borne by the State or result in substantially reduced services to our citizens, the cost of regulating both the licensed practitioners and the increased number of providers included through the waiver process can be expected to increase substantially. This regulatory scheme comes with additional expense, cost and/or likely dysfunction to healthcare for vulnerable populations at a time of great uncertainty and change especially in the State Medicaid program. Further, the SED would have to substantially increase the size and cost of its investigatory and prosecutorial function in the SED Office of Professional Discipline.

Past weaknesses in the “professions” model of regulation in the recent past has resulted in the primary regulatory role being transferred from SED to the delivery system agency. The primary role of the Department of Health (DOH) in regulating the practice & discipline of physicians, physician assistants and specialist assistants as well as certified nurse anesthetists has insured that the key human resources in our State’s health system are accountable in the most efficient manner. The behavioral health professions play a similar integral role in OMH and the exemption provides quality and a more cost effective model which does not go as far as the DOH model.

However well intended, the State should revisit whether a costly regulatory standard and apparatus well intended to address documented problems in private practice settings should be applied in a state operated, funded and/or otherwise well regulated settings. New York State OMH, as evidenced later in this report, has created an oversight mechanism for insuring that quality services are provided competently and safely in a cost effective manner.

In sum, if the “scope of practice” exemption were to be eliminated, it would result in enormous additional costs, would not provide any meaningful measure of increased safety or quality to our citizens as reflected by the survey results and the current regulatory apparatus in place through the OMH.



## II. SED Workforce Survey Results for OMH Programs

Initially a total of **544 programs** responded that their programs were either operated, licensed (includes programs certified or regulated), approved, or funded by OMH. The data was further examined and refined, leaving **426** programs as survey responders for purpose of this analysis. Of the 426 programs that participated in the survey:

Q5	97% answered (number providing assessment/evaluation in program)
Q6	54% answered (number of licensed staff providing assessment/evaluation)
Q7	45% answered (non-licensed providing assessment/evaluation)
Q8	20% answered (re: other titles assessment/evaluation)
Q11	83% answered (programs providing diagnosis)
Q12	47% answered (licensed staff providing diagnosis)
Q13	24% answered (unlicensed staff providing diagnosis)
Q17	83% answered (number of programs providing assessment based treatment planning)
Q18	53% answered (number of individuals providing assessment based treatment plan)
Q19	40% answered (unlicensed staff providing assessment based treatment plan)

The overall response rate for answering one of the key questions that relate to the five services is approximately 55 percent. However, 87 percent of programs answered the question regarding the provision of three of the restricted services: assessment/evaluation; diagnosis; and assessment based treatment planning.

The self-selected sample represents **426** providers or approximately 16% of the OMH service delivery system, an under reporting of OMH's total of **6,759** programs (see attachment #1). State operated programs were under represented in this survey. In a previous analysis OMH identified state operated programs having **4,254** individuals in various titles that could be impacted. (See attachment# 3)

## III. The Five Survey Services

The survey attempted to capture a snapshot of services that the SED Office of Professions considers to be restricted to licensed individuals. Operating under the current extension of the exemption in the social work law, OMH and its affiliated agencies report they are providing the following services (references to the number of **individuals** engaged in any of the five services can be found in attachment #2):

- Assessment/evaluation – Approximately 81 percent of respondents stated that they provide assessment and evaluation. Assessment is provided by a mix of paraprofessional, professional, and licensed staff. Some type of assessment occurs in most all OMH funded services including: psychological evaluation, psychiatric evaluation, psycho-social assessment, rehabilitation assessment.



- Diagnosis – Although 69 percent of the respondents reported that their program provides diagnosis, only OMH licensed clinical programs perform diagnosis. The Article 163 licensees (licensed mental health practitioners) comprised only 4 percent of those staff providing diagnosis. While a total of 392 unlicensed individuals were reported as providing diagnosis, or 8% of the total, in each instance a physician provides the diagnosis and authorizes treatment. Unlicensed individuals may be reporting on symptoms and not actually diagnosing an individual. This disparity between what was reported and what actually occurs in such programs raises serious questions regarding the accuracy of the survey reporting.
- Assessment based treatment planning/Service Planning – 82 percent of providers answered the question that their programs provide assessment based treatment planning. This is one of those terms that, while defined in article 154 of the Education Law for licensed social workers, may be unclear to survey respondents. Assessment based treatment planning is primarily performed in licensed treatment programs and “service planning” is done predominantly in the case management, residential and rehabilitation programs. The survey Case Processing Summary (see attachment #2) identified 4,757 licensed individuals and 1,795 unlicensed individuals engaged in “assessment based treatment planning.” As noted above, “assessment based treatment planning” as a term of art referred to in the statutory provisions which define the scope of practice of social work, while many services under the jurisdiction of OMH include similar activities including screening for co-occurring disorders, and gathering health information, but such functions are not “assessment based treatment planning.” In the performance of such activities OMH programs use a multi-disciplinary team structure that requires physician sign-off for treatment/service plans (Once again, this disparity between the survey results and the actual performance of functions raises questions regarding the accuracy of the survey.)

Of the respondents that reported licensed and unlicensed staff conducting “assessment based treatment planning” in their programs, more than half of the agencies responded they employed titles that can be “licensed or certified” however were reportedly filled with unlicensed staff:

- Psychologist (not licensed)
- CASAC
- Social Worker (not licensed)
- Certified Rehabilitation Counselor
- Vocational Counselor
- Recreation Therapist (not licensed)
- Mental Health Therapy Aide
- Case Worker, Service Coordinator, Social Work Case Manager
- Peer Specialist

For those programs with mixed staff largely through the use of the multidisciplinary treatment team approach, OMH does not find a material difference in the quality of services provided in programs which also employ unlicensed staff.



Psychotherapy – A total of 67 percent of respondents reported that their program provides psychotherapy. A total of 5,613 licensed staff or 93% of the total reported to provide psychotherapy; 9% were reported as interns. Clearly most staff providing psychotherapy in OMH programs are licensed individuals. However a total of 414 non-licensed staff were also reported as providing psychotherapy. The survey did not ask the percent of time the unlicensed individual engaged in psychotherapy or about their supervision. Here again it appears that because of the vague definition of psychotherapy many staff could assume to be providing psychotherapy while being engaged in crisis de-escalation techniques, counseling or behavior modification on a limited basis. In OMH licensed programs, no unlicensed individual performs psychotherapy without the supervision of a licensed professional. OMH’s licensed programs have been competently providing psychotherapy using a multi-disciplinary team model successfully prior to and since the “scope of practice” exemption. It is interesting to note that a large part of the licensed professional workforce receives their training in an OMH program.

Only 13 percent of the licensed category fell under the “other” category, which include titles such as nurses, occupational therapists, and other licensees who may provide psychotherapy under the exemption but otherwise may not have psychotherapy as part of their scope of practice. Less than one percent of programs reported that they had either volunteers or contracts with 26 individuals who provided psychotherapy.

Of the unlicensed staff, 112 or 15 percent of those with a case management/coordination titles reported providing psychotherapy. The total number of individuals in case management titles was 750. According to OMH data, there are 1,854 staff employed in case management programs and the survey captured 40 percent of the OMH case management workforce. Generally, case management programs are confined to linking clients to services and resources in the community. While case management may be part of the scope of practice of a licensed individual, it has not been seen as a restricted activity. In fact, “case management” is specifically listed among the functions that are exempt from the restricted practice of social work (Education Law section 7702 1. (g)).

- Services other than psychotherapy – The OMH service delivery system typically provides a wide range of services to individuals living with serious mental illness. Since services are provided in program settings rather than an individual private practice setting, individuals can receive more comprehensive care, addressing impairments in key life domains.

Restricted Service	Unrestricted Service
<ul style="list-style-type: none"> <li>• Nursing assessment</li> <li>• Psychiatry services, including: medication-treatment, medication management</li> <li>• Psychological testing</li> <li>• Case management</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Skill building</li> <li>• Supported education</li> <li>• Supported employment services</li> <li>• Recreational &amp; socialization services</li> <li>• Discharge planning, advocacy, linkage to social and support services</li> <li>• Respite(short term child supervision)</li> </ul>



## IV. SED Survey

Title	Number	Mean Salary	Total
ABAS	4	\$37,250.00	\$149,000.00
CARECO	7	38,643.00	270,501.00
CASAC	47	35,996.00	1,691,812.00
CASEMGR	67	30,656.00	2,053,952.00
CASEW	11	34,365.00	378,015.00
CRC	20	41,112.00	822,240.00
CSRESAID	27	25,730.00	694,710.00
MHTA	16	36,633.00	586,128.00
NBCC_COU	4	27,000.00	108,000.00
Other -LI	84	52,014.00	4,369,176.00
Other 1	59	35,618.00	2,101,462.00
Other2	20	32,723.00	654,460.00
Other3	3	39,407.00	118,221.00
Other4	1	27,787.00	27,787.00
PREVCSLR	4	32,000.00	128,000.00
PSYCHGOV	16	59,973.00	959,568.00
RECTH	17	36,943.00	628,031.00
REHABTH	6	42,929.00	257,574.00
SERVCOOR	8	31,546.00	252,368.00
SW	109	40,386.00	4,402,074.00
SWCASE	12	36,859.00	442,308.00
SWCSEW	7	38,548.00	269,836.00
YOUTHCSL	21	23,507.00	493,647.00
VOCSLR	21	37,283.00	782,943.00
	591	\$874,908.00	<b>\$22,641,813.00</b>
Avg Unlic. Salary		\$38,039.48	
Avg of LMSW & LCSW Salary		\$47,275.50	
Salary Differential		\$9,236.02	
Unlicensed reported doing at least one of the five services	2,523	\$ 23,302,482.85	Salary differential to replace non-licensed staff with licensed staff



## **V. FISCAL IMPACT**

The salary table above does not reveal which of the titles are providing the five restricted services or how often, however:

- A total of 2523 unlicensed individuals were identified as providing any of the five restricted services.
- The total FTEs as reported on the FY 2010 CFR for non-hospital based programs is 32,000 with 11,000-12,000 FTEs listed in service titles. Hospital based programs and State operations were not included in this number. (See attachment #4)
- The salary differential between an unlicensed employee and a licensed employee identified in this survey is \$9,236. Based on the survey the salary replacement cost to replace unlicensed professionals with licensed staff would total approximately \$23,302,482.
- This cost does not include any potential increase in fringe benefits, lost revenue to the program as they are hiring new employees, costs for training and phasing in a new client caseload, or annualized costs.
- Based on this sample we estimate that there could be double the number of unlicensed individuals providing one or more of the restricted services, with a replacement costs upwards of \$46,604,964.
- In addition, if we include 4,254 positions in state operated programs using the salary differential identified in the survey there could be an addition cost of \$39,290,029.
- Total impact, without including fringe, lost revenue or other costs could be as high as \$85,894,993.

## **VI. Current Public Protection and Quality Standards in OMH**

The articulated purpose of the New York State licensing law that created four new mental health practitioners professions was “to protect the public from unprofessional, improper, unauthorized and unqualified” practices (Legislative Intent of Chapter 676 of the Laws of 2002).

Programs operated, funded, and licensed by OMH have long been recognized for accomplishing this important purpose. Moreover, public behavioral health programs provide high quality services which are provided cost effectively and in underserved areas of the State. The current 2011 fiscal climate calls into question the imposition of additional restrictions on the operation of these programs.

Further, public protection by OMH is enhanced by multiple federal, state and county oversight including:

- Federal audits and review
- State control agency audits and inspections
- County oversight of mental health programs



OMH employs current complex oversight mechanisms to ensure that safe and effective quality services are provided within the various programs that the agency operates, licenses, funds or oversees. This oversight ensures that safe and effective services are provided to the population served whether licensed or non-licensed direct care personnel are providing such services.

## VII. Overview of the OMH Community-Based System

The Office of Mental Health has the responsibility for the development, regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 600,000 outpatients annually.

OMH classifies its programs into four major categories: Emergency; Inpatient; Outpatient; and Community Support. Programs may be operated by the State, county, municipality, or not-for-profit agencies.

- Emergency programs provide rapid psychiatric and/or medical stabilization while assuring the safety of the individuals who present risk to themselves or others. Programs include local emergency services and comprehensive psychiatric emergency programs (CPEPs).
- Inpatient programs are hospital-based psychiatric treatment programs providing 24-hour care in a controlled environment. These may be in State operated or non-State operated hospitals. Institutional programs often serve forensic or dually diagnosed populations.
- Outpatient programs include assessment, symptom reduction, treatment and rehabilitation in an ambulatory setting or in the community. Programs include Clinic, Partial Hospitalization, Continuing Day Treatment; Day Treatment; Intensive Psychiatric Rehabilitation Treatment (IPRT); Assertive Community Treatment (ACT); and Personalized Recovery Oriented Services (PROS).
- Community Support Programs help individuals with severe mental illness with developing the skills and supports to live as independently as possible in the community.
- Community support outreach, clubhouse, sheltered work, affirmative businesses, supported employment, peer support, family support, respite, residential and other services.

## VIII. Program Certification, Monitoring and Oversight Process

OMH's Bureau of Inspection and Certification reports that there are **6759 programs licensed, regulated, or funded by OMH**. This includes State and county operated, not-for-profit, and for profit programs. Programs licensed and funded by OMH are subject to oversight, monitoring, and regulation from numerous entities. These are described below.



Oversight is performed in several ways:

- **Regulation:** OMH has regulatory authority and has established regulations and/or guidance for all licensed programs (e.g., Clinics, CDT, Day Treatment, PROS, IPRT, Partial Hospital, and Residential) and many unlicensed programs (such as case management and supported housing). Links to regulations regarding licensed programs may be found at: [http://www.omh.ny.gov/omhweb/policy\\_and\\_regulations/](http://www.omh.ny.gov/omhweb/policy_and_regulations/)

OMH regulations require OMH licensed providers to:

- Perform comprehensive assessment;
  - Maintain individualized treatment plans;
  - Conduct periodic treatment team meetings and treatment plan reviews;
  - Provide supervisory professional oversight (as contrasted with private independent practitioners where no oversight is required); and
  - Maintain operating policies and procedures, including a staffing
- **Prior Approval and Review** or PAR process: Operators need PAR approval before establishing new programs or substantially changing existing programs. The PAR process includes a review of such areas as operator character and competence, fiscal viability, public need, and charities registration.
  - **Inspection and Certification:** OMH provides ongoing licensure oversight through on-site visits (announced and unannounced). Re-certification visits include a review of clinical practices, staffing credentials, supervision, service utilization, and quality improvement initiatives. The inspection and certification process reviews agency staffing and supervision plans to ensure staff are properly credentialed and trained. OMH policy precludes non-licensed clinical staff performing duties unsupervised.
  - The public sector has the regulatory apparatus that improve the quality and competence of services. The OMH [Balanced Scorecard](#) measures and reports on outcomes experienced by individuals served in our public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance. The Scorecard is designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data to inform decision making and assess the service needs of the community.
  - **Background Checks:** OMH requires providers to conduct background checks for criminal history and child abuse prior to hiring new staff.
  - **Enforcement:** OMH Enforcement mechanisms include issuance of Monitoring Outcome Reports, Plans of Corrective Action, fines, license suspensions, and revocation of licenses. OMH may also withhold payments for an agency's lack of repeated non-compliance.





- **Fiscal Oversight:**

- Reimbursement – OMH establishes Medicaid reimbursement rates for licensed programs and administers State Aid funding to local government. In return, OMH gathers data on services provided by mental health providers.
- Contract Oversight – In addition to Medicaid reimbursement for licensed programs, OMH provides direct contracting & program oversight for many programs. All providers under contract must answer the following questions regarding:
  - The contract’s intent and a justification of need. Explain how this contract is critical to health/safety, revenue collection, and/or core mission of OMH?
  - If this is for a renewal or amended contract, is the work plan remaining the same? If not the same, please explain modifications to the contract's scope and why they are necessary?

For further detailed contracting requirements, see:

<http://www.omh.ny.gov/omhweb/spguidelines/PDF/DirectContractFormsandInstructions.pdf> .

- promotes fiscal viability and accountability in the service delivery system through (a) fiscal reviews and audits and (b) OMH Field Office reviews of fiscal viability through
- **County Oversight:** Section 41.13 of the Mental Hygiene Law establishes the powers and duties of local governmental units in administering local mental hygiene services through planning, oversight, quality assurance, and contracting with voluntary organizations. In regard to local oversight both under its general supervisory functions, and for LGU contracting, Subdivision 8 of 41.13 states:

The local governmental unit shall “make policy for and exercise general supervisory authority over or administer local services and facilities provided or supervised by it whether directly or through agreements, *“including responsibility for the proper performance of the services provided by other facilities of local government and by voluntary and private facilities which have been incorporated into its comprehensive program.”*

Further, under 41.13, Subdivision 14, the oversight of local program services (including contract agencies) by local governmental units includes that the LGU “require the development of a written treatment plan as provided in the rules and regulations of the commissioner which shall included but not be limited to...appropriate programs, treatment or therapies to be undertaken...” This provision underscores the close involvement in individual programs’ service delivery via contracts or other LGU oversight of programs.



Ultimately, specific contractual oversight and supervisory authority over voluntaries will be determined, and vary based on contract terms. Such terms may also vary within and between counties depending on the needs of service recipients, the degree of third party (e.g., State agency) oversight, and the specific program. Examples of oversight of voluntary programs by a local governmental unit per a contract may include the following:

- Establishing and monitoring program process and outcome objectives;
- Require participation in local Community Service Board meetings to educate and encourage programs' service to specific community needs;
- Establish standards and procedure for addressing misconduct and disciplinary measures;
- Required appropriate non-profit corporate compliance plans; and
- OMH Field Office staff work with county/city government in order to assure adherence to the program model, documentation and meeting contract deliverables.

The **OMH County Profiles Home Page** <http://www.omh.ny.gov/omhweb/statistics/> offers consolidated, at-a-glance, and comparative views of key county community characteristics, mental health services expenditures, and outcomes. Its purpose is to enable planners and others to identify service gaps and disparities and plan improved service delivery. Under NYS Mental Hygiene Law, county governments and the City of New York must develop (in conjunction with local stakeholders) a local mental health Plan to address the mental health needs of individuals of all ages with serious mental illness or emotional disturbance. These Plans are reviewed by OMH annually. They must be approved by OMH in order for the State to provide funding through Medicaid reimbursement as well as local assistance funds. All mental health programs licensed or funded by OMH must participate in this process.

- **Other State, Federal and Certification Oversight** – In addition to OMH direct oversight, most programs operated or licensed by OMH receive additional oversight from:
  - NYS Department of Health
  - Federal Centers for Medicare and Medicaid Services (audits and inspections)
  - Federal Department of Justice
  - New York State Office of Medicaid Inspector General
  - New York State Office of State Comptroller (program audits)
  - New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD)
  - Private Certification Agencies including TJC, CARF and others



## IX. Quality Control

OMH is focused on quality in addition to regulation, compliance and oversight. This is done through the use of multidisciplinary teams and standards of care.

- **Multidisciplinary teams** – Many OMH licensed and funded programs are structured to build in quality control through the use of multi-disciplinary teams. These teams are composed of a range of staff from psychiatrists to licensed and experienced therapists to trained peers. The strength of the teams is enhanced by strong supervision and sign off by experienced and appropriately licensed team members. Teams use a multi-disciplinary approach to set the direction with the recipient for treatment. Professional staff on the team have overall responsibility for treatment plan implementation.
- **Standards of Care** – OMH has developed clinical standards of care which are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State. The Standards of Care highlight expectations for:
  - Staffing
  - Caseloads
  - Training
  - Tracer Methodology
  - Screening
  - Assessment Domains
  - Best practices

**Complaint Investigation:** Complaints arrive at the Customer Relations Toll Free Line. The 1-800 Line receives approximately ten-thousand calls each year. The complainants can be mental health service consumers, providers of mental health services who are concerned with some aspect of service provision, family members of persons with mental disorders, or concerned citizens, among others. The Line is open to all. Complaints frequently arrive at the Customer Relations Line by referral from other agencies and organizations such as the Governor’s Office, police departments, the Department of Health, and the Office for Persons with Developmental Disabilities. The majority of the complaints come directly by phone. Complaints are also received at each OMH Field Office, at the Office of the Commissioner, and through the Office of Consumer Affairs. Many complaints come to the Office of Mental Health as letters, faxes, email, or from walk-in complainants, and are routed and resolved commensurate with the consumer’s needs. Simpler complaints are handled by staff of the Customer Relations Line. Complaints related to regional service provision are tasked to the Field Offices. All allegations of abuse or neglect are pursued by Clinical Risk Managers. Depending on need, complaints are also routed to other Agencies and Organizations, such as the Department of Health, Child Protective Services, or Community Mobile Crisis Teams, to name just a few.



**Incident Reporting: NCRR 14 Part 524:** Incident management regulations are intended to ensure the development, implementation and ongoing monitoring of incident management programs, by individual providers, which will protect the health and safety of clients and enhance their quality of care. QA 510 is the policy for State-operated programs. The following link will provide definitions for types and severity of incidents.

<http://www.omh.ny.gov/omhweb/guidance/hcbs/html/DefinitionsForIncidentTypes.htm>

**Mental Hygiene Legal Service (MHLS):** The Office of Court Administration funds MHLS to represent, protect and advocate for the rights of people who reside in, or are alleged to be in need of care and treatment in, facilities which provide services for persons with mental disabilities.

## **X. Conclusion**

To a large extent, OMH is able to shape and regulate community based services through its licensing, regulatory and funding authority. OMH agencies rely on a cadre of non-licensed professionals who provide, to varying degrees, the five services listed in the survey in addition also provide crisis, case management and counseling services within supervised and regulated programs.

Rather than requiring all of our programs' employees to be licensed professionals (and there are not enough licensed professionals to meet the needs of the public services system), our programs operate with all the above redundant protections. Add to these the current enforcement by the Office of the Medicaid Inspector General (OMIG) and others there appears to be no need for further restrictions on the use of non-professional clinical staff in OMH licensed or sponsored programs.

These protections better and more uniformly ensure safe, quality services than reliance upon the individual abilities, character and competence of each licensed professional in the State.

Furthermore, if the exemption for OMH programs ends on July 1, 2013 financial consequences would be catastrophic. Minimally, there would be a need to either increase resources or decrease expenditures by as much as \$46,604,964 million in Medicaid, State Aid or a combination of the two in the first year, for those programs which operate under the jurisdiction of OMH.



## **XI. Recommendations**

- Most importantly, the Legislature should establish a permanent exemption from “scope of practice” restrictions for programs operated, funded, licensed, or regulated by OMH.
  - All of the State mental hygiene (“O”) agencies agree that the Title VII regulatory apparatus has many benefits and where appropriate, as in the recent OMH Part 599 clinic regulation (14 NYCRR Part 599), has been whole-heartedly endorsed. OMH and the “O” agencies also have found that the public behavioral health system has substantial cost-effective public protections, and there is no demonstrated need for additional restrictions on the operation of these programs.
- The OMH has sufficient oversight mechanisms and program supervision in the service delivery system that makes conversion of unlicensed staff to licensed staff unnecessary.
- Extension of the current exemption from the “scope of practice” provisions will preserve the State statutory scheme for the provision of quality behavioral health services as defined in the State’s Mental Hygiene Law, as well as the important oversight role of the “O” agencies within the Department of Mental Hygiene.



**ATTACHMENT #1**

**Office of Mental Health Bureau of Inspection and Certification 6/30/2011**

<b>Number of Programs Licensed, Regulated, or Funded by OMH; by Auspice.</b>						
<b>Programs</b>	<b>Not-for-profit</b>	<b>State</b>	<b>For-profit</b>	<b>County</b>	<b>Total</b>	
Licensed	1384	633	27	69	2113	
Non-licensed	3697	242	4	703	4646	
<b>Total</b>	<b>5081</b>	<b>875</b>	<b>31</b>	<b>772</b>	<b>6759</b>	

**Source: CONCERTS database**

Notes:

1. Licensed programs include residential, inpatient, outpatient, and family care.
2. Non-licensed programs include residential, non-residential/community support, and state PC inpatient.
3. State includes PC-sponsored family care homes (461).
4. Non-state-sponsored family care homes (13) are included under not-for-profit auspice.
5. County includes county-operated programs and NYCHHC municipal programs.



## ATTACHMENT #2 SED WORKFORCE SURVEY ANALYSIS - OMH

### Number of staff engaged in the 5 services

Licensed Practitioners	Assessment	Diagnosis	ABTX Plan	Psychotherapy	other services
Physician	1049	895	240	689	
Physician Assistant	21	18	7	6	
LMSW	1609	1120	1409	1321	
LCSW	1903	1361	1657	1976	
Psychologist	563	317	359	333	
Intern, resident	934	438	533	523	
Nurse Practitioner	200	158	158	125	
Article 163	384	185	301	274	
Other Professionals	0	37	93	366	
<b>Total Licensed</b>	<b>6663</b>	<b>4529</b>	<b>4757</b>	<b>5613</b>	
<b>Unlicensed Practitioners*</b>					
ABAS	13	3	6	3	
CASAC	126	101	154	45	
CASEMGR**	750	58	656	112	
CORRECLSR	0	0	0		
CRC	23	13	28	18	
CSRESAID	177	25	403	17	
MHTA	89	1	33	5	
NBCC	4	0	2	2	
OTHEREOPE***	0	26	83	54	
RECTHER	41	5	31	13	
REHABTHER	32	2	23	5	
SW	269	144	198	102	
VOCSLR	128	2	103	12	
YOUTHCSL	56	0	56	7	
PSCCH GOV	52	12	19	19	
<b>Total Unlicensed</b>	<b>1760</b>	<b>392</b>	<b>1795</b>	<b>414</b>	
Contract titles or					
Volunteers	40	19	93	26	
<b>Total ALL Staff</b>	<b>8463</b>	<b>4940</b>	<b>6645</b>	<b>6053</b>	

\*Omitted PREVCSLR which is typically an OASAS title

\*\*CASEMGR includes similar titles such as:

CARECO, CM, CASEW, SWCSE, SWCAS, SWCES, SERVOOR

\*\*\*Other Titles include: Director, Assist Director, Program Supervisor,

Sr. Counselor, Crisis Response Spec. RN etc.



**ATTACHMENT #3**

**Titles in OMH State operated programs that are believed to require licensure under the existing scopes of practice defined in the statutes.**

**OMH State Titles at Risk\***

<b>Title</b>	<b>Number at risk</b>	<b>Comment</b>
Social Worker 1	41	Unless they met requirement or continue to be exempt they are at risk
Social Worker 2	0	no longer incumbents in these positions
Social Work Supervisor	0	All have their LCSW
Social Work Supervisor 3	1	One incumbent that does not have a LCSW
Licensed Master Social Worker	0	New draft standard sent to Civil Service
Community MH Nurse	0	nurses are exempt
Nurse 3 Psy	0	Nursed exemption prevents impact
Mental Hygiene Therapy Aides, SCTAs & SHTAs	3568	These direct care staff provide counseling, evaluation, crisis de-escalation
Social Work Assistant 1,2,&3	170	These direct care staff provide counseling, evaluation, crisis de-escalation
Rec. Therapist & Sr. Rec. Therapist	248	W/O exemption, this title would be re-allocated at a higher level e.g. Creative Arts Therapist
Rehab Counselor 1 & 2	188	exemption needed to cover counseling duties
Residential Program Counselor	38	functions overlap with LMHC
<b>Total</b>	<b>4254</b>	





New York Consolidated Reporting and Claiming~	Subject: Appendix R - Position Titles and Codes  Reporting Period: January 1,2010 to December 31, 2010	Section: 51.0	Page: 51.4  Issued: 10/10
CODE	<b>DIRECT CARE</b>		
201	Mental Hygiene (not for OMH CR) (Does not apply to	All individuals engaged in providing non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or Rehabilitation. Job titles may include Habilitation Specialist, Residence Counselor, House Parents, ADL Specialist, Instructor and Trainer, Residence Staff, Relief Staff, House Apartment Worker.	
202	Residence Worker (Does not apply to	All individuals engaged in supervising non-discipline specific services which involve the training of ADL skills; provide personal care to program participants; promote habilitation and/or Rehabilitation. Individuals in this position title do not perform other administrative duties beyond the direct supervision of Care staff. If other administrative functions are performed, allocate that portion associated with these functions using Code 501 or 502. Job titles may include Residence Director, Residence Manager, Hostel Manager, Residence Coordinator.	
203	Counselor  (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.	
204	Manager	All individuals who perform this role as defined in the OMH	
	(OMH CR Only)	Community Residence Program Model	
<b>New York State Consolidated Reporting and Claiming Manual</b>	<b>Subject: Appendix R - Position Titles and Codes</b>  <b>Reporting Period: January 1,2010 to December 31, 2010</b>	<b>Section: 51.0</b>	<b>Page: 51.5</b>  <b>Issued: 10/10</b>

\* Original document generated in 2009



**ATTACHMENT #4**

**OMH Local Provider Reporting for Mental Health Programs**

The following a list of the Consolidated Fiscal Report (CFR) **Direct Care and Professional titles** reported by local, non-hospital providers that could be at risk should the extension of the Social Work exemption cease to exist for programs licensed, certified, funded or otherwise regulated by the Office of Mental Health. This list does not include Program Administration Staff titles. We estimate that there may be individuals working in program management and administration titles that overlap in scope of practice.

The OMH Office of Financial Planning determined that there are approximately **11,000 to 12,000** staff in many of these titles and other that could be impacted. Including all reporters of the CFR (OMH only), including the hospitals that reported, there are about 32,000 FTEs.

<b>CODE NUMBER</b>	<b>POSITION TITLE! JOB TITLE(S)</b>	<b>DEFINITION</b>
205	Senior (OMH CR Only)	All individuals who perform this role as defined in the OMH <u>Community Residence Program Mode.</u>
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH <u>Community Residence Program Model.</u>
207	Developmental Disabilities Specialist QMRP - Direct Care (OPWDD Only)	All individuals not included within another listed title with at a Bachelor's degree in an appropriate field or one year of experience working with developmentally disabled persons engage in providing or supervising services to program participants an their families.
213	Paraprofessional - Social Services (SED Only)	All individuals under the immediate supervision and direction supervisor or caseworker and performs various support of case work services. Job title may include: <u>Case Aide, Worker, Intern-Social Services, Family</u>
215	Supervising Teacher (SED Only)	Provides for direct supervision of teachers. Certified Education teacher serving as supervisor of teachers less than percent of assignment pursuant to Part 80 of the Regulations the Commissioner of Education. If supervising more than 25 percent of assignment, see Code 518.
218	Teacher - Education	A certified teacher who provides specialized instruction to students with disabilities.
220	Teacher - Physical Education	Self-
222	Teacher - Other	A teacher performing functions not otherwise coded. Job titles may include teachers of: Drama, Home Economics, Industrial Arts, Keyboarding. See codes 263, 269, 270, 271, 272, 273 274 for other specialized
224	Teacher - Substitute (SED Only)	Self- This is not a permanent position but is maintained on payroll records.
225	Teacher - Certified (SED Only)	Certified as Teacher of Speech and Hearing Handicapped or <u>Teacher of Deaf and Hearing Impaired.</u>
227	Teacher - Coverage/Floating (SED Only)	An individual who covers sick days on a regular basis as a permanent position or as an extra teacher.
228	Teacher Aide	Assists teachers in non-teaching duties such as managing

# Redesigning THE MEDICAID PROGRAM



		materials and equipment, attending to the physical needs of students and supervising students.
230	Teacher Aide/Assistant-Substitute	An individual who covers sick days of teacher aide or teacher assistant personnel. This is not a permanent position but it is maintained on payroll records.
232	Teacher	An individual who, under the supervision of a certified teacher, assists in such duties as working with individual students or groups of students on special instructional projects, providing teachers with information about students, assisting students in the use of instructional resources, assisting teachers in the development of instructional materials and assisting in instructional programs.
236	Guidance Counselor (SED Only)	Self-explanatory. Job titles may include: School Vocational Counselor.
237	Curriculum Coordinator (SED Only)	A certified administrator or certified Special Education teacher with five years teaching experience who is knowledgeable about the New York State Learning Standards and responsible for ensuring that the program's curriculum is developed and aligned to such Standards. Monitors implementation of the curriculum, Oversees curriculum training, and any curriculum adaptations.
238	IEP Coordinator (SED Only)	A certified or licensed individual in one of the job titles below who is responsible for ensuring that IEP recommendations are implemented and that each service provider responsible for implementation of a student's IEP is aware of his or her IEP responsibilities, including specific accommodations, program modifications, supports and/or services for the student, prior to implementation of such program.
243	Behavioral Support Staff (SED Only) Replaces Crisis Intervention Worker	An individual with less than a Master's degree who assists in the implementation of positive behavioral interventions, supports and services.
254	Job Coach/Employment Specialist (OMH & OPWDD Only) (SED- See Codes 255 and 257)	An individual who is responsible for the provision of intensive or extended training related services and supports necessary to obtain employment in the community or for the development of employment opportunities with business and industry.
255	Transition Coordinator (SED Only)	Conducts Level 1 Vocational Assessment, participates in development of transition plans, coordinates school and local resources to provide vocational opportunities, develops post-secondary linkages, and works with VESID' Vocational Rehabilitation Offices to coordinate vocational assessments beyond Level 1.
257	Transition Specialist (SED Only)	Conducts and monitors implementation of transition services on a student's IEP, such as training, education, employment, and where appropriate, independent living skills. May include direct assistance to persons in supported employment placements or other job experiences and to their employer, under the direction of a special education teacher, social worker or psychologist.
260	Teacher - Non-Disabled (SED Only)	Self-explanatory. (For use in Preschool Integrated Programs).



263	Teacher - Blind and/or Deaf (SED Only)	Teacher who provides special education services to students disabilities who are blind and/or deaf. Job titles include certified as Teacher of the Blind and Partially Sighted, the Visually Impaired, Teacher of the Deaf, Teacher of the of Hearing..
265	Paraprofessional - Non-Disabled (SED Only)	Self-explanatory (For use in Preschool Integrated Programs). Includes Non-Disabled Teacher Aides and Assistants.
266	Peer Specialist (OMH Only)	Peer Specialists work with residents to facilitate the individual's recovery process.
267	Counselor - Alcoholism and Substance Abuse (CASAC)	An individual credentialed by the New York State Office of Alcoholism and Substance Abuse Services.
268	Counseling Aide/Assistant - Alcoholism and Substance Abuse (Does not apply to SED)	An individual functionin as defined for Alcoholism and Substance Abuse Counselor under supervision but who does not have a credential issued by the Office of Alcoholism and Substance Abuse Services.
269	Teacher - Art	Teacher who is certified to provide art education to meet Part 100 program and units of credit requirements.
270	Teacher - Music	Teacher who is certified to provide music education to meet Part 100 program and units of credit requirements.
271	Teacher - Technology	Teacher who is certified by SED to provide technology studies to meet Part 100 program and units of credit requirements.
272	Teacher - Foreign	Teacher who is certified by SED to provide foreign language to meet Part 100 program and units of credit requirements.
273	Teacher - Resource Room	Certified special education teacher that provides resource room services consistent with a student's Individual Education Program (IEP).
274	Teacher - Reading	Teacher who is certified in reading by SED to provide reading instruction.
290	Other Direct Care Staff	Anyone not listed in the 200 series engaged in providing direct care services.
<b>CLINICAL STAFF</b>		
301	Case Manager (Does not apply to SED)	Supervises the implementation of each individualized program, monitors services received, records progress and initiates required periodic reviews. Job title may include: Client Coordinator.
305	Counselor - Rehabilitation (Does not apply to SED)	All individuals who have a degree in rehabilitative counseling from a program approved by the State Education Department or with current certification by the Commission on Rehabilitation Counselor Certification.
309	Developmental Disabilities Specialist Habilitation Specialist QMRP - Clinical (OPWDD Only)	All individuals not included in otherwise listed titles with at least a Bachelor's degree in an appropriate field from an accredited program and specialized training or one year experience working with developmentally disabled persons engaged in providing or supervising services to program participants and their families.
312	Emergency Medical Technician (Does not apply to SED)	An individual certified by the New York State Department of Health for a period of three years as being qualified in all phases of medical emergency technology including, but not limited to communications, first aid, equipment maintenance, emergency room techniques and procedures, patient handling and positioning,

# Redesigning THE MEDICAID PROGRAM



		and "knowledge of procedures and equipment used for obstetrics.
355	Student (OMH Only)	Student who is participating in a program approved by the NYS Education Department that lead to a degree or license in one of the Professional Disciplines. Must have a signed agreement and policies And procedures for placement & supervision.
390	Other Clinical Staff (Does not apply to SED)	Student who is participating in a program approved by the NYS Education Department that lead to a degree or license in one of the Professional Disciplines. Must have a signed agreement and policies And procedures for placement & supervision.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number: 10 (Formerly PIR 10 L 45)**

**Recommendation Short Name: Removal of physician supervisory ratio of physician assistants (PAs)**

**Program Area:** Primary and Acute Care

**Implementation Complexity:** Implementation will be of very low complexity. Once the restriction is repealed efficiency will be immediately enhanced.

**Implementation Timeline:** Legislation could be passed in January, 2012.

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

**Proposal Description:** New York currently restricts a physician to supervising two PAs in an office setting, four in a correctional setting and six in a hospital. Placing an arbitrary limit on the number of physician assistants that a physician may supervise restricts full utilization of PAs on physician-directed teams. States are moving away from this sort of restriction, and an increasing number of physician and policy groups are recognizing that the number of PAs that a physician may supervise should be determined at the practice level as each practice and group of providers and patients served is unique.

This proposal removes the arbitrary restriction on the number of physician assistants a physician may supervise, allowing this to be determined by the physician at the practice or facility.

**Financial Impact:** There will be a 15% reduction in cost to Medicaid as the Physician Assistant reimbursement rate for Medicaid Services is 85% of the physician fee. These savings will be realized in all practice settings. This may result in increased efficiencies to the various practice settings and lower overall costs to the system.

**Health Disparities Impact:** Studies consistently document that access to high quality primary care improves health status and decreases the need for invasive and costly interventions. Primary care is inequitably distributed. Enabling physicians in primary care to creatively staff teams has the potential to improve access to primary care and decrease disparities.



**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	***		
Female	***		
People with a primary language other than English	***		
People of Hispanic, Latino, or Spanish origin	***		
People who identify as:			
White	***		
Black or African American	***		
American Indian or Alaska Native	***		
Asian	***		
Native Hawaiian or Other Pacific Islander	***		
People with a disability	***		
People who identify as transgender	***		
People who identify as lesbian, gay, bisexual, or questioning	***		

Additional comments:

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders? Yes**

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities? No**

**Benefits of Recommendation:** Enabling customization and creativity in the health care team design allows for each health professional to utilize their education and skills to provide care absent arbitrary restraints. The current law is archaic and inconsistent with the goal of current projects at the state and federal level which seek to repeal barriers to access and archaic restrictions. Empowering each practice to design teams that best meet the needs of the patients served improves efficiency, reduces cost and ultimately allows for better care.

**Concerns with Recommendation:** Minimal. Laws enabling physicians to extend access by repealing arbitrary limitations on the number of PAs a physician may supervise have been enacted in several other states. No state that has repealed the arbitrary ratio restriction for physician-PA teams has expressed concerns or re-enacted a restriction.



Currently the following states have no numeric restrictions: Alaska, Arkansas, Maine, North Carolina, North Dakota, Rhode Island, Tennessee, and Vermont.

New Mexico statute states, “Pursuant to Section 61-6-10 NMSA 1978 a physician may supervise as many physician assistants as the physician can effectively supervise and communicate with in the circumstances of their particular practice setting.” (*N.M. Code R. §16.10.15.11*)

Connecticut statute states, “No physician shall function as supervising physician for more than 6 PAs practicing full time, or the part-time equivalent thereof.” (*CONN. GEN. STAT. §20-12c*)

**Impacted Stakeholders:** This will benefit physicians in all practice settings in both rural and urban areas of the State. New York State will pay reduced fees of 85% for services provided by physician assistants.

### **Additional Information**

New York State law currently has supervisory ratios in place that limit a physician’s ability to supervise the care provided by a physician assistant as follows:

- Office Setting 2 PAs per physician
- Correctional Setting 4 PAs per physician
- Hospital Setting 6 PAs per physician

These ratios prevent PAs from providing much-needed primary care in many communities and hospitals.

Removal of these barriers would help extend medical practices and bring more cost efficient care to New York.

Currently the following states have no numeric restrictions: Alaska, Arkansas, Maine, North Carolina, North Dakota, Rhode Island, Tennessee, and Vermont

Support:

In a 2010 joint policy monograph with American Academy of Physician Assistants (AAPA), the American College of Physicians (ACP) endorse the idea of appropriate ratios being determined at the practice level:

“AAPA and ACP encourage flexibility in federal and state regulation so that each medical practice determines appropriate clinical roles within the medical team, physician-to-PA ratios, and supervision processes, enabling each clinician to work to the fullest extent of his or her license and expertise.”

American College of Physicians. (2009). *Internists and Physician Assistants: Team-Based Primary Care*. Philadelphia, PA.

The Federation of State Medical Boards (FSMB) also supports ratios being determined at the practice level. In their 2010 *Essentials of a Modern Medical & Osteopathic Practice Act*, FSMB recommends that state laws simply require that “no physician should have under their supervision more staff, physician assistant or otherwise than the physician can adequately supervise.” FSMB does not recommend the inclusion of a specific number in state law.

Federation of State Medical Boards of the United States, Inc. (2010). *A Guide to the Essentials of a Modern Medical and Osteopathic Practice*

Act. Euless, TX.





Current New York State language:

Education Law

Article 131-B, Physician Assistants and Specialist Assistants

§6542. Performance of medical services.

1. Notwithstanding any other provision of law, a physician assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are within the scope of practice of such supervising physician.
2. Notwithstanding any other provision of law, a specialist assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are related to the designated medical specialty for which he is registered and are within the scope of practice of his supervising physician.
3. Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where such services are performed.
4. No physician shall employ or supervise more than two physician assistants and two specialist assistants in his private practice.
5. Nothing in this article shall prohibit a hospital from employing physician assistants or specialist assistants provided they work under the supervision of a physician designated by the hospital and not beyond the scope of practice of such physician. The numerical limitation of subdivision four of this section shall not apply to services performed in a hospital.
6. Notwithstanding any other provision of this article, nothing shall prohibit a physician employed by or rendering services to the department of correctional services under contract from supervising no more than four physician assistants or specialist assistants in his practice for the department of correctional services.
7. Notwithstanding any other provision of law, a trainee in an approved program may perform medical services when such services are performed within the scope of such program.
8. Nothing in this article, or in article thirty-seven of the public health law, shall be construed to authorize physician assistants or specialist assistants to perform those specific functions and duties specifically delegated by law to those persons licensed as allied health professionals under the public health law or the education law.



Proposed New York State language: Education Law Article 131-B, Physician Assistants and Specialist Assistants §6542. Performance of medical services.

1. Notwithstanding any other provision of law, a physician assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are within the scope of practice of such supervising physician.
2. Notwithstanding any other provision of law, a specialist assistant may perform medical services, but only when under the supervision of a physician and only when such acts and duties as are assigned to him are related to the designated medical specialty for which he is registered and are within the scope of practice of his supervising physician.
3. Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place where such services are performed.
4. No physician shall employ or supervise more than ~~two physician assistants~~ two specialist assistants in his private practice. A physician may employ and supervise physician assistants in his or her private practice. The number of physician assistants that such physician may supervise shall be left to the determination of the supervising physician.
5. Nothing in this article shall prohibit a hospital from employing physician assistants or specialist assistants provided they work under the supervision of a physician designated by the hospital and not beyond the scope of practice of such physician. The numerical limitation of subdivision four of this section shall not apply to services performed in a hospital.
6. Notwithstanding any other provision of this article, nothing shall prohibit a physician employed by or rendering services to the department of correctional services under contract from supervising no more than four ~~physician assistants~~ or specialist assistants in his practice for the department of correctional services. A physician employed by or rendering services to the department of correctional services under contract may supervise the number of physician assistants determined to be appropriate by the supervising physician.
7. Notwithstanding any other provision of law, a trainee in an approved program may perform medical services when such services are performed within the scope of such program.
8. Nothing in this article, or in article thirty-seven of the public health law, shall be construed to authorize physician assistants or specialist assistants to perform those specific functions and duties specifically delegated by law to those persons licensed as allied health professionals under the public health law or the education law.

Current N.Y. COMP. CODES R. & REGS. tit.10 §94.2

No physician may supervise more than 6 PAs or specialist's assistants or combination thereof employed by a hospital.

Recommended language:

No physician may supervise more than 6 SAs employed by a hospital. A physician may supervise more than six physician assistants. The number of PAs supervised shall be left to the determination of the supervising physician.



**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number: 11 (Formerly Proposal PIR 3 NL 14)**

**Recommendation Short Name:** Promote underutilized programs such as the Consumer Directed Personal Assistance Program that are cost-effective and build on consumers' strengths.

**Program Area:** Consumer-directed programs

**Implementation Complexity:** The CDPANYS outreach project is currently in the implementation phase.

**Implementation Timeline:** Immediate

**Required Approvals:**       **Administrative Action**       **Statutory Change**  
    **State Plan Amendment**       **Federal Waiver (None required)**

**Proposal Description:** In many areas of the state, individuals do not have access to adequate long term care services because there is a lack of knowledge or understanding about available services. Too often, this results in these individuals going without care, receiving too little care, or being forced into a nursing home. The Consumer Directed Personal Assistance Program (CDPAP) provides a great opportunity to address the needs of difficult to serve or underserved populations by addressing workforce shortages, cultural issues and language issues, among other common issues for shortages. The Consumer Directed Personal Assistance Association of New York State (CDPANYS) was awarded a grant to educate consumers and health care professionals about CDPAP and help expand the knowledge base. The deliverables of this grant are still being met. The proposal supports outreach and education efforts for the consumer directed personal assistance program, targeted at helping populations who are underserved due to geography, culture, language, or other reasons access the program.

**Financial Impact:** CDPAP and consumer direction in general has the potential to save when compared to the agency based home care model.



**Health Disparities Impact:**

**1. Did the Work Group discuss this proposal’s potential effect on disparities in access to care and disease incidence?**

No, the Workgroup did not consider impact on disparities.

Yes, the Workgroup discussed the impact on disparities and found the following:  
(check the appropriate box)

	The proposal may		Insufficient information available to determine impact.
	reduce disparities for this population	increase disparities for this population	
Male	X		
Female	X		
People with a primary language other than English	X		
People of Hispanic, Latino, or Spanish origin	X		
People who identify as:			
White	X		
Black or African American	X		
American Indian or Alaska Native	X		
Asian	X		
Native Hawaiian or Other Pacific Islander	X		
People with a disability	X		
People who identify as transgender	X		
People who identify as lesbian, gay, bisexual, or questioning	X		

Additional comments: This proposal is aimed to specifically target underserved populations. This means it has the potential to address key health disparities in every subcategory of individuals who face them. In fact, CDPAP has traditionally been very effective at resolving issues in communities that face disparities.

**2. Did the Work Group discuss this proposal’s potential impact on disparities with key stakeholders?** No

**3. Did the Work Group discuss an approach to monitoring this proposal’s effect on disparities?** No

**Benefits of Recommendation:** CDPAP and consumer direction in general has the potential to dramatically increase access to services in communities and populations around the state. Individuals are able to receive care at the level they need, from individuals they connect with culturally, whom they can understand. In underserved areas where these and other issues prevent adequate access to care, CDPAP can help restore that access and prevent unnecessary nursing home admissions.



**Concerns with Recommendation:** The original proposal requested continued funding prior to full implementation of the current project; however, as revised, the proposal provides an opportunity for CDPANYS to complete the implementation phase and demonstrate effectiveness of outreach and education efforts.

**Impacted Stakeholders:** None noted.

#### **Additional Information**

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**Medicaid Redesign Team  
Workforce Flexibility / Scope of Practice Workgroup  
Final Recommendations - 11/21/11**

**Recommendation Number:** 12 (Formerly PIR 11 L 16)

**Recommendation Short Name:** Children's Dental Health Certificate

**Program Area:** Oral Health

**Implementation Complexity:** Low

**Implementation Timeline:** Immediately upon enactment

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

**Proposal Description:** Amend education law, Section 903, 2.a. to include Registered Dental Hygienists as an additional oral health provider able to perform the school readiness oral health examination and by means of follow-up, case manage to enroll children within a dental home. This policy change was passed into law in 2007 and enacted in 2009. According to the New York State Technical Assistance Center in Rochester, a center supported in part by funding from the NYSDOH, Bureau of Dental Health, reports approximately 20 counties throughout NYS with limited to no private practice dentists enrolled in the program. Additional issues with consent form gathering and acceptance of the policy change by parents and overwhelmed school personnel continue to plague the success of this intervention. Limited numbers of private practitioners are open to the concept of doing the examinations as they aren't compelled to accept the numbers of Medicaid children for care the assessment may uncover.

**Financial Impact:** This proposal would be revenue neutral.

**Health Disparities Impact:** Did not discuss in Work group.

**Benefits of Recommendation:** This proposal supports the goal of the Workgroup's charge to determine potential flexibility in the practice of the current workforce that adds to ensuring comprehensive healthcare needs are met. Increased numbers of providers willing and able to perform the school readiness assessments as well as move children into dental homes for ongoing comprehensive care. Dental hygienists are out in the community, working in school based and portable dental programs and would offer one avenue for additional assistance in making this policy change effective. As part of their practice, dental hygienists who uncover evidence of dental disease (dental caries, cavities), are bound ethically and professionally to case manage those patients into a dental home situation and may again, add to the effectiveness of the policy change.

**Concerns with Recommendation:** Dental disease will be uncovered and the ongoing issue of lack of providers to handle the restorative aspect of care will continue.

**Impacted Stakeholders:** None listed.



**ENDNOTES:**

<sup>i</sup> Includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian

<sup>ii</sup> Includes Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander

<sup>iii</sup> Includes people who: have difficulty hearing; have serious difficulty seeing even when wearing glasses; because of a physical, mental, or emotional condition, have serious difficulty concentrating, remembering, or making decisions; have serious difficulty walking or climbing stairs; because of a physical, mental, or emotional condition, have difficulty doing errands alone such as visiting a doctor's office or shopping,

<sup>iv</sup> NYS Disparities Workgroup recommendation not included in the ACA.



**Redesigning**  
THE MEDICAID PROGRAM

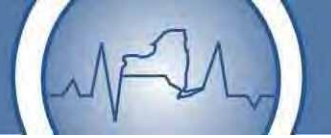


NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Payment Reform and Quality  
Measurement Work Group

**FINAL RECOMMENDATIONS**



## Medicaid Redesign Team

### Payment Reform & Quality Measurement Work Group

### Final Recommendations – November 1, 2011

**Work Group Charge:** The Work Group will develop a series of payment reform and quality measurement recommendations to facilitate the transformation of our health care system. To the extent practicable the Work Group will seek consistency with the reform imperatives of the MRT Phase 1 work, as well as the Patient Protection and Affordable Care Act (ACA).

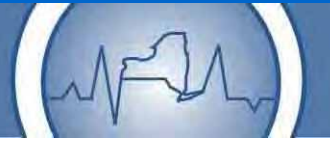
Federal health reform is commencing with a focus on the development of shared savings models, pioneer accountable care organizations, risk-sharing assumption demonstrations, clinical integration, and bundling of services and payment across traditional silos of delivery. Inherent in all of these emerging initiatives is a patient-centric focus on quality improvement and patient safety.

In the context of the above, focused activities for the Payment Reform & Quality Measurement Work Group includes:

- ✓ *Recommend how New York State can encourage the development of innovative payment and delivery models. These may include: Accountable Care Organizations, Bundling, Gain Sharing, Clinical Integration, and other shared savings and/or risk-sharing arrangements.*
- ✓ *Explore and identify evidence-based quality indicators to benchmark New York's Medicaid program and the provider delivery system. Performance goals will also be developed to inform future Medicaid policy.*
- ✓ *Explore issues in the New York State Disproportionate Share Program and related indigent care funding mechanisms, including compliance with federal law and Health and Human Services/Centers for Medicare and Medicaid Services (HHS/CMS) requirements; consider recommendations for needed work to ensure long-term viability.*
- ✓ *Consider criteria that can be used to identify "safety net" providers, and the implications of such a designation on local planning, financing, care delivery, and oversight.*
- ✓ *Should time permit, the Work Group may also assess the implications of the product of other MRT Work Groups on: payment for workforce education, including graduate medical education; workforce shortages; IT investment; and opportunities for access to capital financing.<sup>1</sup>*

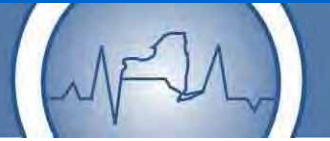
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<sup>1</sup> The Work Group decided not to pursue these additional topics in order to devote their limited time to the discussion and development of recommendations for their focused activities. Given other opportunities, the Work Group will revisit these additional issues.



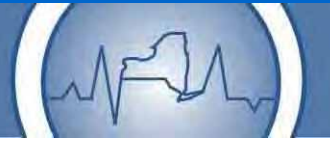
## WORK GROUP MEMBERSHIP:

- **CO-CHAIR: Dan Sisto**, President, Healthcare Association of NYS
- **CO-CHAIR: William Streck, MD**, Chair, New York State Public Health and Health Planning Council
- **Rick Abrams**, Executive Vice President, Medical Society of the State of NY
- **Elisabeth R. Benjamin**, Vice President of Health Initiatives, Community Service Society
- **Scott Cooper, MD**, President and CEO, St. Barnabas in the Bronx
- **Michael W. Cropp, MD**, President and CEO, Independent Health
- **Joanne Cunningham**, President, Home Care Association of NYS
- **Emma DeVito**, President and CEO, Village Care of New York
- **Paloma Izquierdo-Hernandez, MS, MPH**, President & CEO, Urban Health Plan
- **Sneha Jacob, M.D. M.S.**, Assistant Professor of Clinical Medicine, Columbia University, Assistant Medical Director, New York Presbyterian System Select Health
- **James R. Knickman**, President and CEO, NYS Health Foundation
- **Ronda Kotelchuck**, Executive Director, Primary Care Development Corporation
- **Phyllis Lantos**, Executive Vice President and CFO, New York Presbyterian Hospital
- **Art Levin**, Director, Center for Medical Consumers
- **Joseph McDonald**, President and CEO, Catholic Health Services of Western NY
- **Joseph Quagliata**, President and CEO, South Nassau Communities Hospital
- **Steven M. Safyer, MD**, President and CEO, Montefiore Medical Center
- **Susan Stuard**, Executive Director, Taconic Health Information Network and Community
- **James R. Tallon, Jr.**, President, United Hospital Fund
- **Pat Wang**, President and CEO, Healthfirst
- **Marlene Zurack**, Senior Vice President, Finance, NYC Health and Hospitals Corporation



## MEETING DATES AND FOCUS:

- ✓ **September 20:** The Work Group met for the first time in Troy, New York. The Work Group was provided with an overview of the MRT's progress thus far and informed of the timeframe for completion of the Work Group's objectives. The Work Group reviewed and agreed upon its charge. The Work Group then discussed and developed guiding principles, providing staff with a working draft of guiding principles that would be revised and presented at the next meeting. The Work Group agreed that flexibility was an important component to the development of any recommendations. The Chairs then provided a presentation on federal budget challenges (i.e., federal payment reductions, ACA's impact on Medicare management, impact of federal deficit reduction/debt ceiling, Select Committee reduction options, and Medicare Recovery Audit Contractor) and innovative payment models (i.e., the role of the CMMI, available federal demonstration projects, CMS shared savings models, and New York MRT reform options). The Work Group discussed at length the expenditures and unique needs of New York's dual eligible population (i.e., persons eligible for Medicare and Medicaid). In addition, the Work Group spent some time discussing quality measures, with a particular emphasis on the distinction between science-based versus standard of care. The Work Group also reviewed data on Medicaid patients that meet the federal definition for qualifying for health homes and sources of HCRA funding. The Work Group requested additional information from the Department of Health on health homes and DSH/Indigent Care funding.
- ✓ **September 27:** The Work Group met for the second time in Troy, New York. The Department of Health provided further information on health homes and DSH/Indigent Care funding as requested at the September 20 meeting. The Work Group discussed the draft health home payments for sample populations and the role of potentially preventable admissions (PPA) and potentially preventable readmissions (PPR). The Department of Health presented on essential community providers. The Work Group requested additional information from the Department of Health on how the various federal demonstrations and MRT program proposals presented at the first meeting would work together to improve patient care in New York's health care system. The Work Group then reviewed and commented on the proposed guiding principles, providing staff with additional revisions for incorporation and presentation at the next Work Group meeting. The Work Group also reviewed and commented on the first three proposed recommendations, providing staff with revisions for incorporation and presentation at the next Work Group meeting.
- ✓ **October 18:** The Work Group met for the third time in New York City. The Department of Health presented on how the Department of Health sees the federal demonstration projects and MRT program proposals working together to improve patient care in New York's health care system. After the presentation, the Work Group reviewed and adopted the proposed guiding principles. The Work Group then began to review and revise the four proposed recommendations. All four proposed recommendations were adopted by the Work Group.



**Outside Experts Consulted with:** No outside experts were consulted or presented at the Work Group meetings; however, the Work Group was provided with comments and suggestions submitted by stakeholders and the public to the Payment Reform & Quality Measurement Work Group email address. To date, the Work Group has received approximately 25 submissions through its website.

**Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report:** It was particularly important to the Work Group that the concept of patient-focused and patient-centered care be the driving force behind any payment reform and quality measurement recommendations. The Work Group took its responsibility to Medicaid beneficiaries/patients very seriously and tried to ensure that any recommendation they set forth would improve the New York State health care system while improving the overall health outcomes of its patients. To this end, the Work Group felt it was important to establish a set of guiding principles to consider when developing recommendations. The guiding principles adopted by the Work Group are as follows:

✓ ***Innovative payment models should:***

- 1) Be transparent and fair, increase access to high quality health care services in the appropriate setting, and create opportunities for both payers and providers to share savings generated if agreed upon benchmarks are achieved.
- 2) Reduce fragmentation of health care services and promote fully integrated patient centered/directed models where possible.
- 3) Be accountable for patient outcomes and improved health of the population being served.
- 4) Be scalable and flexible to allow providers in all settings and communities (regardless of size) to participate, reinforce health system planning, and preserve an efficient essential community provider network.
- 5) Allow for flexible multi-year phase-in to recognize administrative complexities, including network development and systems requirements (i.e., IT).
- 6) Align payment policy with quality goals.
- 7) Reward improved performance as well as continued high performance.
- 8) Incorporate strong evaluation component and technical assistance to assure successful implementation.



✓ *Quality measures should:*

- 1) Be transparent and fair, be based on a standard of care or evidenced based science, and be cognizant of or align with nationally accepted measures.
- 2) Include metrics to measure health outcomes of the population being served.
- 3) Be flexible enough to recognize advances in medicine that will improve patient care.
- 4) Include patient experience/satisfaction, access to care, and social/economic measurements where applicable.
- 5) Seek to align quality measurement across payers including Medicare and others.
- 6) Be appropriately risk-adjusted, including socio/economic and cultural competence metrics, especially when used to compare providers or make incentive payments.
- 7) Align with appropriate payment models and incentivize providers across the continuum of care.
- 8) Promote patient participation and responsibility in health care decision-making.
- 9) Incorporate strong evaluation component and technical assistance to assure successful implementation.
- 10) Include a public reporting process on measures and outcomes.

The Work Group also recognized that the New York State health care system is on the verge of a major reconfiguration. Governor Andrew Cuomo's call to have virtually all Medicaid recipients enrolled in some form of care management, as well as the immediate need to bend the New York State Medicaid cost curve, was duly noted. The Work Group discussed reform opportunities at both the federal and state level, with a particular emphasis on the ability of such reform opportunities to work cohesively to align payment methodologies, improve the provision of health care services in New York State, and increase patient satisfaction.



## SUMMARY LISTING OF RECOMMENDATIONS:

### 1) Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual eligible population.

#### GOALS:

- ✓ Achieve “triple aim” as defined by CMS: Improve patient care experience; improve the health of populations; and reduce the per capita cost of health care.
- ✓ Create opportunities for providers/payors/patients to realize financial benefits and improved outcomes as system efficiencies are achieved and quality benchmarks attained.
- ✓ Promote improved patient care.
- ✓ Secure investment of resources from CMS which are required to implement this recommendation. Such funds need to be flexible and could be used for continued funding of care management (Health Homes) beyond the two year incentive period; HIT; ACO or Medical Home development; shared savings initiatives; other innovative initiative development; and transition of all patients into care management with a focus on patient-centered/patient-focused approaches.

### 2) Adopt a series of accepted performance measures across all sectors of health, aligning measures already being collected in New York in Medicaid managed care, including managed long term care with federal requirements.

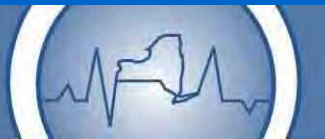
#### GOALS:

- ✓ Need to utilize a core set of measures that are flexible to address the evolving delivery systems and tailored to the setting and population served.
- ✓ Be based on a standard of care or evidence-based science.
- ✓ Implement public reporting process on measures and outcomes.
- ✓ Reward providers for improved and/or continued high performance.
- ✓ Take into consideration differences in clinical conditions as well as social conditions in measuring outcomes when the data is available.

### 3) Develop general principles that can be applied towards revising the New York State DSH/Indigent Care program.

#### GOALS:

- ✓ Develop a new allocation methodology consistent with CMS guidelines to ensure that New York State does not take more than its share of the nationwide reduction.
- ✓ Fair and equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to un/underinsured.
- ✓ Simplify allocation methodology and consolidate pools.



**4) Create financing mechanisms that strengthen the financial viability of New York's essential community provider network.**

**GOALS:**

- ✓ Ensure patient access to provider services that may be otherwise jeopardized by the provider's payer mix or geographic location.
- ✓ Focus should be on essential providers that are not financially viable, provide a disproportionate level of care to financially vulnerable populations, provide essential health care services, and provide a high fraction of health services in their market area.
- ✓ Provide supplemental financial support to ensure the long-term viability of designated providers.
- ✓ Reinvest a portion of savings generated from reforms and downsizing within an impacted community to maintain that community's health care delivery system.
- ✓ Implement review process for designated providers for administrative/operational efficiencies, quality standards, provision of essential services, and potential for integration or collaboration with other entities.

At the October 19 meeting, the Work Group approved each of the above recommendations by a vast majority. The concerns of those few who dissented are articulated in this report or in white papers and presentations included as attachments to this report.





## Medicaid Redesign Team

### Payment Reform & Quality Measurement Work Group

### Final Recommendations – November 1, 2011

**Recommendation Number:** 1

**Recommendation Short Name:** Pursue partnership agreement with CMS to integrate Medicaid & Medicare service delivery and financing for the dual eligible population.

**Program Area:** CMS Waiver

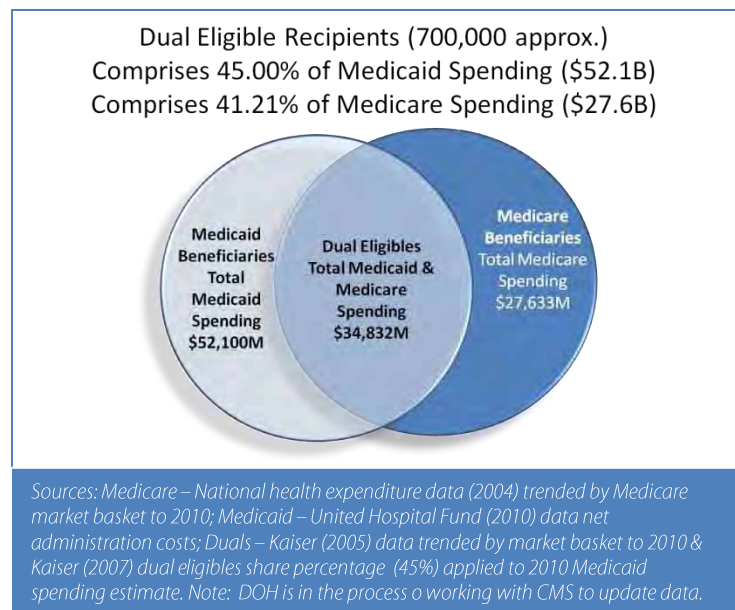
**Implementation Complexity:** High

**Implementation Timeline:** The Department of Health needs to begin discussions with CMS immediately in order to ensure that timeframes for achieving full integration of the Medicaid and Medicare programs can be achieved within 3-5 years.

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** There are approximately 700,000 individuals in New York State that are eligible because of their age or disability for coverage under both the Medicare and Medicaid programs. The expense to care for this population is enormous: DOH estimates that within New York State this population consumes approximately 45% of Medicaid (\$23.4B) and approximately 41% of Medicare (\$11.3B) spending.<sup>2</sup> New York recognizes that there is an opportunity to optimize care and reduce costs for this population by restructuring the system in which they receive care.



<sup>2</sup> It should be noted that DOH is working with CMS to review these New York State estimates. Nationally, the dual eligible population in 2008 consumed \$250 billion – 1/4 of Medicare spending and nearly 1/2 of Medicaid spending.



Governor Andrew Cuomo, through the work of the MRT, has set as a goal that virtually every member of the Medicaid program be enrolled in some kind of care management organization within the next 3-5 years. New York sees full capitation as its preferred financial arrangement, but is open to other financing systems in the interim. The Department of Health recognizes that reaching full capitation where acute, behavioral health and long-term care services are all coordinated by a single accountable entity will take years to develop.

New York has spent considerable time developing managed long term care plans that integrate Medicare and Medicaid. New York's enrollment in Programs of All-Inclusive Care for the Elderly (PACE) is the highest in the nation and the Medicaid Advantage Plus (MAP) program was one of the first in the nation to integrate care through a managed care plan that participates in both Medicare and Medicaid. Nevertheless, each of these models has limitations and enrollment has grown slowly.

Under this recommendation, New York would seek a waiver from CMS that would redefine the relationship between the two largest public health care programs by taking on risk for the delivery and financing of Medicare services for dual eligibles in New York. In turn, New York would partner through "sub-capitation arrangements" with health plans and/or integrated provider groups (ACOs) that have sufficient network capacity and are capable of delivering care and assuming risk for the full spectrum of Medicare and Medicaid covered services.

It will be important to work with health plans and providers in considering inclusion of risk adjustment and other measures into capitation or sub-capitation arrangements.

The dual-integration initiative will be a key component of a CMS waiver. New York will seek to secure an investment of federal resources. New York is optimistic it can secure waiver approval because such investments will generate additional returns and the Federal government will realize significant savings from Phase 1 of New York's Medicaid redesign plan (\$18.8 billion over 5 years).

**Financial Impact:** This proposal will coordinate the care of approximately 700,000 dual eligible beneficiaries who spend a combined total of almost \$34.8 billion in Medicaid and Medicare per year. There is the potential to generate significant savings through the improved management of this population and alignment of billing practices.

**Health Disparities Impact:** Dual eligibles are more than twice as likely to be members of racial and ethnic minorities (42% compared to 16% of non-dually eligible Medicare beneficiaries). They are more than four times as likely to have a cognitive or mental impairment as non-dually eligible Medicare beneficiaries and 60% have a limitation in at least one activity of daily living.<sup>3</sup>

Integrating Medicare and Medicaid services will allow for program design features that recognize the unique demographics and needs of New York's dual eligible population.

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<sup>3</sup> Source: National Academy for State Health Policy; Making Medicaid Work; Issue Brief #6; December 2004.



**Benefits of Recommendation:** This proposal creates a potential WIN-WIN-WIN.

- ✓ *Members win because they will have access to better coordinated health care services.*
- ✓ *The Federal government wins because it has generated savings.*
- ✓ *New York State providers/health plans win because of simplified administration and the opportunity to share in savings that result from care integration.*

By locking in on a guaranteed funding stream, New York can work with the provider/plan community to manage resources and may mitigate the impact of additional federal Medicare cuts beyond those currently programmed through sequestration.

- ✓ *Waiver funds could be used for the implementation/development of Health Homes, Accountable Care Organizations, Patient Centered Medical Homes, Clinical Integration, Shared Savings, and/or Gainsharing.*

The current system is complex. Patients and providers are forced to navigate a variety of plan and program types. There are inconsistent rules and processes that confuse and frustrate patients and providers alike. These complexities and inconsistencies deter participation by providers and decrease patient satisfaction. A single integrated entity will reduce administrative burdens on providers and patients, resulting in a better overall experience for providers and patients.

Most importantly, a single integrated entity will improve patient outcomes through effective care management. The dual eligible population has a high utilization rate of health care services. Establishing a single entity to oversee the care of these patients will ensure that these patients receive the right care at the right time and in the right setting.

**Concerns with Recommendation:** If the New York State health care system does not perform and generate savings under the capitation payment, it could put New York at financial risk for any losses.

- ✓ *It is clear that for this effort to be successful, New York will need a strong partnership with the provider community to work together (to truly bend the cost curve). Through care management and proper financial incentives the reward should far outweigh the risk.*
- ✓ *Moreover, the Department of Health will develop a risk sharing process and phase-in whereby the State will only accept Medicare capitation payments for members in those regions of the State where adequate plan capacity exists. Careful implementation will significantly curb risk for both the State and plans/providers.*



Key to the success of their efforts, the State and CMS need to develop option(s) that allow for the full integration of Medicaid and Medicare programs – both financially and programmatically – while preserving members’ freedom of choice. Furthermore, the State needs to work aggressively with CMS to remove current barriers to the growth in existing programs such as PACE and Medicaid Advantage Plus, add integrated programs for custodial nursing home residents, and develop criteria for potentially new area coordination entities, as appropriate.

There was some discussion regarding the speed, process and design of the waiver initiative New York State is pursuing in order to achieve full integration of the dual eligible population. Specific concerns raised related to the state going at risk for such a large and needy population in light of the State’s current fiscal status and its capability to simultaneously assume responsibility for Medicare risk.

Work Group members also expressed concern that as operational efficiencies are achieved through improved health care systems there is the potential that savings will leave the health care system: Funding could exit the State to the extent for-profit commercial plans withdraw funds from the system. To address this concern, the Department of Health will continue to work with plans and other stakeholders to develop shared savings or other models (e.g., bundled payments, gainsharing, etc.) that will measure system efficiency (e.g., reduce ED use, avoidable hospital admissions, etc.) at the community level and reinvest these savings equitably among accountable entities.

**Impacted Stakeholders:** Medicare and Medicaid beneficiaries; health care providers who care for Medicare and Medicaid beneficiaries; health insurance companies who provide services to Medicare and Medicaid beneficiaries; not-for-profit organizations that currently assist persons eligible to receive Medicare and Medicaid benefits apply for and navigate the Medicare and Medicaid programs.



## Medicaid Redesign Team Payment Reform and Quality Work Group Final Recommendations – November 1, 2011

**Recommendation Number:** 2

**Recommendation Short Name:** Quality Measurement

**Program Area:** Quality

**Implementation Complexity:** Mid to High

**Implementation Timeline:** Continue to collect quality data on Medicaid managed care and Managed long term care (MLTC); begin measurement of Health Home populations in 2012-2013; begin measurement of mental health/substance abuse in 2012; begin measurement of long term care (outside of MLTC) in 2012; expand measurement of mental health/substance abuse in 2013-2014; expand measurement of long term care in 2013-2014.

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

**Proposal Description:** Adopt a series of accepted performance measures across all sectors of health care, aligning measures already being collected in New York in Medicaid managed care (including managed long term care (MLTC) with federal requirements. To the extent that quality measures are used as incentives or penalties in reimbursement, they should be aligned across the managed care and fee-for-service systems to the extent feasible (e.g., preventable admissions).

Governor Cuomo and the MRT have set a goal to not only reduce the cost trend of the Medicaid program, but to also improve quality. New York State has a long history of measuring, monitoring, and improving quality for enrollees in Medicaid managed care through a system called the Quality Assurance Reporting Requirements (QARR). Reported annually, QARR is a set of performance measures for Medicaid, Child Health Plus, and commercial managed care. While significant progress has been made in the quality of care delivered to Medicaid managed care enrollees, currently there isn't a measurement system to monitor the quality of care provided in fee-for-service Medicaid.

Under this recommendation, New York will build off of its experience in quality measurement and monitoring in Medicaid managed care by developing systems to measure the care in Medicaid fee-for-service, specifically in the areas of mental health/substance abuse and long term care. In addition, efficiency metrics including avoidable hospitalizations, avoidable emergency room visits, potentially preventable readmissions, and potentially preventable complications will be measured across various entities including managed care, health home, and patient-centered medical homes.



Key to this redesign effort will be an examination of patient utilization of hospital services, especially patient flow through emergency departments in relation to access and quality of service. This may require discussions with CMS regarding current federal requirements.

**To accomplish this recommendation, the following goals will need to be met:**

- ✓ *Need to utilize a core set of measures that are flexible to address the evolving delivery systems.*
- ✓ *Be based on a standard of care or evidence-based science.*
- ✓ *Implement public reporting process on measures and outcomes.*
- ✓ *Reward providers for improved and/or continued high performance.*
- ✓ *Take into consideration differences in clinical conditions as well as social conditions in measuring outcomes when the data is available.*

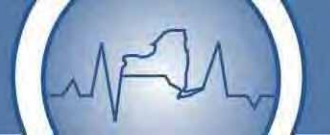
**Financial Impact:** None

**Health Disparities Impact:** Quality measurement will have a positive impact on minorities in the Medicaid program in New York. Building off the work done with Medicaid managed care plans using QARR data, quality measures can be shown by race/ethnicity; this is already being done today for Medicaid managed care and is available on the Department of Health website. Stratification of all quality measures by race/ethnicity will be a requirement.

**Benefits of Recommendation:** Quality measurement across all of Medicaid ensures accountability for process and outcomes. Quality measurement is also the starting point of the quality improvement cycle: Plan, Do, Study, Act. Without measurement, there cannot be improvement.

**Concerns with Recommendation:** Some sectors of the Medicaid program will be accountable for quality outcomes for the first time. There is an initial reluctance to measurement due to uncertainty of the results, but the commitment to measurement and improvement will continue to be the long term goal.

**Impacted Stakeholders:** Managed care plans; health homes; providers; consumers.



## Medicaid Redesign Team Payment Reform & Quality Measurement Work Group Final Recommendations – November 1, 2011

**Recommendation Number:** 3

**Recommendation Short Name:** Indigent Care Funding Program

**Program Area:** Indigent Care

**Implementation Complexity:** High

**Implementation Timeline:** Short-Term

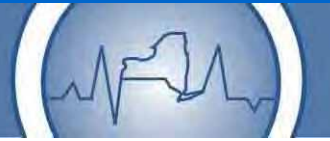
**Required Approvals:**

<input type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input checked="" type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

**Proposal Description:** First, the Medicaid Redesign Team Payment Reform & Quality Measurement Work Group recommends that general principles be developed that will be used to guide the task of reforming the New York State Indigent Care Program. These principles will be applied once the federal Centers for Medicare and Medicaid Services (CMS) provides guidance for determining how state allocations of federal Disproportionate Share Hospital (DSH) funding will be reduced as part of the implementation of the Affordable Care Act. This new federal law requires the reduction of current available federal funding for DSH to pay for care of the newly insured.

**The goals for changes to the State's Indigent Care Program are as follows:**

- 1) *Develop a new allocation methodology (consistent with CMS guidelines) to ensure that New York does not take more than its share in the nationwide reduction.*
- 2) *Develop a fair and equitable approach to allocate funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to the uninsured, underinsured and Medicaid populations.*
- 3) *Simplify the current funding allocation methodology.*
- 4) *Protect access to care for the targeted population as federal health care reform is implemented.*
- 5) *Promote transparency and accountability.*
- 6) *Develop stronger link between compliance with the Hospital Financial Assistance Law and receipt of payments from the Indigent Care Program that is not more onerous for providers and restrictive for patients.*



**The Workgroup has developed a set of guiding principles that should be utilized in the reform of the current Indigent Care Program which are as follows:**

- 1) *It is critical for all New York State health interests to advocate against further reductions in federal funding for DSH and other programs for eligible consumers and providers.*
- 2) *The Indigent Care Program needs to be transparent and accountable.*
- 3) *New York State should make changes in its uncompensated care pool allocation formulas consistent with CMS guidelines in order to preserve its share of available federal DSH funding and to maintain current funding levels to the extent possible.*
- 4) *Uncompensated care pool allocations should preserve separate funding streams for public and private hospitals as is reflected in the current methodology.*
- 5) *Subject to federal guidelines, the components of need in valuing uncompensated care support should be primarily based on charity care and uncompensated care to low-income uninsured, underinsured, and Medicaid patients, but not bad debt.*
- 6) *New York State should distribute funds across hospitals using an allocation methodology that distributes a greater proportion of funds to those hospitals providing a disproportionate share of uncompensated care need. Proper weighting should be given such that the priority is first targeted to the uncompensated care provided to the uninsured and the underinsured, and then to the Medicaid population.*
- 7) *New York State should explore and pursue with the federal government all available options, including but not limited to a waiver, to preserve public hospital essential community provider funding and mitigate shortfalls caused by reductions in federal DSH funding.*

The Indigent Care Program needs to be transparent and accountable. The work group heard serious concerns about variability and compliance with the Hospital Financial Assistance Law. To address these issues of transparency, accountability, and compliance the work group further recommends that a new work group be convened – including DOH representation for input and guidance on administrative, legal and federal share concerns – to:

- Recommend strengthened means to ensure compliance with the Hospital Financial Assistance Law; and
- Consider appropriate links between the Indigent care Program distribution methodologies and Hospital Financial Assistance law.

**Financial Impact:** None at this time, however, it is projected that New York allotment of federal DHS funding will be reduced by \$71 million in federal fiscal year 2013/2014 and increasing to \$85 million in federal fiscal year 2014/2015. It is projected that total funding to New York will be reduced by over \$2.5 billion through federal fiscal year 2019/2020.





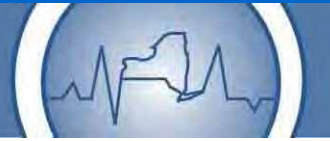
**Health Disparities Impact:** New York needs to ensure that federal DSH funding is distributed in accordance with federal requirements to ensure that access to services for the uninsured, underinsured and Medicaid population is not negatively impacted.

**Benefits of Recommendation:** Hospitals will be appropriately reimbursed for providing services to the targeted population and access to these services will not be negatively impacted.

Pool distributions will be dependent upon compliance with the Hospital Financial Assistance Law.

**Concerns with Recommendation:** Implementation of changes to the funding formulas for DSH in accordance with CMS guidelines may create the potential for a significant reallocation of funding to hospitals. This, in turn, could result in unintended fiscal consequences that may need to be addressed through a waiver or other means.

**Impacted Stakeholders:** Hospitals; consumers.



## Medicaid Redesign Team Payment Reform & Quality Measurement Work Group Final Recommendations – November 1, 2011

**Recommendation Number:** 4

**Recommendation Short Name:** Establish two initiatives – Essential Community Provider Network & Vital Access Providers

**Program Area:** Payment Reform

**Implementation Complexity:** Medium

**Implementation Timeline:** Resources for this initiative will need to be available very soon in order to facilitate the Brooklyn reconfiguration plan and meet other community needs.

**Required Approvals:**

**Administrative Action**

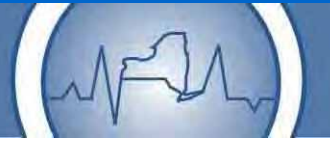
**Statutory Change**

**State Plan Amendment**

**Federal Waiver (Possible)**

**Proposal Description:** The health care system in New York State is undergoing a significant transformation. The Affordable Care Act (which will be implemented in large measure starting in 2014) will significantly decrease the number of uninsured New Yorkers, but these gains come with potentially deep cuts in Indigent Care funding to hospitals and other programs. Moreover, to close the federal budget gap, the Congressional Deficit Reduction Committee is contemplating deep reductions in Graduate Medical Education that will put tremendous pressure on the State's teaching hospitals. And, lastly, the Medicaid Global Cap will limit Medicaid spending to the inflation rate which will further compress growth. These measures, taken in total, could have the unintended consequences of destabilizing health care providers that serve a high proportion of the uninsured, Medicaid, and other vulnerable populations.

The Payment Reform & Quality Measurement Work Group spent considerable time discussing the health care environment and the impact rapid changes will have on providers who serve disproportionate numbers of uninsured, Medicaid, Medicare, and other vulnerable populations. While the Payment Reform & Quality Measurement Work Group recognizes that change is inevitable, it strongly believes that safety-net providers who offer essential services within their communities must emerge from this restructuring stronger financially than they are today.



To this end, the Payment Reform & Quality Measurement Work Group recommends two initiatives – Essential Community Provider Network (short-term funding) and Vital Access Providers (ongoing rate enhancement or other support) - to ensure access to care for patients. The Work Group recommends that New York State assume an active role in ensuring certain essential community providers (hospitals, nursing homes, D&TCs or home health providers) be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services. After collaborating with the members of the Medicaid Redesign Team Health Systems Redesign: Brooklyn Work Group, this measure has the potential to be a useful tool and could be used in concert with HEAL/FSHRP funding in the reconfiguration and rightsizing of the Brooklyn health care system and be consistent with previously endorsed Medicaid Redesign Team recommendations (i.e., MRT #67: Assist Preservation of Essential Safety-Net Hospitals, Nursing Homes and D&TCs).

The Work Group members shared the view that if the State is going to offer certain providers an enhanced Medicaid rate then it needs to be offered in very limited situations to accomplish specific well-defined goals.

In order to receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. This plan will also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement.

Moreover, based on the understanding that the Department of Health has with CMS, it is incumbent upon the facility to also demonstrate how its plan and the investment will ultimately return savings longer term for the Medicaid program.

For this initiative to be successful and not drive significant new expenditures to the Medicaid program, it should be used strategically and sparingly. The Commissioner of Health (with community input) will make the final decision concerning which facilities are eligible by applying the following criteria:

- ✓ *Demonstration of integration of services with other providers and improved quality, access, and efficiency;*
- ✓ *Engagement with community stakeholders and responsiveness of plan to community health needs;*
- ✓ *Financial viability based upon certain metrics (profitability, debt load, and liquidity);*
- ✓ *Provision of care to financially and medically vulnerable populations;*
- ✓ *Provision of essential health services; and/or*
- ✓ *Provision of an otherwise unmet health care need (e.g., behavioral health services).*



**Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:**

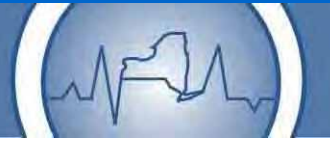
- ✓ *Administrative and operational efficiencies;*
- ✓ *Quality and population health standards;*
- ✓ *Provision of essential services;*
- ✓ *Improved integration or collaboration with other entities; and/or*
- ✓ *Achieving health care cost savings.*

Furthermore, for the Department of Health to make the required investment of taxpayer funds for this purpose, it must have confidence in the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. As a requirement to receive these funds, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

#### Vital Access Provider (VAP):

The Work Group also envisioned the need to provide ongoing rate enhancement or other support to a small group of hospitals, nursing homes, D&TCs, and home care providers, as described above, but under more stringent basis over a longer term. These facilities will still be required to submit a plan and a budget for meeting defined goals, which would include approaches to advance community care, but the purpose of these funds is to provide longer term operational support. Examples of providers that could receive this designation and enhancement could include efficient hospitals and other providers in rural communities that have already reconfigured services to create integrated systems of care and that require a rate enhancement to remain financially viable and continue to provide a service not offered elsewhere in the community (e.g., emergency department, trauma care, obstetrics). Moreover, in urban areas, qualifying providers will be unique in that they serve a very high proportion of Medicaid and financially vulnerable populations, provide unique services that are not offered by other providers within the community, and have serious financial problems. Again, the VAP provider designation and any allocation of funds are subject to approval by the Commissioner of Health and is pursuant to a dynamic plan to better the health of the community. These facilities would also be required to demonstrate satisfaction of benchmarks specified by the Commissioner.

The Work group encourages the state to support the development of physician practices in underserved areas and the involvement of physician practices in integrated systems of care, particularly through electronic health records and payment arrangements. We acknowledge that steps have already been taken in this regard through enhanced Medicaid payments for physician practices that have received patient-centered medical home accreditation and Doctors Across New York practice support and loan repayment assistance grants. The expansion of Medicaid managed care has also driven additional physician participation in the Medicaid program and promoted primary care for Medicaid beneficiaries. Nevertheless, more can be done to support physicians seeking to practice in underserved areas.



**Financial Impact:** This recommendation will need to be funded through a combination of State allocations and up to \$450 million in HEAL/FSHRP funds. State allocations could be generated through the redirection of Transition 1 and/or 2 funds and the New York State General Fund. In addition, the State could also seek a federal Medicaid waiver from CMS to acquire funding specifically designated for VAP.

**Benefits of Recommendation:** This recommendation will ensure continued access to vital health care services for the uninsured, Medicaid, and other vulnerable populations during a period in which the health care system is experiencing significant restructuring and payment reform. VAP funds coupled with HEAL/FSHRP reserves of up to \$450 million provide a sufficient funding source to ensure the smooth transition of services within communities and to provide reinvestment capital for new investment paradigms.

The temporary rate enhancement and the VAP program are expected to improve accountability and transparency while addressing community health needs. Requiring providers to submit plans for how funds will be utilized to achieve specific restructuring goals that meet the community's health care needs will ensure that funds are being used appropriately. To this end, the Work Group recommended that plan, progress reports, and funding allocations be kept current and made available on the Department of Health's website.

**Concerns with Recommendation:** The Payment Reform & Quality Measurement Work Group voiced serious concerns that within the Medicaid Global Cap VAP funding would be used to support/prop-up financially inefficient and ineffective facilities. Furthermore, the Payment Reform & Quality Measurement Work Group worried that parochial interests would drive the inappropriate use of VAP funding and undermine the intent of the program by extending timelines or bending eligibility requirements. Moreover, under the Medicaid Global Cap (where Medicaid spending is fixed to an annual appropriation), there was concern that unwise use of these funds could ultimately impact other providers if spending exceeds the cap and broader based cost containment actions are required.

- ✓ *Accordingly, for reasons explained above, this program will need to be used sparingly to achieve specific strategic goals with public reporting on progress.*

**Impacted Stakeholders:** Health care providers who deliver a significant portion of services to the uninsured, Medicaid, and other vulnerable populations; health care consumers in under-served communities.



## REPORT ATTACHMENTS



COMMISSION ON THE PUBLIC'S HEALTH SYSTEM

45 Clinton Street New York, NY 10002  
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**A New Proposal for Charity Care in New York State**

This proposal contains three major recommendations:

Funds from the Charity Care hospital pool would be distributed to hospitals to provide services for the uninsured. 100% of the funding would be allocated to all hospitals on the basis of actually providing care to uninsured patients. By accomplishing this important new allocation method, hospitals would receive payment to meet their obligation of providing care for the uninsured under the Patient Financial Assistance Law (Manny's Law).

A special Upper Payment Limit (UPL) payment would be developed for safety net hospitals, which are defined as hospitals that provide a significant level of their services – 50% -- to Medicaid and uninsured patients.

The Diagnostic and Treatment Center pool would be increased to a level that would match the percent of coverage of payment for services to the uninsured that is provided to the hospitals from their Charity Care pool.

**Background**

Each year nearly \$1 billion dollars is distributed from a hospital Charity Care pool. This is one of the least accountable, least transparent distributions of public funding. Since 1983, New York State has done the right thing in collecting dollars and distributing the dollars to hospitals but this is done under the guise of providing funding for the care of the uninsured and the under-insured. The problem is the method of distribution of the funding. Hospitals have been allowed to use an antiquated accounting methodology to compute how much they are owed from the pool.

In 2008, the State Health Department set up a Task Force to review the pools and ultimately recommend that 100% of the funding be distributed to hospitals based on the care that they provide to uninsured patients. This makes a great deal of sense, particularly in light of the passage of the Patient Financial Assistance Law (Manny's Law) which requires all hospitals to develop and publicize a Charity Care policy for uninsured patients with low

incomes. With this legal requirement, hospitals should be paid for providing uncompensated care for free or on a sliding fee scale.

There are strong, well-funded efforts by hospital associations and their allies to maintain the current unaccountable system. They claim that many hospitals would be hurt if funds that they get, without earning them, were taken from private hospitals, it would hurt many hospitals. This lobbying effort has been very successful with both houses of the state legislature.

### **The Proposal**

There are safety net hospitals in low-income, medically underserved, immigrant and communities of color that provide many services for Medicaid patients and some uninsured patients. A system should be developed for recognizing the service of these hospitals. We would recommend that the State develop a special Upper Payment Limit (UPL) payment for safety net hospitals that can prove that they provide a significant percent of services to Medicaid and uninsured patients. The special UPL payment would only be available for Safety Net hospitals which will be defined based on services to Medicaid and uninsured. This Medicaid rate could include dollars for providing services for low-income patients and proving that they are efficient. There should also be a limit set on the size of the salaries and compensation packages at \$1 million for the hospital executives and some other staff. If hospitals spend more on salaries for this staff, the overage should be disallowed in any computation of hospital costs for calculating Medicaid reimbursement.

By developing this special rate, the Charity Care dollars could be freed up and used for their primary purpose – paying for care for the uninsured. One hundred percent of the Charity Care pool dollars should be distributed to hospitals based on their accurate reporting of the numbers of uninsured patients to whom they provide services – emergency, clinic, and inpatient care. The hospitals would have to fully, and appropriately, document that the patient was interviewed for, and approved for, financial assistance. All hospitals, including the public hospitals, would be eligible for full reimbursement for providing this care. (Note: in New York City, the public hospitals provide 66% of all hospital-based clinic care for the uninsured). If private hospitals resist the redistribution of charity care dollars based on providing care for the uninsured, a mechanism must be developed to develop a way of referring uninsured patients to these hospitals, such that they actually provide enough services for the uninsured to earn the charity care dollars they receive.

A third component of this modest proposal is an increase in the charity care pool dollars for Diagnostic and Treatment Centers. These facilities, many of them public or FQHC's, also treat large number of uninsured patients. Dollars in this pool should be increased so that the clinics receive the same percentage of funding for caring for uninsured patients as hospitals do from the pool. D&TC's already have a transparent, accountable method of reporting and dollars are distributed from this pool strictly on the basis of providing care for the uninsured.

Revised: January 14<sup>th</sup>, 2011





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The Commission on the Public's Health System is firmly committed to equal access to quality health services for everyone regardless of race, ethnicity, language spoken, diagnosis or the ability to pay. The recommendations that we make are based on that commitment.

**\*We support the proposals put forward by the Center for Disability Rights and the New York Association on Independent Living, that would reduce New York State spending and promote the independence and integration of seniors and people with disabilities.**

**\*We support the recommendations of the Community Health Care Association of New York State and the Primary Care Coalition to expand access to primary health care services. We know that comprehensive, quality, community-based primary care will reduce the cost of care and improve health status – the number of avoidable hospitalizations will decrease.**

**\*We support the Principles of Medicaid Matters New York.**

In addition, we believe that:

- There is enough funding in the Medicaid budget, if spent well, so that savings can be made and access to health care, eligibility, and benefits be maintained. It should be embarrassing to all of us that New York State ranks 50<sup>th</sup> (dead last) with the highest percent of Ambulatory Care Sensitive hospitalizations. With an expansion of primary care services that works for everyone – including expansion of hours, guarantee of continuity and comprehensiveness – New York could change this ranking and save dollars in the Medicaid budget.
- There needs to be full transparency and accountability in the spending of any and all public funds. The charity care pools must become transparent and dollars should be used to pay for services that are rendered to uninsured patients, and patients that are underinsured for particular services. Our more detailed proposals on Charity Care are included.

- New York State must use any and all federal dollars wisely. A recent, not yet approved, Medicaid waiver extension to CMS requested \$300 million over a period of three years to move towards medical home status and improved primary care training programs in teaching hospitals. CPHS has been coordinating an effort to negotiate with the State Health Department to ensure, if the waiver is granted, that there are clear standards within the waiver agreement, monitoring and enforcement of these standards.
- Limits must be set on pricing/costs of personnel and other than personnel costs that are included in calculating the Medicaid reimbursement rate for each facility. There must be a maximum in salary and benefits for any given employee at a facility that will be included in the calculation of Medicaid rates. We would propose that the maximum dollar amount would be \$1 million, but would preferably be set at \$500,000.
- There are health care facilities that are located in low-income, medically underserved, immigrant and communities of color that are needed for the services that they provide. Some of the facilities, and other larger institutions, are not cost-effective because of inefficiencies. The State Department of Health, has and must use, the ability and capacity to manage the finances of these facilities so that they can be viable and remain in operation. The estimates of 40% of patients disappearing from care when their hospital is closed, is unacceptable.

A review of the Berger Commission recommendations give additional proposals for the State to pursue, which for the most part it has not done.

- **Under reimbursement and Medicaid** – “Reimbursement reform should strengthen the long-term viability of institutions that disproportionately serve vulnerable populations including the uninsured and low income patients.”  
 “Reimbursement reform should encourage the provision of preventive, primary and other baseline services and discourage the medical arms race for duplicative provision of high-end services.”  
 “Future capital investments should reflect shifts in the venue of care from institutional to home and community based settings.”  
 “Expand the availability of home and community-based alternatives to nursing home placement and educate physicians, paraprofessionals, and consumers about these alternatives.”
- **Under developing primary care infrastructure** – “ensuring that all New York residents have a primary care ‘home’.”  
 “Stemming the erosion of primary care capacity.”  
 “Ensuring adequate financial support to the primary health care safety net.”

January 19, 2011

## **Proposal (Short Title): Equity for the Uninsured and Safety-Net Providers**

**Theme:** Charity Care for the Uninsured and Medicaid Payment Increases for Safety-Net Providers

### **Proposal Description:**

Distribution of charity care funding will be made transparent and used to pay for the care of the uninsured. New federal law under Health Reform redirects some of the current federal funding under DSH (Disproportionate Share Hospitals) to pay for care of the newly insured. Remaining DSH funding will be distributed to states based on three factors: the remaining number of uninsured; whether the state uses the DSH money to pay for care of the uninsured; and whether the state targets DSH funding to hospitals with high Medicaid patients. To continue getting funding, New York is required to change the current way that the federal funding for charity care is distributed to hospitals.

### **Background:**

New York has a long history of using public financing to help hospitals provide care to uninsured and underinsured patients. The State remains committed to supporting those institutions that provide this care. If you examine the way in which that money has been allocated, however, some inconsistencies arise. The formulas that allocate bad debt and charity care funds are complex and opaque. It is not clear how the allocation of money connects back to actual care provided to actual patients. The Commission on the Public's Health System (CPHS), and others, has long advocated for a more transparent system, where money indeed follows the patient.

Over a period of years, the CPHS documented the allocation of public dollars from the State's \$847 million Hospital Indigent Care Pool intended to compensate hospitals for the indigent care they provided. As a result of this effort, CPHS published two reports that showed little or no relationship between the actual dollars received by the hospitals from the hospital Charity Care pool and the amount of health care services they provided to the uninsured. It is interesting to note that there is a separate community health center pool to pay for the care of the uninsured. This pool of dollars is much smaller than the hospital pool and is funding allocated to health centers based on their reporting care that they provide to the uninsured.

Despite recent efforts to change the allocation of charity care dollars, provider resistance has maintained the system almost untouched. There has, however, been movement over the last several years to ensure that they uninsured have access to health services regardless of their ability to pay. The first change was passage of the Hospital Financial Assistance Law (Subdivision 9-a of Section 2807-k of the New York

State Public Health Law) – also called Manny’s Law. For the first time, the State requires that all hospitals develop a charity care sliding scale fee policy for New York residents with incomes at or below 300% of the federal poverty level, post these policies, and notify patients of their right to a sliding fee scale for payments based on income and family size.

The second important change came as the result of a 2008 State Task Force which reviewed the hospital charity care system, and resulted in the requirement that 10% of the total \$847 million in the hospital Charity Care pool be distributed on the strength of the hospital showing it had cared for numbers of uninsured patients. The benefit of this very small movement is that in order to receive a share of the 10%, hospitals have to report all of the care they delivered to people with no health insurance. The reporting has enabled a more in-depth look at what hospitals are doing to provide care and to match that care to the dollars being distributed to these institutions.

**Proposal:**

Two Principles should guide the distribution of charity care funds: (1) Funding should follow the patient – hospitals should be paid from the charity care pool for providing care to uninsured patients; and (2) Payments to hospitals should be progressively increased based on providing a larger proportion of care for the uninsured.

Based on these principles, CPHS and an Advisory Committee worked with a consultant to developed specific changes in the way the State distributes Charity Care funding:

- The first step was to start with a uniform reimbursement, the median statewide Medicaid reimbursement rate, as a leveler for all hospitals in the state.
- The second step was to add to this median rate the regional costs for things like salaries and then to add more for the care of sicker patients.
- The third step is to add more dollars on a progressive scale for hospitals that treat a higher percentage of uninsured patients.
- The final step only occurs if the federal DSH dollars are greatly reduced; we proposed a way of combining the current pools to fund public and private hospitals. This is very important because the 21 public hospitals in the state provide the lions’ share of services for the uninsured.

In a separate proposal, CPHS addresses additional funding for safety-net hospitals that provide a high proportion of care for Medicaid patients but do not provide as much care for the uninsured. To ensure that these hospitals do not lose money as a result of the charity care recommendations, we propose a special increase in the Medicaid reimbursement rate to cover potential funding shortfall. We also propose an increase in

the dollar amount of the Charity Care pool which funds community health centers for the care of the uninsured. This pool is much smaller than the hospital pool, even though health centers report the number of uninsured patients/visits and get paid for the care of the uninsured. The Health Centers/D&TC's provide services for large number of uninsured patients.

### **Financial Considerations**

The Hospital Indigent Care (Charity Care) Pool has \$847 million annually for distribution to hospitals. Redistribution will also serve as a powerful incentive for hospitals providing care for the uninsured are paid for providing this care. This is also a way for encouraging hospitals to meet their obligations under Manny's Law, including posting information and informing patients of a sliding fee scale for uninsured patients with family income under 300% of the federal poverty level. Although this is currently a legal requirement, it is not at all clear how many hospitals are actually informing patients about charity care at the time that they arrive for services. If hospitals are motivated to inform patients about available charity care prior to hospitalizations for emergencies, more of the charity care funding would be used for preventive and primary care, which could lead to a reduction in expensive Emergency Room visits and a reduction in overall costs.

Another very important consideration is that in the not too distant future there will be a reduction in federal Disproportionate Share Hospital dollars to pay for newly insured patients under the Affordable Care Act (ACA). Federal DSH dollars will be reduced by \$500 million in 2014. Allotment of the remaining dollars will be governed by regulations from the HHS Secretary.

"The methodology will be structured to ensure that states using DSH funding appropriately are able to retain such funding. Specifically, the methodology will:

\*apply the largest reductions to states that (i) have the lowest uninsured rates (based on Census data), (ii) have the lowest levels of uncompensated care (excluding bad debts), and (iii) do not target DSH payments to hospitals with high volumes of Medicaid inpatient care..."<sup>1</sup>

If New York State does not make changes in the hospital charity care distribution formula this year, the state stands to lose millions of federal dollars.

Submitted by: Commission on the Public's Health System (CPHS). [www.cphsnyc.org](http://www.cphsnyc.org)

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<sup>1</sup> *Implementing Federal Health Care Reform: A Roadmap for New York State.* Boozang, Patricia, Dutton, Melinda, Lam, Allce and Bachrach, Deborah. August 2010. New York State Health Foundation.

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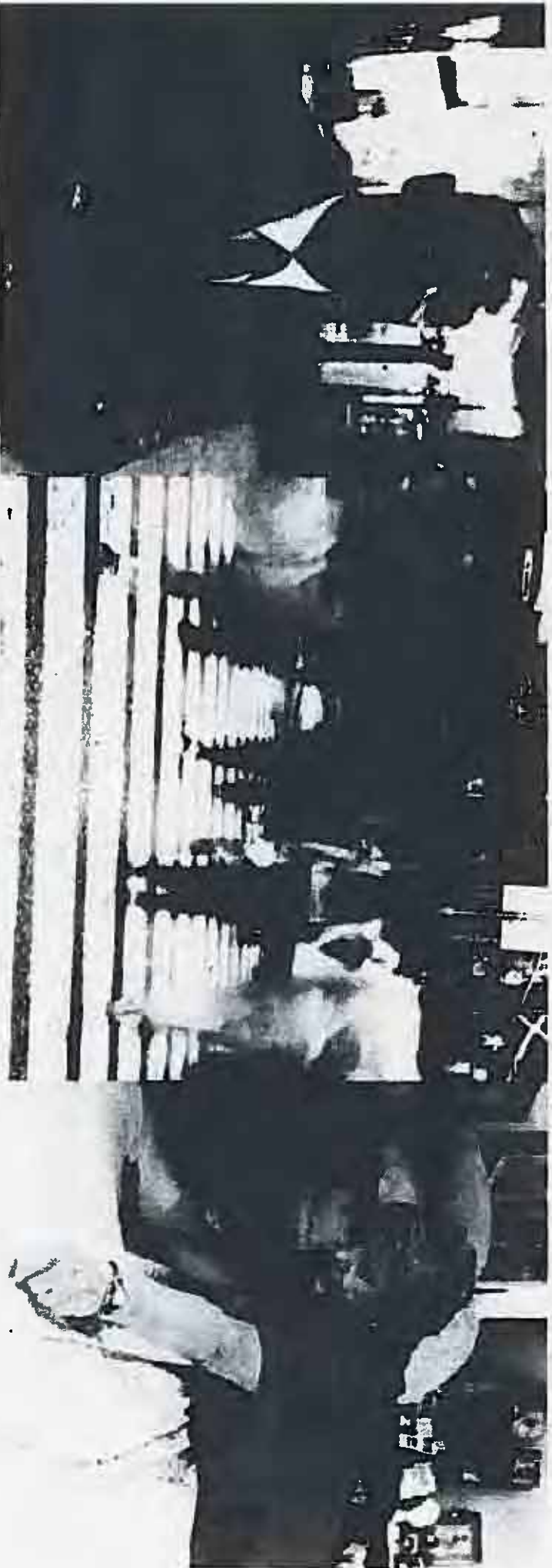
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# Removing Obstacles to Patient Financial Assistance in New York



September 26, 2011

Elisabeth Benjamin, MSPH, JD, Vice President of Health Initiatives,  
Carrie Tracy, JD, Policy Associate  
Arianne Slagle, MPA, Policy Associate

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**Community**  
**Service** | **Fighting Poverty**  
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**New York**

**DRAFT -- 09/26/11**

# Outline of Presentation

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- Executive Summary
- Background on Hospital Financial Assistance in NY
- Front-end Barriers to Hospital Financial Assistance
- Back-end issues Related to Hospital Financial Assistance
- Impending Funding Issues
- Conclusions & Recommendations





# **Executive Summary:**

## **CSS identifies problems with NY's uncompensated care system**

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- CSS analysis of SDOH data reveals that:
  - Hospitals do not comply with the Hospital Financial Assistance Law, but still get \$1.1 billion in State Indigent Care Pool (ICP) funds.
  - ICP funds distributed are not tied directly to individual patients.
  - Hospital reporting practices are unaccountable and opaque.
- These practices put NY at risk of losing millions of dollars in federal DSH funds come 2014.

# Executive Summary:

## Recommendations

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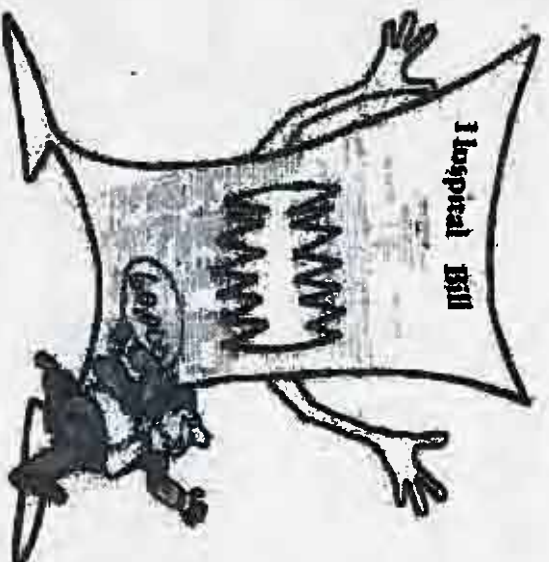
- **The State should enforce and improve the Hospital Financial Assistance**

### Law

- SDOH should perform statewide audits & enforcement annually.
  - Hospitals that fail to comply with HFAL should not receive any ICP funds.
  - To ensure consistency and fairness, the State should adopt and disseminate widely one uniform state-wide application used for financial assistance.
- **The State should directly tie the ICP funds to individual financial aid patients**
    - Hospitals should be incentivized to provide financial assistance. Hospitals should be required to process all uninsured and self-pay patients for financial assistance.
  - **The State should develop a transparent ICP distribution methodology**
    - Adopt a 100% units of service methodology for distributing ICP funds.
    - Prioritize patients certified funder HFAL.
    - Any leftover funds can be used to reimburse for bad debt using a sliding scale.

# **Background on Hospital Financial Assistance in NY**

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# **Background: What is the current status of New York's hospital financial aid system?**

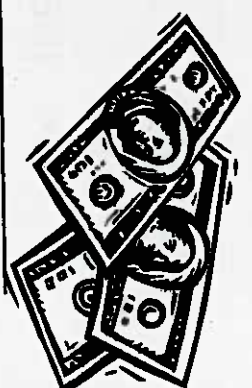
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- Depressed job market and increasing number of uninsured results in more demand for uncompensated care at New York hospitals.
  - Under EMTALA, hospitals may not turn away emergency patients, but they bill a patient regardless of his or her ability to pay.
- The federal and NYS governments provide hospitals over \$1 billion in Medicaid funds per year to cover uncompensated care costs.
- But, these funds are not directly tied to individual uninsured patients.
  - Hospitals send individual patients to collections, but are inconsistently reimbursed for costs they claim are associated with uncompensated care and bad debt.
  - Compliance with new financial aid law is patently flawed.
- Come 2014, under the ACA, there will be fewer uncompensated care dollars and those dollars will have much stricter rules.

# Background: New York's Indigent Care Pool

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- Since 1983, NYS has provided funds to hospitals to help cover uncompensated care and bad debts costs.
- Today, NY's "Indigent Care Pool" (ICP) is funded by federal Disproportionate Share Hospital (DSH) funds paid for by Medicaid (State match comes from various sources of revenue, including HCRA and hospital assessments).
- Uncompensated care in ICP is categorized in two ways:
  - Bad debts: unpaid medical bills from insured and uninsured patients that are considered to be uncollectable.
  - Charity care: financial assistance (free or reduced-cost care) given to low-income, uninsured patients considered to be "indigent" or "medically indigent."



## **How are patients supposed to get financial assistance?**

---

- From 2003 to 2005, advocates complained that hospitals were not providing financial aid and engaged in overly harsh collection practices, but still received funds from ICP.
  - Extensive media coverage on the issue.
- In response, in 2006, the Hospital Financial Assistance Law (HFAL) enacted.
  - Requires all hospitals to have financial aid policies and applications to qualify for ICP funds.
- But ICP is still allocated under old rules that are unrelated to individual patient care of the new HFAL.

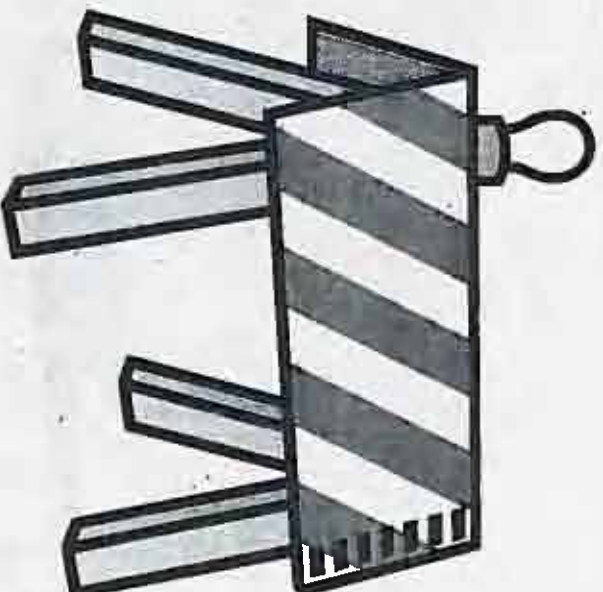
# What the harm if patients do not get financial assistance?

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- All patients who receive care at a hospital will receive a bill for that care. If they cannot pay it, many go into collections.
  - Medical debts and illness account for 62% of all personal bankruptcies in the United States (E. Warren et al, Am. J. of Med. 2009).
- Hospitals are allowed to place liens on primary residences as part of the hospital collection process.
  - 23% of all home foreclosures in the United States are caused by unmanageable medical bills (C. Robertson et al, Health Matrix, 2008).
- Fear of compounding medical bills can deter many patients from seeking necessary medical care until its too late. This leads to:
  - Worse health outcomes, even death.
  - Higher medical costs due to having to treat a worsened condition.
  - Higher medical bills for the patient.

# **Front-end Barriers to Hospital Financial Assistance**

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# Junko M. experiences how one hospital violates the HFAL



Junko is a single mom from Japan with a young daughter. Both are uninsured. In early 2011, Junko's daughter received emergency medical care at New York Downtown Hospital. Afterwards, Junko was left with a bill that she could not afford. She tried to call the number for hospital financial assistance listed on her bill, but could not get through.

Frustrated, Junko sought out help from Make the Road New York. Junko's case handler found out that the phone number for financial assistance that was listed on the bill was incorrect. After getting the correct contact information, she was told that in order to apply for financial assistance, Junko needed to provide a social security card or US passport, and copies of bank statements, mortgage payments and utility bills.

Knowing that this information was not required by the Hospital Financial Assistance Law, the case handler asked the hospital representative to send her a copy of the hospital's financial assistance application. She was told that no such application exists, and that Junko just needed to bring the documents to their office.

# Barriers to patient financial assistance

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- Hospital financial assistance policies can be hard to find.
  - Hospitals supposed to publicly post financial aid info, but not all do.
  - SDOH website does not include copies of hospital policies.
- Consistent with the requirements of HFAL and SDOH rules, Hospitals allowed to design unique applications, procedure, and outreach strategy. But these applications and policies often:
  - Are often inconsistent with HFAL rule
  - Some hospitals have added impermissible barriers, like:
    - copies of bank statements or tax returns
    - social security cards or U.S. passports
    - credit card numbers
    - utility bills, or mortgage payments
    - proof of a Medicaid denial



# CSS's survey of hospital financial aid policies: Access to information

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What CSS did: CSS formally asked each New York hospital for a copy of its financial aid application and policy to help health consumers who seek health help through Community Health Advocates (CHA).  
✓ Follow up requests were made to non-responders.

## What CSS found:

- 161 (81%) hospitals and hospital systems provided us with their policy summary and/or application or posted the information on their website.
- 37 (19%) did not provide CSS the information requested or did not respond.
  - ✓ After CSS sent a follow-up letter to HANYs with the results of our survey, 18 additional hospitals agreed to provide us with their policies.
- 6 (3%) provided their policy summary and/or application, but asked CSS not to post them on CHA website.

# CSS's review of hospital financial aid policies: Application issues

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- CSS evaluated each application and policy to determine if it met 5 basic HFAL requirements:
  - Explanation of income level eligibility (PHL § 2807-k-9-a (c))
  - Information on geographic service area (PHL § 2807-k-9-a (c))
  - Explanation of how to apply (PHL § 2807-k-9-a (c))
  - Instruction to ignore bills while application is pending (PHL § 2807-k-9-a (c))
  - Hospital contact information for financial assistance (PHL § 2807-k-9-a (a); SDOH guidance dated 5/11/09)
  
- CSS determined whether the policy:
  - Was available in languages other than English (PHL § 2807-k-9-a (e));
  - Included illegal barriers (asked patients for tax returns, monthly bill information, or a Medicaid denial) (PHL § 2807-k-9-a (e); PHL § 2807-k-9-a (a); SDOH guidance dated 5/11/09) )

# CSS's finds widespread violations of the HFAL

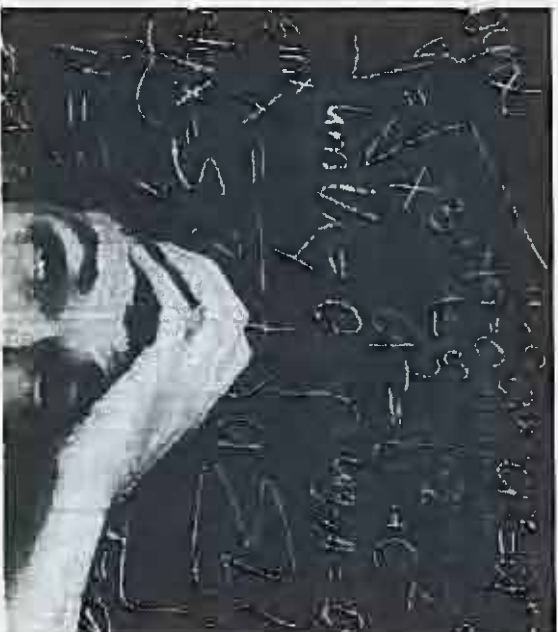
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## What we found:

- 70 percent (112) of hospitals who had provided us with application materials failed to meet the 5 basic legal requirements under the HFAL.
- 24 percent (39) hospitals who provided us with application materials have financial assistance applications that have additional, unlawful, barriers, such as demands for: tax returns, monthly bill information, or a Medicaid denial before application.
- 76 percent (122) of hospitals fail to provide financial assistance information in languages other than English.

# Back-end Issues Related to Hospital Financial Assistance

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# Current SDOH reporting requirements for hospitals to get ICP funds

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- To qualify for Indigent Care Pool funds, a hospital must:
  - Submit an annual institutional cost report (ICR)
  - Incur uncompensated care costs, or “targeted need,” greater than ½ of 1% (.50%) of the hospital’s total inpatient and outpatient costs
  - Provide an annual independent CPA certification that the hospital’s billing, collection and account write-off procedures are consistent with the law and regulations
  - Comply with the requirements established by the hospital financial assistance law

# **Current SDOH reporting requirements on hospital financial assistance law**

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HFAL requires hospitals to report aggregate data to the SDOH, including:

- Hospital costs incurred and uncollected amounts due to providing services to patients with and without insurance, and those eligible for financial aid.
- The number of patients (by zip code) who applied for financial aid and how many were approved, denied, pending, or deemed incomplete.
- Reimbursement received from the Indigent Care Pool.
- The number of liens placed on primary residences through the hospital collection process.

**The provision of financial assistance to patients under HFAL is unrelated to the costs listed on hospital ICP reports (prior page).**



# Key metrics: How hospitals measure losses for the purpose of getting indigent care pool funds

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## Bad debt/charity care (BDCC) – [Existing methodology]

- 90% of indigent care pool funds are distributed based on hospitals' reported losses due to bad debts and charity care for insured and uninsured patients.
  - Hospitals use unique accounting methodologies to determine bad debts and charity care, which can have different results.
  - These currently are reported in aggregate based on hospital charges.
  - The SDOI reduces each hospital's reported charges down to cost using a converter formula.
- Under the BDCC methodology, uncompensated costs include:
  - Insured patients who did not pay their co-pays or deductibles, or whose insurance only partially covers a service provided.
  - Self-pay patients who have insurance but it does not cover a service provided at all.
  - Uninsured patients (who have no form of health insurance coverage).

# Key metrics: How hospitals measure losses for purposes of getting indigent care pool funds

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## Units of service

- 10% is distributed based on hospitals' reported losses measured using units of service to uninsured patients.
  - These are calculated by multiplying the number of inpatient and outpatient units of service provided to uninsured patients by the applicable Medicaid reimbursement rate, less any payments made by the patients.
  - Hospital losses reported are also due to bad debts and charity care.
- Under the units of service methodology, uncompensated costs include:
  - Self-pay patients who have insurance but it does not cover a service provided at all.
  - Uninsured patients (who have no form of health insurance coverage).



# Distribution methodologies = many moving parts

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- The indigent care pool is made up of several smaller sub-pools for major public hospitals, voluntary hospitals, minor public hospitals, high need voluntary hospitals, rural hospitals, and other targeted funding to hospitals who partake in graduate medical education.
- For the most part, each pool has its own methodology for distribution of funds. For example:
  - Major voluntary hospitals, the allocation is based on its share of total reimbursable costs relative to total reimbursable costs for all major hospitals.
  - These hospitals receive a greater distribution amount based on a sliding scale which provides more funds for hospitals with a higher targeted need (ratio of uncompensated care relative to total patient volume).
- Hospitals are generally reimbursed for only a portion of their reported uncompensated care costs.

**Current Indigent Care Methodology and Funding**  
**\$1,182.5M in Total Funds**

**\$395.2 Based on Uninsured Allocations\*, \$787.3 based on "Other" Allocations**

*\* \$310.5M of the \$395.2M is targeted to specific groups of hospitals*

**\$765M: PHL 2807-k**

**Major Public Distribution: \$139.3M**

(\$125.4M distribution based on 1996 allocation;  
 \$13.9M based on uninsured units x MA rates)

**Voluntary High Need: \$32.4M**

(Distribution based on BDCC  
 targeted need > 4% of costs)

**Voluntary Distribution: \$593.3M**

(\$530.7M distribution on BDCC targeted need;  
 \$62.6M on uninsured units x MA rates)

**\$82M: PHL 2807-w**

**Rural Hospitals Distributions:**  
**\$32.3M**

(\$126K grants + BDCC based upon  
 bed size and need statistic)

**Supplemental Voluntary High Need:**  
**\$32.4M**

(Distribution based on BDCC  
 targeted need > 4% of costs)

**Supplemental Voluntary  
 Distribution: \$17.3M**

(\$9.1M distribution on BDCC targeted need,  
 \$8.2M on uninsured units x MA rates)

**\$335.5M: PHL 2807-k (5-b)**

**Voluntary Teaching Regional  
 Distributions:**  
**\$269.5M**

(Based on 2007 unmet need - uninsured units x  
 MA rate less hospital share of \$84.7M  
 allocation)

**Voluntary High MA Safety Net:**  
**\$25M**

(Uncompensated care based on  
 uninsured units x MA rates)

**Voluntary High MA Safety Net:**  
**\$25M**

(Net MA losses from reform/DRP)

**Non-Teaching Hospitals: \$16M**

(Uncompensated care based on  
 uninsured units x MA rates)

# CSS's analysis of hospital ICR data: Hospital financial aid policies vs. financial aid distributed

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## What CSS did:

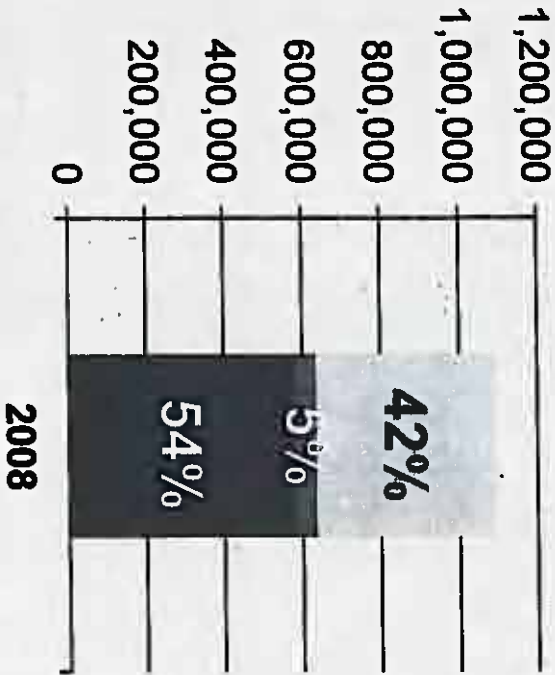
- Requested ICR data from the SDOH on all of hospitals that receive ICP funds.
- Analyzed the spreadsheets to determine:
  - Reporting of amount of financial aid provided and the amount of indigent care funds received;
  - Reporting on HFAL compared to claimed “targeted need”;
  - Reporting on uncompensated care costs related to “bad debts”;
  - Reporting on hospitals with CSS-identified barriers and liens taken on patients’ homes v. number of approved applications.

## What CSS found:

*See next slides...*

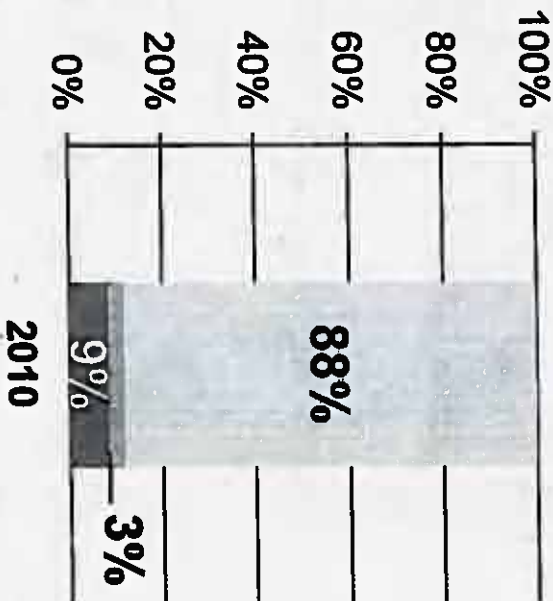
# Public hospitals, who give the most financial assistance, get the least amount of indigent care funds

**% of Total Applications Approved**



- Voluntary Applications Approved
- Non-HHC Major Publics Applications
- HHC Applications Approved

**% of Total ICP Funds Distributed**



- % total ICP payments received by HHC hospitals
- % total ICP payments received by non-HHC major public hospitals
- % total ICP payments received by voluntary hospitals

Note: Major public hospitals also receive an additional \$1.5 B in UPL and IGT DSH payments.

# The accuracy of costs reported for financial assistance recipients is questionable



## Hospitals are required to report:

- Total costs for services to all uninsured patients
- Costs incurred in rendering services to uninsured patients eligible for financial aid (that were approved).
  - Patients eligible for financial assistance should be a subset of total uninsured .

## However, CSS found that: Hospital reporting is patently flawed.

- Some report *more than* 100% of costs incurred on patients eligible for financial assistance than the total spent for all uninsured patients.
- Others report spending 0% on patients eligible for financial assistance.
- These numbers fluctuate each year.
  - 2007: 9 hospitals spent 100% to 419% on patients receiving FA; 9 spent 0%
  - 2008: 17 hospitals spent 100% to 826% on patients receiving FA; 9 spent 0%
  - 2009: 12 hospitals spent 100% to 482% on patients receiving FA; 18 spent 0%

# Data on financial aid application approval rates is inconsistent across hospitals

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## Approvals:

- 119 hospitals approved more than 85%; 24 approved less than 50%; 3 approved none.

## Denials:

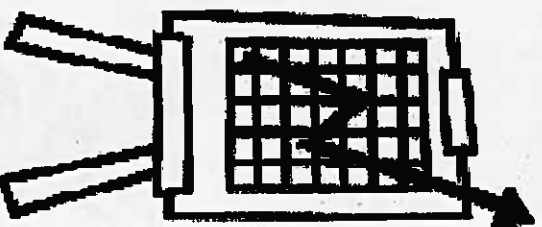
- 55 hospitals reported no denials; 37 reported denial rates of 10% or more.

## Pending:

- 94 reported no pending applications; 28 had more than 10% pending.

## Incomplete:

- 102 had no incomplete applications; 36 had more than 10% incomplete.





# The amount of financial assistance given to patients does not correlate with ICP funds received.

Hospital Name	FA apps. approved (2008)	Indigent care funds rec'd per approved app.	# Apps. approved per certified bed (2008 apps, 2011 beds)
JACOBI MEDICAL CTR	52,702	\$167	115.3
BELLEVUE HOSPITAL	69,636	\$208	76.4
KENMORE MERCY	3,078	\$308	16.7
MERCY HOSPITAL BUFFALO	8,583	\$369	22.2
ST. BARNABAS HOSPITAL	51,210	\$561	114.8
STRONG MEMORIAL	15,480	\$870	20.9
ERIE COUNTY MED CTR	3,706	\$1,137	6.7
LUTHERAN MEDICAL CTR	29,761	\$1,273	63.6
BRONX-LEBANON	18,549	\$3,235	44.7
STONY BROOK	1,243	\$5,104	2.2
MAIMONIDES	2,260	\$7,870	3.2
KALEIDA HEALTH	683	\$8,782	0.7
CORNING HOSPITAL	161	\$13,892	1.6
ROCHESTER GENERAL	620	\$20,176	1.2
MONTEFIORE	2,287	\$21,093	2.0
JAMAICA HOSPITAL	1,365	\$26,292	3.6
BEHNSRAEL MEDICAL CTR	691	\$41,065	0.8
NYU HOSPITAL CTR	256	\$41,984	0.2
LENOX HILL HOSPITAL	130	\$84,469	0.2
BROOKDALE HOSPITAL	278	\$93,929	0.5

Note: Major public hospitals also receive an additional \$1.5 B in UPL and IGT DSH payments.

The statewide average number of apps approved per certified bed is 16.

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# Many of the top hospitals reporting the highest targeted need reported lower than average financial assistance distribution relative to their size

Hospital name	Targeted need (2010) (Cost in 90% method)	Apps approved (2008)	Apps approved (2008) per certified bed (2011)
MOUNT VERNON HOSPITAL	13.5%	1553	9
ELLENVILLE REGIONAL HOSPITAL	12.4%	12	0
JAMAICA HOSPITAL	10.8%	1365	4
CATSKILL REGIONAL MED CTR	10.3%	647	4
ST JOSEPHS HOSPITAL YONKERS	10.2%	157	1
SOUND SHORE WESTCHESTER	9.3%	1341	5
INTERFAITH MEDICAL CENTER	9.1%	2012	7
BROOKDALE HOSP MED CTR	8.1%	278	1
BON SECOURS COMM HOSP	8.0%	0	0
IRA DAVENPORT MEM HOSP INC	7.7%	159	4
MOUNT SINAI HOSPITAL OF QUEENS	7.3%	1187	5
SUNY HEALTH SCIENCE CENTER	7.0%	381	1
WAYNE HEALTH CARE	6.8%	130	1
MARGARETVILLE HOSPITAL	6.0%	48	3

The statewide average number of apps approved per certified bed is 16.

# 70% of hospitals reported that more than 50% of their uncompensated care costs were due to patient bad debts.

Hospital Name	% of uncompensated care costs due to bad debt (2008)	Indigent Care pool payment (2010)	Apps approved per cert. bed
STONY BROOK	96%	\$6,344,162	2.2
CORTLAND MEMORIAL	93%	\$1,462,926	4.4
GLENS FALLS HOSP	92%	\$6,321,820	2.5
NYU HOSPITAL CENTER	90%	\$10,747,952	0.2
CORNING HOSPITAL	90%	\$2,236,620	1.6
BETH ISRAEL MEDICAL CTR	89%	\$28,375,694	0.8
JAMAICA HOSPITAL	89%	\$35,889,008	3.6
BERTERAND CHAFFEE HOSP	86%	\$412,954	0.0
BROOKDALE	85%	\$26,112,334	0.5
SUNNY DOWNSTATE	85%	\$5,411,530	17.8
JOHN T MATHER MEMORIAL	85%	\$2,344,368	5.2
NASSAU JUNY MEDICTR	85%	\$7,434,717	57.7
BROOKHAVEN MEM HOSP	82%	\$7,680,614	2.8
ROCHESTER GENERAL HOSP	81%	\$12,509,009	1.2
WYCKOFF HEIGHTS HOSP	75%	\$20,510,496	23.1
ST LUKE'S / ROOSEVELT	74%	\$37,643,016	9.4
ST BARNABAS HOSPITAL	17%	\$28,708,796	114.8

The statewide average number of apps approved per certified bed is 16.

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# Hospitals with financial aid applications that include impermissible requirements are less likely receive and approve applications.

	App. without impermissible requirements	App. with impermissible requirements
# of Hospitals	161	36
# Apps. rec'd./ Hospital	6,574	2,024
% of total apps. received	93.6%	6.4%
% of total apps. approved	93.9%	6.1%
% of total apps. denied	77.8%	22.2%
% of total apps. pending	91.0%	9.0%
% of total apps. incomplete	92.0%	8.0%
% Apps. approved	95.2%	90.0%
% Apps. denied	1.3%	5.3%
% Apps. pending	1.3%	1.9%
% Apps. incomplete	2.2%	2.8%
Avg. # apps. approved / certified bed	18.0	7.8
Total ICP funds received	\$1,051,354,685	\$131,145,315

The statewide average number of apps approved per certified bed is 16.

# Many hospitals aggressively pursue collection of bad debt by placing liens on patient homes.

Hospital name	Total Liens (2008)	Liens per bed	Apps approved per certified bed	% of uncompensated costs due to bad debt	Total indigent care pool funds received
SUNNY DOWNSTATE	1053	2.80	17.80	85%	\$5,411,530
STONY BROOK	680	1.19	2.20	96%	\$6,344,162
SARATOGA HOSPITAL	450	2.63	4.80	47%	\$2,314,574
GOOD SAM HOSP / WEST ISLIP	406	0.93	40.10	16%	\$8,480,429
MASSENA MEM HOSP	249	4.98	6.30	60%	\$1,263,935
CROUSE HOSP-COMMONWEALTH	92	0.20	1.50	68%	\$6,462,589
BROOKS MEMORIAL HOSP	77	1.18	8.80	74%	\$606,969
VASSAR BROTHERS MEDICAL CTR	72	0.20	43.00	33%	\$5,961,049
ROSWELL PARK MEMORIAL INST	71	0.53	1.10	69%	\$2,227,030
UNITED HEALTH SERVICES, INC	70	0.15	5.00	78%	\$8,005,842
SIT FRANCIS HOSP Poughkeepsie	68	0.20	18.80	45%	\$4,304,773
CORTLAND REGIONAL MED CTR	66	0.37	4.40	93%	\$1,462,926
SIT JOSEPHS HOSP OF ELMIRA	66	0.29	1.60	89%	\$1,221,417
NIAGARA FALLS MEML MED CTR	63	0.37	1.70	90%	\$1,858,979
ORANGE REGIONAL MED CTR	52	0.12	0.70	88%	\$2,778,459
CHAMPLAIN VALLEY PHYS HOSP	51	0.16	1.50	78%	\$2,178,680
ERIE COUNTY MEDICAL CTR	44	0.08	6.70	54%	\$4,213,019
NATHAN LITTAUER HOSP	38	0.51	15.10	82%	\$2,244,666
OUR LADY OF LOURDES MEM HOSP	37	0.14	11.60	89%	\$3,785,336

The statewide average number of apps approved per certified bed is 16.

DRAFT -- 09/26/11

# Impending funding issues

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DRAFT -- 09/26/11

# Changes to the federal indigent care pool funding source

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- **New DSH audit requirements:** Federal DSH payments are supposed to be used only to reimburse hospitals for uncompensated care costs for Medicaid and uninsured patients. New DSH audit requirements are more stringent on this rule:
  - States are now required to submit more information to CMS on Medicaid and uninsured costs to ensure compliance (see Appendix C).
- **How this will affect New York:** Currently, New York uses two methodologies to calculate uncompensated care: BDCC and Units of Service (see slides 17-22).
  - Both include patients who are “uninsured” and “self-pay” under the same category.
  - Hospitals will need to separate these two categories when reporting costs.
  - Bad debts also will need to be reported separately from financial assistance.

# Changes to the federal indigent care pool funding source

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- **DSH cuts under the ACA:** The ACA reduces nationwide DSH funding yearly starting in 2014, for a total cut of 50% by 2019. Preference for funding will go to states that:
  - have high rates of uninsurance.
  - have high levels of uncompensated care for Medicaid and uninsured patients.
  - target DSH funds to hospitals with high Medicaid inpatient rates.
- **How this will affect New York:**
  - New York already accounts for 14% of the federal DSH payments nationwide but only 6% of the nation's uninsured. So, any cuts made to the total available will result in a significant cut for New York.
  - These cuts will have important policy ramifications both for targeting the use of the indigent care pool to maximize access to federal DSH funds, and for reallocating state funds previously used to match newly-cut funds.



# Conclusions & Recommendations

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## **Conclusion: Unlawful hospital policies hurt low-income New Yorkers by impeding access to financial assistance.**

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- Patients who are eligible for financial assistance under the law may never receive it because:
  - They do not know financial assistance is available.
  - They have difficulty finding information on how to apply.
  - Hospitals are imposing unlawful barriers that result in incorrect denials or deter patients from applying in the first place.

## **Conclusion: There is no incentive for hospitals to offer financial assistance vs. sending patients to collections.**

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- ICP payments are made to hospitals regardless of if losses are due to bad debt or for financial assistance provided.
- The vast majority of ICP funds are used to pay hospitals for patient bad debt rather than for providing financial assistance.
  - High levels of bad debt reported in relation to financial assistance given are a disservice to low-income New Yorkers.
- Opaque hospital reporting obscures real patient need.
  - Hospital reporting is difficult to comprehend, inconsistent, and inaccurate.

# Recommendation: Improve guidance and Enforcement of the HFAL

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- There should be one single state-wide application used for financial assistance in New York.
  - Uniform application should be developed by the SDOH.
  - SDOH should mandate all ICP hospitals to use uniform application.
  - SDOH's financial assistance policy summary template should be a "floor" that all hospitals must meet at minimum.
- All hospital policies and the uniform application should be prominently posted.
  - SDOH website should include all hospital policies and the statewide application.
  - Each hospital's website should include its own policy summary as well as the statewide application.
- SDOH should perform statewide hospital audits & enforcement
  - Hospital policies and procedures should be audited to ensure compliance with the law.
  - Hospital reporting data on financial assistance applications received, approved, denied, pending, or incomplete, should be audited to ensure accuracy in reporting.

# **Recommendation: Tie distribution of ICP funds to financial aid given**

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- **Incentivize hospitals to provide financial assistance:**
  - Hospitals should be required to process all uninsured and self-pay patients for financial assistance as a requisite for receipt of ICP funds.
  - Hospitals which provide financial assistance should be prioritized for ICP payments.
  - Any funds left in the ICP after reimbursement for financial assistance should be distributed to reimburse hospitals for bad debt.

# **Recommendation: Make the distribution mechanism for ICP funds more transparent.**

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- **Adopt a 100% units of service methodology for distribution of all ICP funds.**
  - Uncompensated care costs for uninsured and self-pay patients should be reported separately
  - This will allow the State to target ICP funds to New Yorkers who don't have insurance to cover the services they need.
  - This will maximize New York's ability to avoid federal DSH funding cuts.

# Additional recommendations

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- **Provide an enhanced allocation to hospitals with higher volumes of Medicaid patients.**
  - This will protect hospitals with a high volume of Medicaid patients from losses due to the adoption of the units of service methodology, which equates hospital costs with Medicaid rates.
  - Will offer some protection from further reductions in federal DSH funds.
- **Raise the floor for financial assistance.**
  - To comply with the ACA and current state law, the Hospital Financial Assistance Law should be revised to require hospitals to provide financial assistance up to 400% of FPL (\$43,000 annually for an individual). The current asset test should also be removed.
  - More patients would benefit from getting financial assistance vs. being sent to collections.
  - Hospitals should continue to be allowed to offer financial assistance to patients with higher incomes if they so wish.

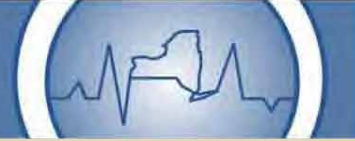
# Long-term recommendations: Back-end issues

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- **Allow pre-qualification for financial assistance.**
  - Starting with the launch of the statewide health insurance Exchange in 2014, New Yorkers who are uninsured and do not qualify for or cannot afford insurance products on the Exchange should be allowed to fill out a financial aid application annually to pre-qualify for financial assistance should they require medical care during the year.



**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Affordable Housing Work Group

FINAL RECOMMENDATIONS



## **Medicaid Redesign Team Affordable Housing Work Group Final Recommendations**

### **WORK GROUP CHARGE:**

- The work group will evaluate New York's current programs of supportive housing in reference to the reasonable availability and adequacy of those programs for the purpose of assuring that individuals unable to live independently are neither inappropriately institutionalized nor denied the availability of necessary care and services. Supportive housing will be broadly defined as any combination of market rate or subsidized housing and services that will meet the needs of the targeted populations.
- The work group will identify barriers to the efficient use of available resources for the development and utilization of supportive housing. It shall make recommendations intended to overcome those barriers, including, if appropriate, revisions of program design proscribed by statute or regulation and the reassignment of responsibilities and resources for supportive housing development and oversight.
- The work group will identify opportunities for the investment of additional resources for supportive housing that will result in savings to the Medicaid program and improvements in the quality of services to targeted individuals. It shall identify opportunities and make recommendations for enhancing private sector participation in the provision of such housing.
- In making its recommendations, the work group shall be mindful of the rights of individuals conferred upon them by the Olmstead Decision and applicable Federal and State law. It also shall be mindful of the resource limitations that affect State and local decision-making.
- The work group will create opportunities for stakeholders to contribute ideas and information and it will consult with New York City and other local governments and authorities actively engaged in the provision of housing.
- This work is related to MRT recommendation #196.



## WORK GROUP MEMBERSHIP:

- Co-Chair: James Introne, Deputy Secretary for Health and the Director of Healthcare Redesign
- Co-Chair: Ed Matthews, CEO, United Cerebral Palsy Association of New York City, President of the Interagency Council
- Laray Brown, Senior Vice President, New York City Health and Hospitals Corporation
- Steve C. Bussey, CEO, Harlem United Community AIDS Center, Inc.
- Donna Colonna, Executive Director, Services for the Underserved
- Rosanne Haggerty, President, Community Solutions
- Tony Hannigan, Executive Director, Center for Urban Community Services
- Tino Hernandez, Chief Executive Officer, Samaritan Village
- Marjorie Hill, PhD, President & CEO, Gay Men's Health Crisis
- Leon Hofman, Chief Administrator, Queens Adult Care Center
- Ted Houghton, Executive Director, Supportive Housing Network of New York
- Adam Karpati, Executive Deputy Commissioner, NYC Department of Health and Mental Hygiene
- Charles King, President & CEO, Housing Works
- Antonia M. Lasicki, J.D., Executive Director, ACLAIMH/ACL
- Ginger Lynch Landy, Co-Director, New York Chapter of the Assisted Living Federation of America
- Jason Lippman, Senior Associate for Policy and Advocacy, The Coalition of Behavioral Health Agencies, Inc.
- Diane Louard-Michel, New York Director, Corporation for Supportive Housing
- Lindsay Miller, Advocacy Coordinator, New York Association on Independent Living
- Lisa Newcomb, Executive Director, Empire State Association of Assisted Living
- Deborah Damm O'Brien, Executive Director, DePaul Management Services
- Harvey Rosenthal, Executive Director, NY Association of Psychiatric Rehabilitation Services
- Abby Jo Sigal, Vice President, Enterprise Community Partners, Inc.
- Connie Tempel, COO, Corporation for Supportive Housing
- Steve Volza, Senior Vice President for Housing, Loretto
- Bobby Watts, Executive Director, Care for the Homeless
- Elisabeth Wynn, Senior Vice President, Finance & Reimbursement, Greater NY Hospital Association



## MEETING DATES AND FOCUS:

**October 24, 2011** – Agencies with oversight of affordable and supportive housing in New York State (OMH, NYSHCR, OPWDD, OASAS, OTDA, and DOH) presented their housing related programs and services to the work group. This level setting exercise was followed by a presentation by the Executive Director of the Supportive Housing Network that provided a snapshot of the benefits of supportive housing, a census of available housing units, and some of the barriers to expanding both the housing and service opportunities that comprise supportive housing in New York State. Work group members were asked to identify barriers to creating and operating supportive and affordable housing and propose solutions that would address development, access and the provision of needed services. In addition, a subcommittee on Assisted Living Programs was recommended to expand the number of beds available for individuals in need of less intensive care who wish to remain in the community or return to the community from more restrictive institutional settings. The ALP subcommittee was also asked to propose solutions to improve the ALP program to encourage additional development and better assist individuals who rely on New York's ALP to receive needed personal and health care services.

**November 7, 2011 – ALP Subcommittee** Discussion focused on identifying issues and proposing solutions that would help the Assisted Living Program serve more individuals who require less intensive care in community settings with a high-quality level of care.

**November 21, 2011** – Staff presented a framing chart that summarized the barriers and solutions submitted by work group members between the two meetings. OMH and the Corporation for Supportive Housing presented research findings connecting the provision of supportive housing with reduced Medicaid and other public support costs. In one Massachusetts study, Medicaid costs were reduced by an estimated 41-67% due to supportive housing. In a 2011 study of NYC's HHC placement of chronically ill homeless individuals in supportive housing an average annual savings of \$14,082 per recipient in Medicaid expenditures was realized. Work group members provided vital feedback on the chart. Discussion focused on developing a list of recommendations with which all could be comfortable forwarding to the Medicaid Redesign Team. In addition, the group was asked to consider how best to invest any additional resources that may become available as a result of Medicaid savings attributable to expanded supportive housing opportunities in New York. These are the recommendations contained in this report.

**December 6, 2011** – Staff presented draft recommendations that were created based on the discussions of the previous work group meetings and submissions from a number of members. A vigorous discussion ensued on a number of important issues including: how specific to be in referencing the many populations that comprise beneficiaries of supportive housing, the need to target efforts toward high-need, high cost Medicaid recipients, the importance of assuring that other less intensive users of Medicaid and other public programs are not overlooked, recognizing the confines of two year budgeting and the Medicaid global cap, and the appropriateness of inclusion of specific proposals relative to special populations such as people living with HIV/AIDS and those at high risk of HIV infection. Ultimately, the work group agreed to move forward with the recommendations outlined below.



## OUTSIDE EXPERTS CONSULTED WITH:

No outside experts were brought in other than those serving on the work group and representatives of state agencies with oversight of affordable and supportive housing in New York State. Presentations by the Supportive Housing Network of New York (Ted Houghton) and the Corporation for Supportive Housing (Connie Temple and Diane Louard-Michel) informed the discussion of the group, as did the presentations offered by agencies overseeing housing efforts. In addition, a number of interested individuals who were not represented on the work group contributed barriers and solutions for work group members to consider in developing recommendations.

## CONTEXT :

Charged in January 2011 with recommending changes that would reduce the dramatic growth in Medicaid spending in New York while maintaining or improving health outcomes for Medicaid beneficiaries, the Medicaid Redesign Team identified increasing the availability of affordable and supportive housing for high-need Medicaid beneficiaries who are homeless, precariously housed or living in institutional settings as a significant opportunity for reducing Medicaid cost growth. There is strong and growing evidence in New York and around the country that a lack of stable housing results in unnecessary Medicaid spending --on individuals in nursing homes and hospitals who cannot be discharged only because they lack a place to live, and on repeated emergency department visits and inpatient admissions for individuals whose chronic conditions cannot be adequately managed on the streets or in shelters.<sup>1</sup> The lack of appropriate affordable housing, especially in New York's urban areas, may be a major driver of unnecessary Medicaid spending. In New York City, for example, among high cost Medicaid beneficiaries with expected high future costs identified for participation in the Chronic Illness Demonstration Project, 15 -30 percent were homeless and even more were precariously housed or living in transitional settings.<sup>2</sup> Similarly, approximately 10-15% of clients served through NYC's Managed Addiction Treatment Services (MATS) programs are homeless and over 60% are at risk of becoming homeless.<sup>3</sup>

Targeted investments in affordable and supportive housing for high need, high cost Medicaid populations can be an effective strategy for addressing high Medicaid costs. A growing body of literature shows reductions in Medicaid and other health care spending when special needs individuals are placed in supportive housing.

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<sup>1</sup> Salit, S.A., Kuhn, E.M., Hartz, A.J., Vu, J.M., & Mosso, A.L. (1998). Hospitalization costs associated with homelessness in New York City. *The New England Journal of Medicine*, **338**, 1734-1740; Kushel, M.B., Perry, S., Bangsberg, D., Clark, R. & Moss, A.R. (2002). Emergency department use among the homeless and marginally housed: Results from a community-based study. *American Journal of Public Health*, **92**, 778-784.

<sup>2</sup> SDOH data on CIDP

<sup>3</sup> "NYC Human Resources Administration MATS Vendor Reports 2011"



A preliminary analysis of Medicaid spending on individuals housed under the NY/NY III supportive housing initiative in their first year of placement found substantial reductions in annual Medicaid spending, averaging nearly \$30,000, for the highest cost individuals in the first full year after placement in housing, compared to spending in the prior three years.<sup>4</sup>

A study examining homeless individuals with alcohol problems in Seattle found that utilization of Medicaid funded health services declined by 41% in the year following program entry.<sup>5</sup> Another study examining acute care services in a large population of homeless individuals prior and subsequent to entry into a housing program found that the amount billed to Medicaid was reduced by \$4.5 million over a two year period.<sup>6</sup> In Denver, the utilization of 19 chronically homeless adults with disability was compared two years before and two years after placement in supportive housing, finding a decrease in emergency room and inpatient visits and associated costs and providing a net savings of \$4,745 per person over the 24 month period.<sup>7</sup> Numerous other studies confirm these findings,<sup>8</sup> supporting the MRT's conclusion that the provision of supportive housing can be a promising strategy for decreasing health care costs.

Extensive studies have added validity to the connection between the provision of stable, affordable housing and improved health outcomes for some of New York's most vulnerable, high-cost, high-need individuals -- those with HIV/AIDS. A randomized control trial of a housing intervention found that homeless persons with HIV who received a housing placement were twice as likely to achieve an undetectable viral load as a matched comparison group that continued to rely on "usual care" in the community.<sup>9</sup> In addition, a large randomized trial examining the impact of HIV rent supports found that health outcomes improved dramatically with increased housing stability – including a 35% reduction in emergency room visits, a 57% reduction in the number of hospitalizations, and significantly improved

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<sup>4</sup> NYC Human Resources Administration unpublished eval.

<sup>5</sup> Larimer, M.E., Malone, D.K., Garner, M.D., Atkins, D.C., Burlingham, B., Lonczak, H.S., Tanzer, K., Ginzler, J., Clifasefi, S.L., Hobson, W.G. & Marlatt, G.A. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *Journal of American Medical Association*, **301**(13), 1349-1357.

<sup>6</sup> Culhane, D.P., Metraux, S. & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, **13**, 107-163.

<sup>7</sup> Perlman, J. & Parvensky, J. (2006). *Denver housing first collaborative: Cost-benefit analysis and program outcomes report*. Denver, CO: Colorado Coalition for the Homeless.

<sup>8</sup> For a review of the literature, see Culhane, D.P. & Byrne, T. (2010). Ending chronic homelessness: Cost-effective opportunities for interagency collaboration. *Penn School of Social Policy and Practice Working Paper*.

<sup>9</sup> Buchanan, D.R., Kee, R., Sadowski, L.S. & Garcia, D. (2009). The Health Impact of Supportive Housing for HIV-Positive Homeless Patients: A Randomized Controlled Trial. *American Journal of Public Health*, 99 (Supp 3):S675-80.



mental health status.<sup>10</sup> Decreasing prospective long term avoidable costs must be taken into account in calculating the benefit of investment in affordable housing to achieve Medicaid savings. This includes housing for homeless people at any stage of HIV infection both to promote treatment adherence and to prevent transmission of the virus. It also includes housing for LGBTQ youth, who represent a significant portion of both homeless youth and of all new HIV infections, and other youth at high risk of long term homelessness and associated chronic conditions.

The evidence base for housing as an HIV health care intervention has broader implications for persons managing other chronic conditions. While the “hard markers” of HIV disease status – laboratory measures of viral load and immune function – provide particularly clear evidence of the independent impact of housing on HIV health outcomes, work group members believe that the lessons learned from this research demonstrate the importance of early intervention with safe and affordable housing to ensure effective and cost-efficient management of any chronic health condition.

Although the mandate of the MRT Affordable Housing Workgroup was to find opportunities for supportive housing to reduce Medicaid spending, it is important to note that there are populations in need of supportive housing that are not high-cost users of Medicaid and that supportive housing has been and must continue to be a successful intervention for these households. It should also be noted that even those supportive housing eligible households who are not currently high-cost Medicaid users often belong to populations that tend to be either high-cost users of other systems (for example, public hospitals, the criminal justice system and shelter systems) and/or at-risk of being high-cost users of Medicaid should their housing crises continue. Moreover, in looking at potential reductions in costs to Medicaid, there are certain groups who are not currently high-cost users of Medicaid, such as persons with HIV and persons at highest risk of HIV, who will become high-cost users in future years without appropriate interventions, which may include affordable or supportive housing.

Finally, it is important to note that where “supportive” housing is referenced throughout the below recommendations the term has meaning well beyond the housing-with-services-attached model in New York that this term is often used to describe. The creation of affordable, accessible and integrated housing for all New Yorkers who require publicly supported housing and related support services should be the priority objective of this workgroup’s recommendations to ensure housing and community-based supports are provided in the most integrated setting appropriate to the individual being served, as required by the Olmstead Decision.

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<sup>10</sup> Wolitski, R. J., Kidder, D. P., Pals, S. L., Royal, S., Aidala, A., Stall, R., Holtgrave, D. R., et al. (2010). Randomized trial of the effects of housing assistance on the health and risk behaviors of homeless and unstably housed people living with HIV. *AIDS & Behavior*, 14(3), 493-503.



SUMMARY LISTING OF RECOMMENDATIONS:

**A. PROPOSALS FOR INVESTING IN NEW AFFORDABLE HOUSING CAPACITY**

- 1. Work with New York City to develop a NY/NY IV agreement and with other interested counties to make a similar commitment that will provide integrated funds for capital, operating expenses/rent and services in new supportive housing units targeting high-cost, high need users of Medicaid, especially those transitioning out of restrictive institutional settings. State housing and health and human services agencies should participate in the process.** Key to expanding supportive housing opportunities across the state is the ability to ensure that units developed are available and accessible to individuals in need through sufficient funding for capital, operating costs (including rent subsidies), and related support services. A supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing. Accordingly, a new NY/NY agreement /partnership should be developed to target these individuals. As such an initiative may generate significant Medicaid savings to the federal government, a substantial federal investment should supplement the monies the state and localities can invest in supportive housing.
- 2. Establish a formal mechanism to set aside a portion of Medicaid and non-Medicaid savings related to any reduction of inpatient hospital or nursing home capacity to a fund dedicated to housing development.** It is important to recognize the connection between adequate and accessible supportive housing and adequate funding of services and Medicaid savings. A portion of any closure savings should be mandated to be invested in housing related programs. These savings should be reinvested in the development of new and rehabilitated housing, both scattered site and congregate, as well as the supports necessary to ensure that vulnerable populations receive the services they need to maximize expected outcomes. Many work group members were interested in exploring related, non-Medicaid savings to other public programs for reinvestment within the communities where the savings were recouped, if unmet needs were extant.
- 3. A portion of the \$75 million in the SFY 2012-13 MRT funding allocation plan should be transferred to OMH, OTDA and HCR for distribution through HHAP, OMH programs, Housing Trust Fund and tax-exempt bond programs. OPWDD programs should also be considered for investment.** This will allow the funding to leverage substantial additional public and private investment, will ensure quick distribution of the funds, and create integrated housing opportunities for people with mental illness, substance abuse, chronic illnesses and developmental disabilities. Recent funding challenges at all levels of government have jeopardized supportive housing development, access and services. Immediate assistance directed toward stabilizing supportive housing production targeted toward those with the most intensive needs will go a long way toward restoring investor and developer confidence, as well as ensuring adequate funding for both single site and new scatter site housing units. This funding may also be used as a non-capital resource to be





distributed to agencies that provide supports to targeted populations, including OASAS and the AIDS Institute. While there are significant needs across many vulnerable populations, it is imperative that initial MRT housing investment efforts focus on adding system capacity for high-need, high cost Medicaid beneficiaries. Research indicates that the greatest savings to public services programs are generated when resources are targeted at individuals with the most cost intensive needs. In this way, New York can maximize its investment and recoup greater savings, a portion of which may be reinvested in other supportive housing efforts.

- 4. OMH capital and operating funding should be unfrozen for supportive housing for SFY2012-13 and SFY2013-14.** The OMH development model results in significant savings that help support the cost of operation and services in supportive housing created to shelter those struggling with mental illnesses. Making this investment in the coming budget cycle will ensure that the anticipated supply of stable and secure housing remains available to homeless and deinstitutionalized persons receiving critical mental health services.
- 5. Set-asides and incentives for supportive housing construction in HCR Qualified Allocation Plan should be evaluated and considered for an increase when awarding federal Low-income Housing Tax Credits.** Increasing the share of HCR tax credits that go to supportive housing to would allow the state to further target existing resources to additional vulnerable populations, like high-cost Medicaid users. Tax credit allocations for supportive housing can be increased by adjusting requirements of the State's Qualified Allocation Plan (QAP) for tax credits, such as increasing the typical HCR supportive housing set aside to \$6 million and requiring developers qualifying for set-aside funds to reserve 50% rather than 30% of their units for supportive housing. Careful consideration should be given to mandating rather than encouraging developers to set-aside a minimum of 15% of units for special needs populations, requiring a minimum percentage of all units developed be made affordable to individuals living on extremely low incomes well below 30% AMI. These set asides require tradeoffs against other housing related goals. The tradeoffs need to be carefully considered before any changes can be made.
- 6. Include in MRT 1115 Medicaid waiver funding for ongoing housing services and supports and operating costs.** Supportive housing has been shown to reduce the cost of public services, including Medicaid, by stabilizing the conditions of its beneficiaries. People who are securely housed with sufficient resources to maintain that housing and the ability to receive needed services through their housing connection are much more likely to achieve expected outcomes such as health maintenance, reduced drug and alcohol abuse, and medication management. However, it is not enough to provide funding to support the development of additional housing units. Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing, including realized savings.



- 7. Explore the creation of a pilot program of “social impact investment bonds” that would pay for development, operations and services in supportive housing.** Social impact investment bonds are a relatively new mechanism that allows qualified nonprofits to assume the risk typically undertaken by government to address a specific societal need such as homelessness or reducing criminal justice recidivism. The nonprofit would propose an intervention intended to address a stated problem and contract with the state and/or local government to be repaid for the cost of implementing the intervention if targeted savings to the government(s) were achieved. The contract could allow for payments exceeding the cost of the intervention if greater savings were achieved. This mechanism to leverage private investment for the public good has begun to take hold in several communities. Similar programs have been undertaken in the UK and Massachusetts is currently developing an RFP for nonprofits to develop an intervention that would reduce the Medicaid costs associated with hospital and ER overuse due to chronic illness in the homeless population. This initiative should be explored in tandem with the MRT 1115 Medicaid Waiver.

## **B. COLLABORATION/COORDINATION OF SUPPORTIVE HOUSING POLICY**

- 1. Establish an interagency council of state and local agency representatives to assist with coordination and implementation of supportive housing policy.** Overlapping regulatory frameworks, programs and services may be a disincentive to private investment and development of additional supportive housing units and generally complicates the provision of housing and related services to affected populations. Efficiencies can be achieved if agencies regularly engaged in policy discussions related to supportive housing, shared best practices, and pooled resources. The content and timing of RFPs and other funding allocations would be considered by the council. In addition, a needs assessment exercise should be undertaken to identify high-cost, high-need Medicaid users among all special needs populations and in all types of settings. This analysis should inform state and local policy makers as they seek to address the needs of the targeted populations to achieve the greatest impact on health and quality of life outcomes.
- 2. Establish a work group of experienced State and local agency representatives, nonprofit providers, supportive housing experts, and housing development professionals to identify and improve the supportive/affordable housing capital development process with a focus on identifying ways to maximize federal and private funding leverage and replicating state and local agency best practices. Work group efforts should be coordinated with the Regional Economic Development Councils. Recommendations should:** a) improve coordination of multiple agency funding application processes; b) coordinate awards of capital, service and operating funds; c) address need for adequate pre-development and acquisition funds; d) review regulatory requirements and make recommendations that provide for more flexibility and innovation; e) reassure investors about State service and operating funding commitments; f) ensure an adequate share of tax-exempt bonds are



made available for affordable and supportive housing; g) align program and funding structures to be more responsive to concerns of underwriters; h) streamline development and construction oversight in multiagency projects; i) create state financed development targets in each community, with a focus on additional state rent subsidies and maximization of existing resources; and j) benchmark the original NY/NY III rollout plan and expedite development according to the agreement. Recommendations of this working group should be submitted to the Governor's Office by July 1, 2012. These issues are complex and require more time to address than was available to the Affordable Housing Workgroup, which identified the issues most harmful to sustained capital development for further study.

3. **Evaluate perceived barriers to proper utilization of existing supportive housing units such as the state's interpretation of Section 504 requirements for accessible housing, whether existing special needs stock reserved for those with mobility impairments are occupied by such individuals, whether providers are maximizing opportunities for accessible housing units and whether effective compliance reviews are included in regulatory agreements for set-aside projects. Additionally, identify and target existing and new resources to fund rental subsidies for all high-cost Medicaid populations.** A number of work group members indicated that the state and local governments should review existing regulatory guidance with an eye toward granting providers greater flexibility to develop innovative solutions to the growing crisis of inadequate development of new housing and maximizing existing resources. Along these lines, state and local officials should identify potential resources, such as tenant-based Section 8 Housing Choice Vouchers, PHA units, HUD 811 programs, and existing HCR housing stock, for rental subsidies that could be targeted for high-cost Medicaid users.
  
4. **a) Establish an additional State-led work group that includes sector experts to identify barriers to moving high-need individuals into supportive housing. This work group's charge would include identifying the need and developing subsequent targets for heavy Medicaid users. This work group will review state and local application procedures, eligibility guidelines, and waitlist policies; and develop solutions that may include new assessment tools, geographically-based registries of highest need individuals and new service models.**  
  
**b) This work group should also design a "Moving On" Initiative to incentivize and support tenants who are ready to or already live in independent housing. This group will identify resources as well as incentives and supports needed to support this effort including: a) supporting and enhancing NYHousingSearch.gov to all existing supportive and affordable housing units using the current HCR effort as a platform; b) creating backfill strategies for MRT priority populations, c) establishing a viable, ongoing safety net and crisis response**



system for graduated tenants that will allow them to maintain independence, d) setting targets and timelines for results, f) assessing the adequacy of funding and services of existing housing resources to ensure that they remain viable and have the ability to serve priority populations, and g) evaluating mechanisms for supporting tenants whose chief barrier to independent living is a lack of a cap on the tenant contribution in subsidized rental programs such as the enhanced rental assistance program for people with HIV disease/AIDS.

Recommendations for both areas should be submitted to the Governor's Office by December 1, 2012. The work group should include representatives from newly formed health homes projects so that these high-users of Medicaid may have their housing needs addressed in a community-based setting. Research indicates that savings to Medicaid and other public programs are greatest when the targeted beneficiary group is comprised of heavy users of public services. Resolving barriers to transitioning high-need individuals from restrictive institutional settings offers a significant return on investment and is also likely to improve expected outcomes from the provision of services. One way to maximize existing supportive housing resources is to ensure that those capable of living successfully in more independent housing are supported and encouraged. Developing adequate incentives and supports may assist this transition, ensure that it holds and free up existing resources for new beneficiaries. Expediting this transition and taking advantage of synergies that exist with similar State undertakings are key to maximizing Medicaid savings and supportive housing reinvestment.

## C. ALP REFORM

The Medicaid Assisted Living Program was enacted in 1991. While it has been a good resource to help divert recipients from more costly nursing homes placements, the program design needs to be modernized. Below is a series of reform recommendations that will help move the program forward as an interim step in the eventual move to a managed long term care/care coordination policy. Many of these recommendations will require changes to state law.

### 1. Reform the State's Medicaid Assisted Living Program; specifically by:

- a) **Allowing the Registered Nurse (RN) employed by the ALP's Licensed Home Care Services Agency (LHCSA) to conduct assessments to determine initial and ongoing clinical eligibility for ALP services.** Current law requires that the Certified Home Health Agency (CHHA) or Long Term Home Health Care Program (LTHHCP) with which the ALP contracts must conduct all resident assessments to determine that the person is clinically eligible for the program. The ALP provider must pay the CHHA for all post-admission assessments, and the CHHA bills Medicaid separately for the pre-admission assessment. Unfortunately, due to lack of resources in some regions, and changes in CHHA reimbursement and resulting changes in business practices, ALPs are struggling to get CHHAs and LTHHCPs to conduct these assessments. The result is a delay in accessing the assessments and commensurate



necessary services. At times, this leads to unnecessary nursing home placement. The ALP's RN, employed by their LHCSA, is appropriately licensed and qualified to conduct all such assessments, which would save money for both the ALP provider and the State. This type of admission process is consistent with how assessments are conducted in nursing homes and home care, enabling quicker admissions to their programs. This recommendation is intended to increase the likelihood that medically eligible people are admitted into the ALP, consistent with the state's goals to provide services to individuals in the most integrated setting possible. Checks and balances in the process of determining appropriateness of admissions and retention of residents would continue to be achieved through the local department of social service's review of clinical eligibility determination (discussed below), as well as the Department of Health surveillance process.

- b) With regard to the pre-admission assessment, we propose that the ALP receive additional Medicaid reimbursement but at a lesser rate than what the CHHA is currently paid, thereby saving the State additional funds.** The start date of care for would be the day after the assessment is completed.
- c) Expediting enrollment into ALPs by allowing for an individual to be admitted to an ALP without an assessment conducted by local department of social services (LDSS) or HRA prior to admission. Rather, the LDSS can conduct post-admission audits to ensure appropriate admissions.** Currently, an ALP resident must go through a "triple screen" before being admitted to the ALP: being evaluated by the ALP, CHHA or LTHHCP and local district. This means that admissions rarely happen quickly. The goal of this provision is to speed up this process and prevent unnecessary nursing home placement. This change is consistent with recent changes in managed care; PACE and MLTC are subject to a retroactive review.
- d) Repealing the section of social services law that requires a reduction in nursing home beds to create new ALP beds, but maintain the expansion of the ALP.** The beds would be available to any eligible applicant through a modified Certificate of Need process or RFP.
- e) Lifting the moratorium on CHHAs to enable ALPs to serve their residents.** ALPs could more effectively deliver services and manage the care of their residents if enabled to do so directly through CHHA services. The state is currently evaluating lifting the CHHA moratorium in certain circumstances, where doing so will further MRT initiatives. Allowing ALPs to develop CHHAs will further MRT initiatives and allow more integrated service delivery so ALPs should be one of the priority groups considered under the emergency regulation pending with the Public Health and Planning Council.
- f) Allowing ALPs the option to utilize their LHCSA home health aides to perform all functions within their scope of practice/tasks.** We propose that HHAs working in an ALP setting should be able to perform the functions that their training allows them to perform. Access problems are growing because the CHHAs/LTHCCPs with which the ALPs contract are unable or unwilling to provide some home health aide level services commonly needed by the elderly in the ALP (i.e. eye, nose, and ear drops, nebulizers, etc.) Further, it has been confusing for providers to understand the limitations of the HHA in the ALP. ALPs should



have the option to use the certified home health aides that they employ in their LHCSA to perform functions within their scope of tasks. Just as they provide supervision of aides for personal care tasks provided to residents (i.e. Activities of Daily Living-ADLs), the ALP's RN could provide the required aide supervision for the home health tasks.

- g) Enabling the ALP to contract with more than one CHHA or LTHHCP.** Current statute limits the contracting relationship to a single entity (requiring authorization for more in limited circumstances). Allowing the ALP more flexibility to contract with multiple entities would allow it to serve residents most efficiently. This will also allow more consumer choice.
- h) Allowing ALPs to access Medicare-covered therapy services from providers other than CHHAs or LTHHCPS.** Regulations state that the ALP must contract with a CHHA or LTHHCP for "nursing and therapy services." The Department of Health interprets this to mean that the contracted CHHA or LTHHCP is the only organization that may provide such services. However, there are circumstances where an ALP resident can appropriately receive physical therapy, occupational therapy and/or speech therapy services from another entity. For instance, maintenance Physical Therapy is available from private PT companies under a different Medicare benefit. In addition, nursing homes licensed to provide outpatient therapies that are located on the same campus as ALPs could provide therapies under a different Medicare benefit. ALP residents' right to choose providers should be promoted so that they have access to all of their Medicare benefits. Allowing ALPs to access therapies from other outpatient therapy providers will also allow more flexibility and more efficient service delivery. Because the ALP is responsible for any *Medicaid*-covered therapy services within its capitated rate, this change would not incur any additional costs to the state.
- i) Improving the ALP survey process.** Currently, the ALP survey process is disjointed. The ALP is surveyed as its components (ACF, home care and ALP) rather than an integrated program. At times, the requirements conflict or do not serve the best interests of the residents. Integrated training for surveyors joint ACF/ALP and home care surveys would facilitate a more integrated approach.
- j) Developing a forum to revisit the ALP program in one year to evaluate implementation of these reforms and determine what more change is needed.** Develop a forum of all interested parties to evaluate the implementation of these recommendations and to consider other changes to improve the program by meeting the growing demand in the most cost effective, efficient manner possible. The impact of the Medicaid Redesign Team's initiatives, including the expansion of Medicaid Managed Care and the implementation of the uniform assessment system, will be considered, as well as additional changes that may be warranted to streamline administrative functions and costs and expand access to assisted living.



#### D. ADDITIONAL RECOMMENDATIONS

- 1. Explore ways that community health centers (e.g. Federally Qualified Health Centers) can be co-located with supportive housing environments to provide additional supports and services to high-need populations, including primary and behavioral health care.** Making additional services easily accessible to the populations benefitting from supportive housing may afford state and local governments certain efficiencies and improve the health and well being of residents.
- 2. Encourage communities to support populations in need of supportive and affordable housing by evaluating whether local requirements could be aligned to require community "notice and best effort education."** Discrimination against developing supportive housing in local communities affects the ability to raise capital, develop additional housing units and maintain vulnerable populations in integrated community settings. Current practice in some localities requires community approval for new units and where this has been changed to "notice and best effort education," policy barriers to development have been ameliorated.
- 3. Address concerns about independent senior housing by: clearly defining independent senior housing in regulation; streamlining regulatory barriers to improve outcomes and achieve efficiencies; identifying resources to develop and preserve quality independent affordable housing for seniors that can serve as a platform for services to maximize their ability to be maintained in their homes and communities; and identifying new funding sources and new services from best practices in the supportive housing industry to support independent senior housing.** With the proportion of aged individuals in our population growing at a rapid rate, there is considerable need for a broad range of options for senior living. Currently, the variety of senior housing options is not well delineated and the landscape of offerings often confuses potential residents and their caregivers. Work group members seek to ensure that New York's aged individuals are not forgotten in the quest for adequate, safe and secure housing -- whether publicly supported or not.
- 4. Ensure continuation of housing subsidies provided through the NHTD/TBI Medicaid Waivers after the transition to Managed Long Term Care (MLTC) and that these programs, and their housing focus, are fully incorporated into MLTC and other Care Coordination Models.** These waiver models provide important examples of the effectiveness of combining housing with needed supports and services to successfully transition individuals into integrated community settings from restrictive institutional settings.
- 5. Develop programs that serve the short term needs of people who need a temporary increase in the level of care in order to avoid hospitalization and emergency departments or in order to be discharged in a timely fashion (e.g. crisis intervention, hospital diversion, hospital step-down programs and medical respite care).** Some OMH certified residential beds could be converted to this use for mental health clients. OASAS-funded crisis centers should be upgraded to be eligible for Medicaid reimbursement as an alternative to more expensive forms of detox and drug treatment.



- 6. Health Homes should work with supportive housing providers to insure their residents and clients have maximum opportunities for inclusion and that the supportive housing provider has the opportunity to participate in service coordination.** It is important that as New York State undertakes Medicaid Redesign that efforts are coordinated to maximize positive impacts, improving health outcomes and achieving better value in its investment.





## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A1

**Recommendation Short Name:** New York/New York IV Agreement

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** TBD

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

### Proposal Description:

**Work with New York City to develop a NY/NY IV agreement and with other interested counties to make a similar commitment that will provide integrated funds for capital, operating expenses/rent and services in new supportive housing units targeting high-cost, high need users of Medicaid, especially those transitioning out of restrictive institutional settings. State housing and health and human services agencies should participate in the process.** Key to expanding supportive housing opportunities across the state is the ability to ensure that units developed are available and accessible to individuals in need through sufficient funding for capital, operating costs (including rent subsidies), and related support services. A supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing. Accordingly, a new NY/NY agreement /partnership should be developed to target these individuals. As such an initiative may generate significant Medicaid savings to the federal government, a substantial federal investment should supplement the monies the state and localities can invest in supportive housing.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities through a NY/NY IV partnership is expected to address the most severely impacted Medicaid recipients in need of housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

A supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing a large investment like NY/NY IV on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs in order to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A2

**Recommendation Short Name:** Establish dedicated fund for housing development

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** TBD

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Establish a formal mechanism to set aside a portion of Medicaid and non-Medicaid savings related to any reduction of inpatient hospital or nursing home capacity to a fund dedicated to housing development.** It is important to recognize the connection between adequate and accessible supportive housing and adequate funding of services and Medicaid savings. A portion of any closure savings should be mandated to be invested in housing related programs. These savings should be reinvested in the development of new and rehabilitated housing, both scattered site and congregate, as well as the supports necessary to ensure that vulnerable populations receive the services they need to maximize expected outcomes. Many work group members were interested in exploring related, non-Medicaid savings to other public programs for reinvestment within the communities where the savings were recouped, if unmet needs were extant.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

A supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing. By reinvesting Medicaid and non-Medicaid savings in a fund dedicated to housing development and support, supportive housing opportunities in the state may be expanded cost-effectively.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing investment on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs in order to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A3

**Recommendation Short Name:** Provide immediate support to SH development

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**A portion of the \$75 million in the SFY 2012-13 MRT funding allocation plan should be transferred to OMH, OTDA and HCR for distribution through HHAP, OMH programs, Housing Trust Fund and tax-exempt bond programs. OPWDD programs should also be considered for investment.** Required funding challenges at all levels of government have jeopardized supportive housing development, access and services. Immediate assistance directed toward stabilizing supportive housing production targeted toward those with the most intensive needs will go a long way toward restoring investor and developer confidence, as well as ensuring adequate funding for both single site and new scatter site housing units. This funding may also be used as a non-capital resource to be distributed to agencies that provide supports to targeted populations, including OASAS and the AIDS Institute. While there are significant needs across many vulnerable populations, it is imperative that initial MRT housing investment efforts focus on adding system capacity for high-need, high cost Medicaid beneficiaries. Research indicates that the greatest savings to public services programs are generated when resources are targeted at individuals with the most cost intensive needs. In this way, New York can maximize its investment and recoup greater savings, a portion of which may be reinvested in other supportive housing efforts.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

A supportive housing program targeted to heavy Medicaid users is likely to return the greatest savings to the state, local and federal governments in terms of reduced hospitalizations, reduced lengths of stay in long term care facilities, and unnecessary Emergency Room visits as well as improved outcomes from supportive services provided in stable, affordable housing.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing investment on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs in order to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A4

**Recommendation Short Name:** Unfreeze OMH capital funding

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** SFY 2012-2013; SFY 2013-2014

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**OMH capital and operating funding should be unfrozen for supportive housing for SFY2012-13 and SFY2013-14.** The OMH development model results in significant savings that help support the cost of operation and services in supportive housing created to shelter those struggling with mental illnesses. Making this investment in the coming budget cycle will ensure that the anticipated supply of stable and secure housing remains available to homeless and deinstitutionalized persons receiving critical mental health services.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### Benefits of Recommendation:

The OMH development model results in significant savings that help support the cost of operation and services in supportive housing created to shelter those struggling with mental illnesses.



**Concerns with Recommendation:**

Budgetary trade-offs in a time of need across the State.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs in order to address their illness or condition and generate savings to the Medicaid program because their care is better managed.





## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A5

**Recommendation Short Name:** Increase set-asides and incentives for supportive housing

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Set-asides and incentives for supportive housing construction in HCR Qualified Allocation Plan should be evaluated and considered for an increase when awarding federal Low-income Housing Tax Credits.**

Increasing the share of HCR tax credits that go to supportive housing would allow the state to further target existing resources to additional vulnerable populations, like high-cost Medicaid users. Tax credit allocations for supportive housing can be increased by adjusting requirements of the State's Qualified Allocation Plan (QAP) for tax credits, such as increasing the typical HCR supportive housing set aside to \$6 million and requiring developers qualifying for set-aside funds to reserve 50% rather than 30% of their units for supportive housing. Careful consideration should be given to mandating rather than encouraging developers to set-aside a minimum of 15% of units for special needs populations, requiring a minimum percentage of all units developed be made affordable to individuals living on extremely low incomes well below 30% AMI. These set asides require tradeoffs against other housing related goals. The tradeoffs need to be carefully considered before any changes can be made.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

Increasing the share of HCR tax credits that go to supportive housing would allow the state to further target existing resources to additional vulnerable populations, like high-cost Medicaid users.

### **Concerns with Recommendation:**

These set asides require tradeoffs against other housing related goals. The tradeoffs need to be carefully considered before any changes can be made.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs in order to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A6

**Recommendation Short Name:** Include funds for ongoing services and operating costs in MRT 1115 Medicaid Waiver

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

### Proposal Description:

**Include in MRT 1115 Medicaid waiver funding for ongoing housing services and supports and operating costs.** Supportive housing has been shown to reduce the cost of public services, including Medicaid, by stabilizing the conditions of its beneficiaries. People who are securely housed with sufficient resources to maintain that housing and the ability to receive needed services through their housing connection are much more likely to achieve expected outcomes such as health maintenance, reduced drug and alcohol abuse, and medication management. However, it is not enough to provide funding to support the development of additional housing units. Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing, including realized savings.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



**Benefits of Recommendation:**

Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing, including realized savings.

**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** A7

**Recommendation Short Name:** Pilot "Social Impact Investment Bonds" for SH

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** TBD

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Explore the creation of a pilot program of “social impact investment bonds” that would pay for development, operations and services in supportive housing.** Social impact investment bonds are a relatively new mechanism that allows qualified nonprofits to assume the risk typically undertaken by government to address a specific societal need such as homelessness or reducing criminal justice recidivism. The nonprofit would propose an intervention intended to address a stated problem and contract with the state and/or local government to be repaid for the cost of implementing the intervention if targeted savings to the government(s) were achieved. The contract could allow for payments exceeding the cost of the intervention if greater savings were achieved. This mechanism to leverage private investment for the public good has begun to take hold in several communities. Similar programs have been undertaken in the UK and Massachusetts is currently developing an RFP for nonprofits to develop an intervention that would reduce the Medicaid costs associated with hospital and ER overuse due to chronic illness in the homeless population. This initiative should be explored in tandem with the MRT 1115 Medicaid Waiver.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing, including realized savings. This type of approach is consistent with pay for performance models. Innovative funding sources will allow the state to address specific needs that may be underfunded or unexplored in traditional approaches.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** B1

**Recommendation Short Name:** Improve interagency coordination of supportive housing policy and implementation

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** ASAP

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

### Proposal Description:

**Establish an interagency council of state and local agency representatives to assist with coordination and implementation of supportive housing policy.** Overlapping regulatory frameworks, programs and services may be a disincentive to private investment and development of additional supportive housing units and generally complicates the provision of housing and related services to affected populations. Efficiencies can be achieved if agencies regularly engaged in policy discussions related to supportive housing, shared best practices, and pooled resources. The content and timing of RFPs and other funding allocations would be considered by the council. In addition, a needs assessment exercise should be undertaken to identify high-cost, high-need Medicaid users among all special needs populations and in all types of settings. This analysis should inform state and local policy makers as they seek to address the needs of the targeted populations to achieve the greatest impact on health and quality of life outcomes.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



**Benefits of Recommendation:**

Coordinating the supportive/affordable housing efforts of the state across all agencies that oversee programs in these areas will improve the efficacy of these programs and services in New York State.

**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.





## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** B2

**Recommendation Short Name:** Establish a work group to identify and improve the supportive/affordable housing capital development process

**Program Area:** Housing

**Implementation Complexity:** Low

**Implementation Timeline:** Report by July 1, 2012

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

**Proposal Description:**

Establish a work group of experienced State and local agency representatives, nonprofit providers, supportive housing experts, and housing development professionals to identify and improve the supportive/affordable housing capital development process with a focus on identifying ways to maximize federal and private funding leverage and replicating state and local agency best practices. Work group efforts should be coordinated with the Regional Economic Development Councils. Recommendations should: a) improve coordination of multiple agency funding application processes; b) coordinate awards of capital, service and operating funds; c) address need for adequate pre-development and acquisition funds; d) review regulatory requirements and make recommendations that provide for more flexibility and innovation; e) reassure investors about State service and operating funding commitments; f) ensure an adequate share of tax-exempt bonds are made available for affordable and supportive housing; g) align program and funding structures to be more responsive to concerns of underwriters; h) streamline development and construction oversight in multiagency projects; i) create state financed development targets in each community, with a focus on additional state rent subsidies and maximization of existing resources; and j) benchmark the original NY/NY III rollout plan and expedite development according to the agreement. Recommendations of this working group should be submitted to the Governor's Office by July 1, 2012.



**Financial Impact:** TBD

**Health Disparities Impact:**

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

**Benefits of Recommendation:**

These issues are complex and require more time to address than was available to the Affordable Housing Workgroup, which identified the issues most harmful to sustained capital development for further study.

**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** B3

**Recommendation Short Name:** Evaluate perceived barriers to maximizing existing resources and expanding opportunities

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Evaluate perceived barriers to proper utilization of existing supportive housing units such as the state's interpretation of Section 504 requirements for accessible housing, whether existing special needs stock reserved for those with mobility impairments are occupied by such individuals, whether providers are maximizing opportunities for accessible housing units and whether effective compliance reviews are included in regulatory agreements for set-aside projects. In addition, identify and target existing and new resources to fund rental subsidies for all high-cost Medicaid populations.** A number of work group members indicated that the state and local governments should review existing regulatory guidance with an eye toward granting providers greater flexibility to develop innovative solutions to the growing crisis of inadequate development of new housing and maximizing existing resources. Along these lines, state and local officials should identify potential resources, such as tenant-based Section 8 Housing Choice Vouchers, PHA units, HUD 811 programs, and existing HCR housing stock, for rental subsidies that could be targeted for high-cost Medicaid users.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

While creating more units of housing is important, it is also imperative that the existing system of housing and supports is preserved and that existing resources are maximized to serve the greatest number of individuals in need of supportive and/or affordable housing.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** B4

**Recommendation Short Name:** Identify and resolve barriers to transitioning individuals to supportive housing; Establish “Moving On” initiative

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** Establish in first quarter of 2012; Report December 1, 2012

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

**Proposal Description:**

a) Establish an additional State-led work group that includes sector experts to identify barriers to moving high-need individuals into supportive housing. This work group’s charge would include identifying the need and developing subsequent targets for heavy Medicaid users. This work group will review state and local application procedures, eligibility guidelines, and waitlist policies; and develop solutions that may include new assessment tools, geographically-based registries of highest need individuals and new service models.

b) This work group should also design a “Moving On” Initiative to incentivize and support tenants who are ready to or already live in independent housing. This group will identify resources as well as incentives and supports needed to support this effort including: a) supporting and enhancing NYHousingSearch.gov to all existing supportive and affordable housing units using the current HCR effort as a platform; b) creating backfill strategies for MRT priority populations, c) establishing a viable, ongoing safety net and crisis response system for graduated tenants that will allow them to maintain independence, d) setting targets and timelines for results, f) assessing the adequacy of funding and services of existing housing resources to ensure that they remain viable and have the ability to serve priority populations, and g) evaluating mechanisms for supporting tenants whose chief barrier to independent living is a lack of a cap on the tenant contribution in subsidized rental programs such as the enhanced rental assistance program for people with HIV disease/AIDS.



**Recommendations for both areas should be submitted to the Governor's Office by December 1, 2012. The work group should include representatives from newly formed health homes projects so that these high-users of Medicaid may have their housing needs addressed in a community-based setting.** Research indicates that savings to Medicaid and other public programs are greatest when the targeted beneficiary group is comprised of heavy users of public services. Resolving barriers to transitioning high-need individuals from restrictive institutional settings offers a significant return on investment and is also likely to improve expected outcomes from the provision of services. One way to maximize existing supportive housing resources is to ensure that those capable of living successfully in more independent housing are supported and encouraged. Developing adequate incentives and supports may assist this transition, ensure that it holds and free up existing resources for new beneficiaries. Expediting this transition and taking advantage of synergies that exist with similar State undertakings are key to maximizing Medicaid savings and supportive housing reinvestment.

**Financial Impact:** TBD

**Health Disparities Impact:**

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

**Benefits of Recommendation:**

Resolving barriers to transitioning high-need individuals from restrictive institutional settings offers a significant return on investment and is also likely to improve expected outcomes from the provision of services. The "Moving On" Initiative will help make use of existing resources.

**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** C1

**Recommendation Short Name:** ALP Reform

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**  Administrative Action  Statutory Change

State Plan Amendment  Federal Waiver

### Proposal Description:

#### 2. Reform the State's Medicaid Assisted Living Program; specifically by:

- a) **Allowing the Registered Nurse (RN) employed by the ALP's Licensed Home Care Services Agency (LHCSA) to conduct assessments to determine initial and ongoing clinical eligibility for ALP services.** Current law requires that the Certified Home Health Agency (CHHA) or Long Term Home Health Care Program (LTHHCP) with which the ALP contracts must conduct all resident assessments to determine that the person is clinically eligible for the program. The ALP provider must pay the CHHA for all post-admission assessments, and the CHHA bills Medicaid separately for the pre-admission assessment. Unfortunately, due to lack of resources in some regions, and changes in CHHA reimbursement and resulting changes in business practices, ALPs are struggling to get CHHAs and LTHHCPs to conduct these assessments. The result is a delay in accessing the assessments and commensurate necessary services. At times, this leads to unnecessary nursing home placement. The ALP's RN, employed by their LHCSA, is appropriately licensed and qualified to conduct all such assessments, which would save money for both the ALP provider and the State. This type of admission process is consistent with how assessments are conducted in nursing homes and home care, enabling quicker admissions to their programs. This recommendation is intended to increase the likelihood that medically eligible people are admitted into the ALP, consistent with the state's goals to provide services to individuals in the most integrated setting possible.



Checks and balances in the process of determining appropriateness of admissions and retention of residents would continue to be achieved through the local department of social service's review of clinical eligibility determination (discussed below), as well as the Department of Health surveillance process.

- b) With regard to the pre-admission assessment, we propose that the ALP receive additional Medicaid reimbursement but at a lesser rate than what the CHHA is currently paid, thereby saving the State additional funds.** The start date of care for would be the day after the assessment is completed.
  
- c) Expediting enrollment into ALPs by allowing for an individual to be admitted to an ALP without an assessment conducted by local department of social services (LDSS) or HRA prior to admission. Rather, the LDSS can conduct post-admission audits to ensure appropriate admissions.** Currently, an ALP resident must go through a "triple screen" before being admitted to the ALP: being evaluated by the ALP, CHHA or LTHHCP and local district. This means that admissions rarely happen quickly. The goal of this provision is to speed up this process and prevent unnecessary nursing home placement. This change is consistent with recent changes in managed care; PACE and MLTC are subject to a retroactive review.
  
- d) Repealing the section of social services law that requires a reduction in nursing home beds to create new ALP beds, but maintain the expansion of the ALP.** The beds would be available to any eligible applicant through a modified Certificate of Need process or RFP.
  
- e) Lifting the moratorium on CHHAs to enable ALPs to serve their residents.** ALPs could more effectively deliver services and manage the care of their residents if enabled to do so directly through CHHA services. The state is currently evaluating lifting the CHHA moratorium in certain circumstances, where doing so will further MRT initiatives. Allowing ALPs to develop CHHAs will further MRT initiatives and allow more integrated service delivery so ALPs should be one of the priority groups considered under the emergency regulation approved by the Public Health and Planning Council.
  
- f) Allowing ALPs the option to utilize their LHCSA home health aides to perform all functions within their scope of practice/tasks.** We propose that HHAs working in an ALP setting should be able to perform the functions that their training allows them to perform. Access problems are growing because the CHHAs/LTHCCPs with which the ALPs contract are unable or unwilling to provide some home health aide level services commonly needed by the elderly in the ALP (i.e. eye, nose, and ear drops, nebulizers, etc.) Further, it has been confusing for providers to understand the limitations of the HHA in the ALP. ALPs should have the option to use the certified home health aides that they employ in their LHCSA to perform functions within their scope of tasks. Just as they provide supervision of aides for personal care tasks provided to residents (i.e. Activities of Daily Living-ADLs), the ALP's RN could provide the required aide supervision for the home health tasks.





- g) Enabling the ALP to contract with more than one CHHA or LTHHCP.** Current statute limits the contracting relationship to a single entity (requiring authorization for more in limited circumstances). Allowing the ALP more flexibility to contract with multiple entities would allow it to serve residents most efficiently. This will also allow more consumer choice.
- h) Allowing ALPs to access Medicare-covered therapy services from providers other than CHHAs or LTHHCPs.** Regulations state that the ALP must contract with a CHHA or LTHHCP for “nursing and therapy services.” The Department of Health interprets this to mean that the contracted CHHA or LTHHCP is the only organization that may provide such services. However, there are circumstances where an ALP resident can appropriately receive physical therapy, occupational therapy and/or speech therapy services from another entity. For instance, maintenance Physical Therapy is available from private PT companies under a different Medicare benefit. In addition, nursing homes licensed to provide outpatient therapies that are located on the same campus as ALPs could provide therapies under a different Medicare benefit. ALP residents’ right to choose providers should be promoted so that they have access to all of their Medicare benefits. Allowing ALPs to access therapies from other outpatient therapy providers will also allow more flexibility and more efficient service delivery. Because the ALP is responsible for any *Medicaid*-covered therapy services within its capitated rate, this change would not incur any additional costs to the state.
- i) Improving the ALP survey process.** Currently, the ALP survey process is disjointed. The ALP is surveyed as its components (ACF, home care and ALP) rather than an integrated program. At times, the requirements conflict or do not serve the best interests of the residents. Integrated training for surveyors joint ACF/ALP and home care surveys would facilitate a more integrated approach.
- j) Developing a forum to revisit the ALP program in one year to evaluate implementation of these reforms and determine what more change is needed.** Develop a forum of all interested parties to evaluate the implementation of these recommendations and to consider other changes to improve the program by meeting the growing demand in the most cost effective, efficient manner possible. The impact of the Medicaid Redesign Team’s initiatives, including the expansion of Medicaid Managed Care and the implementation of the uniform assessment system, will be considered, as well as additional changes that may be warranted to streamline administrative functions and costs and expand access to assisted living.

**Financial Impact:** TBD

**Health Disparities Impact:**

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

New York's Medicaid-funded Assisted Living Program allows many individuals to remain in community settings with appropriate supports rather than in a more restrictive institutional setting. However, modernizing the program, which began in 1991, would allow the state to expand the number of beds available and make the provision of supports and services to ALP residents more effective and efficient.

### **Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D1

**Recommendation Short Name:** Co-locate community health centers to expand services available to SH residents

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** During the 2012 calendar year

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Explore ways that community health centers (e.g. Federally Qualified Health Centers) can be co-located with supportive housing environments to provide additional supports and services to high-need populations, including primary and behavioral health care.** Making additional services easily accessible to the populations benefitting from supportive housing may afford state and local governments certain efficiencies and improve the health and well being of residents.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### Benefits of Recommendation:

Making additional services easily accessible to the populations benefitting from supportive housing may afford state and local governments certain efficiencies and improve the health and well being of residents.



**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D2

**Recommendation Short Name:** "Notice and best effort education"

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Encourage communities to support populations in need of supportive and affordable housing by evaluating whether local requirements could be aligned to require community "notice and best effort education."** Discrimination against developing supportive housing in local communities affects the ability to raise capital, develop additional housing units and maintain vulnerable populations in integrated community settings. Current practice in some localities requires community approval for new units and where this has been changed to "notice and best effort education," policy barriers to development have been ameliorated.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### Benefits of Recommendation:

Changing community approval processes to "notice and best effort requirements removes a significant barrier to siting and developing new projects.



### **Concerns with Recommendation:**

The need for supportive housing and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a broader based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D3

**Recommendation Short Name:** Expand and improve independent senior housing opportunities

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Address concerns about independent senior housing by: clearly defining independent senior housing in regulation; streamlining regulatory barriers to improve outcomes and achieve efficiencies; identifying resources to develop and preserve quality independent affordable housing for seniors that can serve as a platform for services to maximize their ability to be maintained in their homes and communities; and identifying new funding sources and new services from best practices in the supportive housing industry to support independent senior housing.** With the proportion of aged individuals in our population growing at a rapid rate, there is considerable need for a broad range of options for senior living. Currently, the variety of senior housing options is not well delineated and the landscape of offerings often confuses potential residents and their caregivers. Work group members seek to ensure that New York's aged individuals are not forgotten in the quest for adequate, safe and secure housing -- whether publicly supported or not.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.



### **Benefits of Recommendation:**

With the proportion of aged individuals in our population growing at a rapid rate, there is considerable need for a broad range of options for senior living. Currently, the variety of senior housing options is not well delineated and the landscape of offerings often confuses potential residents and their caregivers. Work group members seek to ensure that New York's aged individuals are not forgotten in the quest for adequate, safe and secure housing -- whether publicly supported or not.

### **Concerns with Recommendation:**

The need for supportive housing and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a broader based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.





## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D4

**Recommendation Short Name:** Maintain housing subsidies and focus of NHTD and TBI Waiver Programs in MLTC and Care Coordination models

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

### Proposal Description:

**Ensure continuation of housing subsidies provided through the NHTD/TBI Medicaid Waivers after the transition to Managed Long Term Care (MLTC) and that these programs, and their housing focus, are fully incorporated into MLTC and other Care Coordination Models.** These waiver models provide important examples of the effectiveness of combining housing with needed supports and services to successfully transition individuals into integrated community settings from restrictive institutional settings.

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### Benefits of Recommendation:

Individuals must be able to transition to housing, pay the rent and access the support services they need to manage their condition. Expanded funding to support these costs is essential to the success of supportive housing, including realized savings.



### **Concerns with Recommendation:**

The need for supportive housing and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a broader based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D5

**Recommendation Short Name:** Medical Respite for homeless individuals

**Program Area:** Housing

**Implementation Complexity:** High

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input checked="" type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### **Proposal Description:**

**Develop programs that serve the short term needs of people who need a temporary increase in the level of care in order to avoid hospitalization and emergency departments or in order to be discharged in a timely fashion (e.g. crisis intervention, hospital diversion, hospital step-down programs and medical respite care).** Some OMH certified residential beds could be converted to this use for mental health clients. OASAS-funded crisis centers should be upgraded to be eligible for Medicaid reimbursement as an alternative to more expensive forms of detox and drug treatment.

**Financial Impact:** TBD

### **Health Disparities Impact:**

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### **Benefits of Recommendation:**

Better health outcomes for homeless persons experiencing illness, reduced hospital stays for homeless persons and reduced readmissions and emergency room visits post-hospitalization.



### **Concerns with Recommendation:**

The need for supportive housing and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a broader based constituency.

### **Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.



## Medicaid Redesign Team Affordable Housing Work Group Final Recommendations

**Recommendation Number:** D6

**Recommendation Short Name:** Coordinate supportive housing with Health Homes Initiative

**Program Area:** Housing

**Implementation Complexity:** Medium

**Implementation Timeline:** SFY 2012-2013

**Required Approvals:**

<input checked="" type="checkbox"/> Administrative Action	<input type="checkbox"/> Statutory Change
<input type="checkbox"/> State Plan Amendment	<input type="checkbox"/> Federal Waiver

### Proposal Description:

**Health Homes should work with supportive housing providers to insure their residents and clients have maximum opportunities for inclusion and that the supportive housing provider has the opportunity to participate in service coordination.**

**Financial Impact:** TBD

### Health Disparities Impact:

Expansion of supportive housing opportunities is expected to address the most severely impacted Medicaid recipients in need of stable and affordable housing to support their health or maintenance needs.

### Benefits of Recommendation:

It is important that as New York State undertakes Medicaid Redesign that efforts are coordinated to maximize positive impacts, improving health outcomes and achieving better value in its investment.



**Concerns with Recommendation:**

The need for supportive housing, and affordable housing generally, is significant across all populations and while focusing housing related investments on heavy Medicaid users makes sense in the context of Medicaid Redesign writ large, it dilutes the contribution the state and federal government may make toward this effort for a more broad based constituency.

**Impacted Stakeholders:**

High cost, high need Medicaid consumers who have critical housing needs and underfunded supports to address their illness or condition and generate savings to the Medicaid program because their care is better managed.

# STEPHEN BERGER

*1050 Park Avenue  
New York, NY 10028*

November 28, 2011

Honorable Nirav R. Shah, M.D., M.P.H.  
Commissioner  
New York State Department of Health  
Corning Tower  
Albany, NY 12237

Dear Dr. Shah,

In June you created our Brooklyn MRT Health Systems Redesign Work Group and charged us with assessing the strengths and weaknesses of Brooklyn hospitals and their future viability. You also charged us with making specific recommendations that will lead to a high quality, financially secure and sustainable health system. While your specific request was focused on Brooklyn you stated your hope that our proposals could be used as a template where appropriate throughout the state. The attached report, "At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn," is our response to that mandate. It is the product of six months of information gathering, consultation with the Brooklyn community, analysis and deliberation.

Our report focuses not only on hospitals, but also on communities, their residents and the other providers that serve them. The data before us confirms that health status, health care utilization, and health care resources vary by neighborhood, with some neighborhoods exhibiting higher rates of chronic disease, avoidable emergency room visits and preventable hospitalizations, and fewer primary care providers and visits, than others. This report endorses the creation of integrated systems of care aligned with community needs as a means of improving individual health and community health, while reducing unnecessary health care spending.

As you have recognized, New York's healthcare delivery system is evolving in response to federal health care reforms, Governor Cuomo's Medicaid Redesign Team initiatives, and advances in medical practice and technology. Emerging value-based and performance-based payment mechanisms that emphasize prevention, quality, and outcomes demand greater collaboration among health care providers than ever before and create opportunities for integrated systems of care that can improve outcomes while reducing costs. At the same time, impending reductions in Medicare payments and New York's global cap on Medicaid spending will require providers to adapt rapidly.

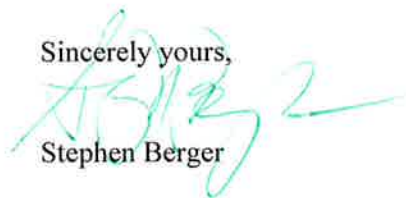
The recommendations in this report are intended to begin a process of reshaping the healthcare delivery system in Brooklyn and hopefully throughout the State. The report lays out principles, tools, and structural recommendations which should be seen as the framework and first stage of a multi-year process designed to strengthen primary care, improve care coordination and chronic disease management, and reduce wasteful health care utilization and provider inefficiency. Its primary focus is on six hospitals – Brookdale Hospital Medical Center, Brooklyn Hospital Center, Interfaith Medical Center, Kingsbrook Jewish Medical Center, Long Island College Hospital, and Wyckoff Heights Medical Center-- that are not currently positioned to seize the opportunities and manage the risks associated with the changes under way at the state and federal levels.

The monumental task in front of us, which can no longer be avoided, will demand redefining the roles and relationships among health care providers and between providers and patients. Primary care, acute care, behavioral health care and long-term care must all be linked in a patient-centered system, with the ultimate goal of achieving the CMS Three-Part Aim: better health care for individuals, better health for communities, and lower costs through improvement. To accomplish these ends, in an environment of necessary revenue neutrality, will require creativity, compromise and the willingness of many groups and institutions to work together in ways they never have before.

On a personal note, it has been an honor and a pleasure to serve with the other members of the Work Group: Ramon Rodriguez, Elizabeth Swain, William Toby, and Arthur Webb. I could not have asked for a more thoughtful, hard-working, and experienced team.

We hope this report will be a useful template for moving forward.

Sincerely yours,



Stephen Berger

Cc: Ramon Rodriguez  
Elizabeth Swain  
William Toby  
Arthur Webb

Enclosure





## **At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn**



### **REPORT OF THE BROOKLYN HEALTH SYSTEMS REDESIGN WORK GROUP**

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## Executive Summary

Brooklyn's healthcare delivery system is at the brink of dramatic change – change that will be characterized either by a reconfiguration of services and organizations to improve health and health care, or by a major disruption in services as a result of financial crises at three hospitals. Today, Brooklyn is grappling with high rates of chronic disease and a healthcare delivery system that is, in many areas, ill-equipped to address them. High rates of preventable hospital admissions and avoidable emergency department visits indicate deficiencies in primary care and inefficient use of high-cost resources. Further, while there are several fine hospitals in Brooklyn that are well-managed and financially-stable, Interfaith Medical Center, Wyckoff Heights Medical Center and Brookdale Hospital Medical Center are experiencing financial crises. At the same time, great opportunity presents itself in new models of patient-centered care, focused on prevention, and supported by technology and appropriate reimbursement incentives. We must choose the affirmative path of opportunity and transformation.

Six months ago, Commissioner Nirav Shah of the New York State Department of Health appointed the Brooklyn Health System Redesign Work Group (“the Work Group”) to assess the strengths and weaknesses of Brooklyn's hospitals and healthcare system and evaluate the longer-term viability of the hospitals as providers of care to the borough's 2.5 million residents. The Work Group was convened in the context of growing financial distress at the three hospitals and concerns about the long-term stability of other providers given changes in Medicaid and Medicare funding and an evolving healthcare marketplace. With Brooklyn's high rates of obesity, high blood pressure and diabetes, and 1 million Medicaid beneficiaries among its residents, the state has a strong interest in the quality, accessibility, efficiency and viability of healthcare in the borough.

Over the past six months, the Work Group has convened three public meetings, visited all 15 hospitals in Brooklyn and a federally qualified health center, met with hospital executives, board members, medical staffs and healthcare experts, and reviewed reams of data. We have also considered the healthcare environment in New York and around the nation. The Medicaid and Medicare programs are undergoing ambitious and forward-looking reforms unprecedented in at least 30 years. These reforms include new models of care and payment that emphasize care coordination, prevention, and performance. They demand integration and collaboration among providers along the continuum of care, in order to improve the quality of care for individuals, improve the health of communities, and reduce costs through improvement. With or without federal reforms, clinical integration, clinical outcomes, expansion of primary care and contraction of inpatient beds must be priorities in order to improve health and healthcare, while reducing unnecessary costs.

In this context, the Work Group has developed a set of findings, principles and tools to guide the reconfiguration of Brooklyn's healthcare delivery system. We believe these principles and tools are applicable to delivery systems around the state. This report also sets forth recommendations pertinent to certain at-risk hospitals in Brooklyn, but does not direct the elimination of a specified number of beds or the relocation of specified services in Brooklyn. Instead, it creates a process through which restructuring plans can be developed, evaluated and implemented with community involvement and state oversight.

The findings, principles, and process set forth here are intended to transition healthcare in Brooklyn into integrated and comprehensive systems aligned with community needs. All of the following recommendations are based on the determination that the state has an interest that goes beyond saving any single institution and extends to ensuring the well-being of its citizens.

## *Workgroup Findings: Brooklyn Health Care*

Based on its review of data, interviews of healthcare facility executives, board members, and medical staffs, public hearing testimony, discussions with experts, and site visits, the Work Group has made the following findings:

- Brooklyn faces daunting population health challenges. High rates of chronic disease are exacting a human and economic toll.
- Community health needs and health care resources vary widely by neighborhood. Disparities in health status are also associated with poverty, race and ethnicity.
- Brooklyn hospitals compete for market share amongst themselves and with academic medical centers in Manhattan. Brooklyn patients, particularly those with commercial insurance and those seeking high-end surgical services, are increasingly seeking care in Manhattan.
- More than 15 percent of adult, medical-surgical hospital admissions and 46 percent of all emergency department visits that do not result in a hospital admission in Brooklyn could be averted through high quality, accessible care in the community. High rates of primary care treatable and preventable emergency department use and preventable (PQI) hospitalizations suggest that many Brooklyn patients are not using appropriate, effective, and less costly primary care necessary to keep them healthy and out of the hospital.
- While nearly one-third of the residents of several Brooklyn neighborhoods report that they lack a primary care provider, there is also evidence that many Brooklyn patients seek care in the ED, not because they lack a primary care provider, nor because they believe their condition is emergent, but rather based on convenience or the nature of their primary care provider's practice.
- High rates of preventable hospitalizations and above-average lengths of stay suggest that a significant portion of inpatient care in Brooklyn hospitals would not be necessary, if primary and other outpatient care were improved and inpatient care were managed more efficiently.
- Almost 30 percent of Brooklyn's hospital beds are vacant on an average day. Given low occupancy levels, modest reductions in preventable hospitalizations and lengths of stay would permit the elimination of 1,235 beds, even after taking into account projected population growth.
- Heavy use of hospital services among people with mental illness and substance use disorders suggests that these conditions, and associated co-morbidities, could be managed better in the community.
- Six Brooklyn hospitals – Brookdale Hospital Medical Center (Brookdale), Brooklyn Hospital Center (Brooklyn Hospital), Interfaith Medical Center (Interfaith), Kingsbrook Jewish Medical Center (Kingsbrook Jewish), Long Island College Hospital (LICH), and Wyckoff Heights Medical Center (Wyckoff), collectively referred to as the "focus hospitals" -- do not have a business model and sufficient margins to remain viable and provide high quality care to their communities as currently structured. Three of these hospitals, Interfaith, Brookdale, and Wyckoff are experiencing financial crises and require aggressive action. The financial position of Long Island College Hospital (LICH) has also been grim, but it has recently been placed under the umbrella of SUNY

Downstate Medical Center and can be turned around with its support. Brooklyn Hospital and Kingsbrook Jewish have effected restructurings that have stabilized their positions, but will not remain viable in the long run, as stand-alone facilities under their current business models, given changes in Medicare, Medicaid and the healthcare market. These two institutions can play a leadership role in creating integrated systems to strengthen healthcare delivery in the communities served by all six hospitals.

- The boards of some of these hospitals have failed to satisfy fully their responsibilities to the organizations and their communities. They have not evaluated financial and clinical performance, set strategic goals to address them, and held management accountable for achieving them. Instead, they have adopted a strategy that seeks merely to be the last man standing in their communities. It is clear that this strategy is a failed one.
- Healthcare reforms at the federal and state levels demand a fundamental change in the clinical, organizational and financial paradigm for these institutions to permit them to participate effectively in new models of integrated care that emphasize prevention, care coordination, and performance and produce real value for individual patients and the community.
- In order to realize the promise of these reforms, it is necessary to engage patients, and other community stakeholders, at the local level, in data-driven planning processes to develop patient-centered systems of care that address community health needs, while reducing excess utilization and costs.

### ***Recommended Restructuring Principles***

The Work Group recommends that the following principles drive the restructuring of the delivery system:

- In order to improve the health status of Brooklyn residents and to succeed under emerging payment methodologies, health care providers must create integrated systems of care and service delivery models, comprised of physicians, federally-qualified health centers, hospitals, nursing homes, home care agencies, behavioral health providers, and hospice programs.
- New models of payment and delivery will require a rethinking of the hospital-based bricks and mortar pattern of health care.
- Patient-centered primary care services, strategically-located and linked to acute and long-term care providers, must be developed.
- Restructuring must reduce waste and improve the quality of care, the settings for care, the engagement of patients in care, the way clinicians deliver care, and ultimately community health.
- Strong institutional governance and experienced leadership are needed to stabilize Brooklyn's most troubled hospitals and to steer them into new integrated healthcare systems.
- Academic medical centers and other providers from outside Brooklyn that seek to establish affiliations or ambulatory care facilities in the borough must partner with local hospitals and other providers and strive to serve Brooklyn residents in Brooklyn.

- Restructuring support, whether in the form of debt relief, grants, loans or reimbursement adjustments, must be conditioned on the creation of a sound governance and management structure; the development of viable strategic, financial, and operational plans consistent with the principles outlined here; and the achievement of quality benchmarks and savings. Any support must be revenue neutral.
- The Brooklyn crisis and the state’s response highlight the need for more structured, collaborative health planning and oversight of troubled facilities.
- Innovative options for capital formation, including private investment, are needed to support capital and operational improvements in Brooklyn hospitals; but private investment must not be allowed to undermine a facility’s commitment to the community or its accountability for the quality of care.
- The cost structure of healthcare facilities in Brooklyn, including labor and medical education cost centers, must be rationalized.
- The state should support the participation of nursing homes in emerging systems of care.

### *Recommended Tools for Change*

The Work Group recommends that the following tools be developed and deployed, where applicable, to support change not just in Brooklyn and not just for troubled hospitals, but across the state and along the continuum of care, among strong and fragile providers alike:

#### **Expand the State Health Commissioner’s Powers over Healthcare Facility Operators**

Effective governance of health care facilities and systems will be essential to the future of healthcare in Brooklyn. To ensure that the he or she has the necessary power to protect the public health, the Commissioner of the New York State Department of Health (henceforth “the Commissioner”) should be granted expanded authority over healthcare facility operators as follows:

- Legislation should be enacted to give the Commissioner authority, at his or her discretion, to appoint a temporary operator for health care facilities that present a danger to the health or safety of their patients; or have operators that have failed in their obligations; or are jeopardizing the viability of essential health care capacity, absent intervention by the state.
- Legislation should be enacted to give the Commissioner authority to replace healthcare facility board members who are not fulfilling their duties to the organizations they are charged with governing.

#### **Appoint a Brooklyn Healthcare Improvement Board**

The Commissioner should appoint a Brooklyn Healthcare Improvement Board (BHIB) to advise the Commissioner and, at his or her direction, oversee, initiate where necessary, manage and ensure the implementation of this report’s recommendations.

## **Provide Financial Support for Restructuring through an Application Process**

This application process, as envisioned by the MRT Payment Reform Work Group, will provide a vehicle for supporting and overseeing implementation of the recommendations in this report as they apply to particular facilities. The application will require feasible and actionable plans for restructuring, as well as strong governance, long-term oversight, and cost savings.

To support this process, legislation should be enacted to provide these focus hospitals, and others that qualify, under the principles outlined in this report, with access to capital and/or the means of reducing debt burdens that substantially impair the hospitals' ability to restructure. In addition, the subsidiary legislation for the Dormitory Authority of the State of New York (DASNY) should be extended.

## **Rationalize the Distribution of DSH/Indigent Care Pool Funds**

Brooklyn's hospitals serve significant numbers of uninsured and Medicaid patients and will be affected by pending changes in the distribution of federal disproportionate care (DSH) funds. The MRT Payment Reform Work Group's has articulated the following principles for reform of the allocation of these funds, which should be adopted:

- Develop a new allocation methodology consistent with CMS guidelines to ensure that New York State does not take more than its share of the nationwide reduction;
- Adopt a fair and equitable approach to allocate funds across hospitals, with a greater proportion of funds allocated to those hospitals that provide services to uninsured and underinsured patients;
- Simplify the allocation methodology and consolidate the Indigent Care pools.

## **Provide Funding for a Multi-Stakeholder Planning Collaborative in Brooklyn**

To assure that the new healthcare systems under development address community health needs, a data-driven, multi-stakeholder health planning collaborative, like the Brooklyn Health Improvement Project, should be created or expanded with state and other support. It should include representatives of consumers, health plans, providers, business, labor, and New York City Department of Health and Mental Hygiene. This collaborative would provide input into the development of health systems and the deliberations of the Brooklyn Healthcare Improvement Board, and support interventions to improve health care utilization and health status in Brooklyn. It could also engage in activities to curb unnecessary health spending, such as such as the creation of a community advisory board for major investments in medical technology like the CTAAB in the Finger Lakes region.

## **Support Involvement of Private Physician Practices in Integrated Health Systems**

The Work Group encourages the state to support the development of large physician practices in under-served areas and the involvement of physician practices in integrated systems of care. The state should consider working with Medicaid managed care plans, commercial payers and foundations to fund embedded care managers or social workers in physician practices, who can help to prevent hospitalizations and readmissions and assist in addressing health-related needs such as transportation to appointments and housing. Tax credits for physicians who provide significant charity care should also be considered. To the extent that physician practices receive enhanced support from the state, however, the funding should be tied to the satisfaction of quality standards, like patient-centered medical home accreditation, and to services to Medicaid beneficiaries and uninsured patients.



## **Develop new alternatives for capital support for primary care providers**

Primary care providers are often undercapitalized and have difficulty securing affordable capital financing necessary to expand and build facilities. To expand primary care in the communities most in need, the state should explore new programs that use public support to leverage outside investment in high quality primary care projects.

### ***Brooklyn Hospitals: Specific Recommendations***

The Work Group focused its attention on the three most troubled hospitals in Brooklyn that require immediate intervention to avert financial collapse: **Brookdale Hospital Medical Center, Interfaith Medical Center, and Wyckoff Heights Medical Center**. The Work Group notes that **Long Island College Hospital (LICH)** also would also fall into this category, but for its recent affiliation with SUNY Downstate Medical Center which has created the potential for a turnaround. In addition, the Work Group considered the position of two other key hospitals, **Brooklyn Hospital Center and Kingsbrook Jewish Medical Center**, that do not exhibit the same level of financial distress as the others. However, they need to put in place plans for long-term for sustainability and can play a leadership role in creating integrated systems to strengthen healthcare delivery in the communities served by all six hospitals. Specific recommendations are made for these six hospitals:

**Brookdale Hospital Medical Center and Kingsbrook Jewish Medical Center:** The Work Group recommends that Kingsbrook Jewish take the lead in establishing an integrated system with Brookdale, either under a common active parent or other accountable governance structure. The Work Group recommends new executive leadership at Brookdale and a separation from MediSys. A viable plan would require the creation of a new governance structure and a new board of directors for the integrated system.

The restructuring of Brookdale's debt and other obligations is essential to the success of this proposal. Any reconfiguration would also require the implementation of a plan to strengthen primary care in the communities served by the two institutions and clinical integration among participating providers. The Kingsbrook/Brookdale system should also consider reducing its bed complement and investing in additional ambulatory care services. Development and implementation of this plan recommendation should take place under the guidance of the Brooklyn Healthcare Improvement Board, with input from the communities served.

**Brooklyn Hospital Center, Interfaith Medical Center, and Wyckoff Heights Hospital:** The Work Group recommends the integration of these three institutions into a single system under an active parent, or other accountable governance structure, led by Brooklyn Hospital Center. In light of the precarious financial positions of Interfaith and Wyckoff, the Work Group would like to ensure that Brooklyn Hospital, which has recently emerged from bankruptcy and is demonstrating sound financial practices, is not brought down by this plan. Indeed, we recommend that Brooklyn Hospital be given the support to lead the transformation and restructure the operations at Interfaith and Wyckoff.

This system should streamline inpatient and tertiary care in a manner that is sustainable and aligned with community needs. A critical element of the restructuring plan must be enhanced access to high quality primary care and outpatient services. Development and implementation of the plan should proceed under the guidance of the Brooklyn Healthcare Improvement Board, with input from the communities served.

**SUNY Downstate Medical Center and Long Island College Hospital (LICH):** In light of the recent acquisition of LICH, SUNY Downstate should consider consolidating inpatient services at

the LICH campus, thereby eliminating excess capacity and permitting the medical center to focus its inpatient resources and expertise on one location. With the new campus and the expansion of services at the neighboring Kings County Hospital, SUNY Downstate should reconsider any planned expansion of beds at the former Victory Hospital site and any development of an ambulatory facility in the vicinity of University Hospital or at the former Victory Hospital site. Any request by SUNY Downstate to open additional inpatient beds at the Victory Hospital site should be denied.

**Kingsboro Psychiatric Center:** The Office of Mental Health (OMH) should close the inpatient service of Kingsboro Psychiatric Center (KPC) and, working with the Department of Health, redirect resources to community-based behavioral health services that would function in collaboration with Brooklyn hospitals. Intermediate psychiatric hospital care for Brooklyn residents and court referrals should be provided primarily by South Beach Psychiatric Center, which currently serves a large section of Brooklyn. KPC's existing array of community-based services should remain within the community.

Conversion of a majority of the high cost KPC inpatient beds into intensive community treatment and support services would be well-timed with the implementation of the Medicaid Health Home initiative in the borough. Improved coordination, coupled with expanded service availability, will significantly reduce the burden on Brooklyn's emergency rooms and inpatient services.

**Woodhull Hospital, Kings County Hospital and Coney Island Hospital:**

These hospitals are operated by the New York City Health and Hospitals Corporation (HHC). Although they have been linked principally with the other institutions in the HHC system, rather than with local facilities, it is now essential that they become more active partners in the Brooklyn delivery system.



# **At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn Group**



## **Report of the Brooklyn Health Systems Redesign Work**

Stephen Berger, Chair  
Ramon Jesus Rodriguez  
Elizabeth Swain  
William Toby  
Arthur Y. Webb

November 28, 2011

## ACKNOWLEDGEMENTS

The Work Group would like to thank the New York State Health Foundation for its support and James Welsh of Welsh Analytics, LLC for his tireless efforts in analyzing the data that form the foundation of this report. We would also like to thank Paul Williams, Larry Volk, Tracy Raleigh, Portia Lee, and the staff of the Dormitory Authority of the State of New York for their input and analysis. We also appreciate the information and insight provided by Bruce Feig and the staff of the New York State Office of Mental Health and Kathleen Caggiano-Siino and the staff of the New York State Office of Alcohol and Substance Abuse Services. Finally, the Work Group is deeply grateful to the staff of the New York State Department of Health for its help in the research and creation of this report. Karen Starke, John Piddock, Patrick Roohan, Joseph Anarella, Mary Beth Conroy, Trang Nguyen, and John Gahan provided much of the data we used. Richard Cook, Joseph Dimura, Christopher Delker, Colleen McLaughlin, Norman Marshall, and Tracy Mann were instrumental in supporting our work. We would particularly like to thank Lora Lefebvre and Karen Lipson for their extraordinary efforts in helping us to meet our mandate from the Commissioner.

## **INTRODUCTION**

Brooklyn's 2.5 million residents need and deserve a high-quality, accessible, and financially-stable, health care delivery system that also serves as a safety net for Brooklyn residents who face barriers to health care. This report's focus is on communities and their residents, not on the needs of "safety net hospitals." Brooklyn residents have high rates of obesity, hypertension and diabetes; nearly a quarter live in poverty; many are uninsured; almost half are on Medicaid; and relatively few have commercial health insurance. Our analysis of data shows that Brooklyn residents too often find themselves in an emergency department or a hospital bed for conditions that are not emergent or that could have been prevented or treated in a doctor's office or community health center. More than 15 percent of adult, medical-surgical hospital stays in Brooklyn and 46 percent of all emergency department visits that do not result in a hospital admission could be averted through appropriate primary care in the community.

In the face of high rates of chronic disease and a heavy reliance on hospitals for care, financial crises at three Brooklyn hospitals – Brookdale Hospital Medical Center, Interfaith Medical Center, and Wyckoff Heights Medical Center -- are jeopardizing access to quality care for thousands of Brooklyn residents. Like most Brooklyn hospitals, these hospitals serve low-income communities where Medicaid is the predominant payer. After years of relying heavily on shrinking Medicaid dollars, along with excess borrowing, wasteful spending, and mismanagement, these three most troubled hospitals are no longer viable as stand-alone inpatient facilities. In addition to these three institutions, this report focuses on three other hospitals (Brooklyn Hospital Center, Long Island College Hospital, and Kingsbrook Jewish Medical Center) that are working to regain financial stability and restructure in the face of low inpatient occupancy rates and an unfavorable payer mix. Although all six hospitals provide substantial outpatient care, none has invested in developing a system of high-quality primary and community-based specialty care that could improve the health of its community and its own long-term financial viability. Meanwhile, Brooklyn residents are increasingly seeking hospital care outside of the borough, diverting precious inpatient revenues to other institutions.

The Work Group is acutely aware that we must find sound, feasible solutions to the health care crisis in Brooklyn. In Brooklyn, we confront the central issue of access to *appropriate* care. Our deliberations reveal that access to appropriate care does not necessarily equal proximity to hospital care. Brooklyn has 15 hospitals with nearly 6,400 licensed beds. But, almost 30 percent of those beds are vacant on an average day, and more than 15 percent of adult medical-surgical admissions could be prevented with appropriate primary care. Clearly, there is adequate inpatient capacity. High rates of avoidable emergency department use and preventable hospitalizations, moreover, suggest that Brooklyn residents are not accessing care in the most effective and efficient setting. Despite heavy use of hospital services, the health status of Brooklyn residents is no better, and in many respects is worse, than that of other New Yorkers. A hospital cannot, and should not, provide all of the health care that a community needs. Indeed, access to hospital care is not the benchmark against which to judge the health status of a community. Access to high quality primary care and community-based specialty care is a critical component of an effective system of care.

Decades ago, New York State built, funded and supported a "big box" health care system, dominated by hospitals, and fostered a regulatory and reimbursement environment to oversee and support it. The big box system's importance to the economy has strengthened its ability to resist desirable change and efforts to rein in costs. Until very recently, our big box system has been able to secure grants and other revenue enhancements from Albany and has forestalled the necessity to manage costs.

What we are now facing is a confluence of factors that force our hospitals, in Brooklyn and across the state, to confront economic reality. Federal and state resources continue to shrink, and new payment methodologies are demanding quality and efficiency. Further, due to advances in medicine, many health care services that were once the exclusive domain of hospitals can now be delivered as effectively and often more efficiently in an outpatient setting or at home. The roles and responsibilities of hospitals continue to change as modern medicine evolves through the discovery of new techniques, procedures and medications and the implementation of technology, including electronic health records.

Therefore, the Work Group would like to stress that, although much of our work has focused on the Brooklyn hospitals, hospitals are not the health care system. They are just a part of it, albeit an integral part. Medical care in the 21<sup>st</sup> century will not be centered within the bricks and mortar of a massive hospital. Instead, care should be centered on the patient, and will rely heavily on comprehensive primary care and other ambulatory services. Changes in medical practice, combined with both federal and state redesign of payment mechanisms and care models, are moving us away from episodic care focused on disconnected, big box solutions to comprehensive care in more integrated and distributed environments.

The federal Affordable Care Act (“ACA”) has introduced the most far-reaching changes in federal health care policy since the creation of the Medicare and Medicaid programs. In implementing the ACA, the Centers for Medicare and Medicaid Services (CMS) are working to strengthen the ability of the delivery system to achieve the “Three Part Aim” – better care for individuals, better health for populations, and lower costs through improvement. CMS has launched, and Governor Cuomo’s Medicaid Redesign Team (MRT) has embraced, new strategies for delivering and paying for care that emphasize care coordination, prevention, and performance, such as accountable care organizations, patient-centered medical homes and health homes. Fee-for-service payment mechanisms that incentivize volume are being phased out in favor of performance-based payments that incentivize value and efficiency, such as bundled payments and value-based purchasing. To participate effectively in these models, providers along the continuum of care must integrate or collaborate with each other to improve the health of Medicare and/or Medicaid beneficiaries and accept payment arrangements that reward positive outcomes and lower costs.

In the face of the Medicare cuts and the state’s global cap on Medicaid, health care providers in Brooklyn must change the way they operate so that they can remain financially viable. They must streamline operations and partner with other providers, so that they can reduce operating costs and unnecessary utilization, while improving outcomes. This is important not just to providers, but also to the people they serve. These new integrated models of care and performance-based reimbursement arrangements show promise in improving the health of individuals and communities. With or without federal reforms, clinical integration, a focus on clinical outcomes, expansion of primary care and contraction of inpatient beds must continue.

### ***Transforming the “Big Box” into Integrated Systems Aligned with Community Needs***

There are hospitals in Brooklyn that are well-managed, have maintained high quality in the face of financial pressure, and have shown flexibility in responding to their communities’ needs. However, there are others that are at the brink of failure -- the products of a failed system of health care financing and delivery, where a combination of inadequate payer mix, weak governance and management, and the inability to respond to changes in medicine and the marketplace jeopardize their ability to serve their communities.

There is an immediate need to deal with the problems of those troubled institutions, whether or not they will ultimately be or should be part of the next generation of health care delivery. To let

them fail in free-fall bankruptcies would threaten access to health care for large numbers of people. The way to a healthy tomorrow is to avoid chaos today, to approach Brooklyn's problems with both a short-term and a longer-term prospectus, and to come up with the changes that are necessary first to stabilize and then to revitalize the way health care is delivered in the borough.

While it is certain that there is excess inpatient bed capacity in Brooklyn, this report does not recommend the closure of any hospitals at this time. Nor does it recommend that the state use its limited dollars merely to extend the lives of institutions that cannot survive as they currently operate. Given that 15 percent of medical-surgical admissions could be avoided, it is likely that the development of integrated and more efficient networks of care will entail the elimination of acute care beds, consolidation of capacity, and the re-purposing of hospitals. And, with the resulting savings, there should be development of new primary care capacity in high-need communities. This reconfiguration must be developed through an active collaboration among healthcare providers, payers, consumers, and other stakeholders, in order to succeed in improving individual health care, improving the health of Brooklyn residents, and reducing health care costs through systemic improvement.

This report provides a set of findings, principles and tools to guide the reconfiguration of Brooklyn's healthcare delivery system and the delivery systems of other communities around the state. It also sets forth recommendations specific to certain, at-risk hospitals, but it does not direct the elimination of a specified number of beds or the relocation of specified services in Brooklyn. Instead, it creates a process through which restructuring plans can be developed, evaluated, and implemented, with community involvement and state oversight. The findings, principles and process set forth here are intended to transition healthcare in Brooklyn into integrated and comprehensive systems aligned with community needs.

All of these recommendations are based on the determination that the state has an interest that goes beyond saving any single institution and goes to ensuring the well-being of its citizens. The Medicaid and Medicare programs are undergoing ambitious and forward-looking reforms unprecedented in at least 30 years. These reforms must be leveraged to drive appropriate changes in the delivery system for all New Yorkers. They should be used to improve access to high quality care, and to promote better health outcomes and efficient practices, while living within state budget constraints. We believe effective care is cost-effective care.

This report endorses the creation of integrated systems of care as a means of improving health outcomes, quality and efficiency. Some may argue that integration will merely drive up costs by reducing competition. The Work Group has concluded that there will be ample competition in Brooklyn even after the reorganization of five independent facilities into two integrated systems. Moreover, the benefits to be derived from this reconfiguration far outweigh any negative effect on competition. By reducing fragmentation in the delivery system, rationalizing capacity and services, strengthening primary care, supporting performance-based payment mechanisms, and enhancing community engagement in health planning, these recommendations have the potential to improve the health of communities throughout New York and reduce unnecessary health care spending.

## **I. THE CHARGE TO THE WORK GROUP AND ITS ACTIVITIES**

As the state's most populous county, with approximately 1 million Medicaid beneficiaries among its residents, Brooklyn and its health care delivery system are pressing concerns for New York State. Recognizing the financial fragility of some of Brooklyn's hospitals and the potential for disruptions in care if one or more were to fail, Commissioner Nirav Shah, of the New York State Department of Health, established the Brooklyn Work Group (the Work Group) of the Medicaid Redesign Team (MRT), in June 2011, to: (1) assess the strengths and weaknesses of Brooklyn's hospitals and their future viability; and (2) make specific recommendations that will lead to a high quality, financially sustainable health system in Brooklyn (see Appendix M). This examination of Brooklyn's health care delivery system is part of the MRT's larger effort to reduce costs and improve quality, access, and efficiency throughout the state's health care delivery system.

While hospitals are a component of Brooklyn's healthcare delivery system, the Work Group would like to stress that they are not *the* healthcare delivery system. Due to their role in providing services to some of the borough's most vulnerable residents, their size, and their status as major employers, they tend to overshadow other elements of the health system. However, there is a wide variety of health care providers in Brooklyn, from private physician practices, to federally-qualified health centers, to behavioral health providers, to nursing homes, among many others. The Work Group has sought to develop recommendations that focus not on the needs of one health care sector or another, but rather on the needs of communities they serve and the people who live and work in them. Our recommendations are intended to create a framework for high-performing, integrated systems of care in Brooklyn that address community needs along the health care continuum.

Two components of the healthcare delivery system have, nevertheless, received heightened attention in this report: hospitals and primary care providers. The Work Group recognizes that access to high-quality hospital care is an important element of any health care delivery system. However, the vitality of Brooklyn's hospitals has for some years been uneven, with some hospitals in marginal financial condition or worse. Several carry heavy debt burdens with insufficient revenues to cover rising costs; three appear to be on the verge of financial collapse. Several have insufficient margins to make the investments necessary to upgrade their physical plants or keep pace with advances in medicine and models of care. Furthermore, many of these hospitals have been unable to address the very challenging health needs of their communities.

We also focus on primary care. Brooklyn's population health indicators and health care utilization data show high rates of chronic disease and suggest inadequate access to high quality primary care in several neighborhoods. Given that innovations in care models and reimbursement created by the Accountable Care Act (ACA) and Governor Cuomo's MRT require robust primary care integrated with acute, long-term and behavioral health care, we conclude that development of accessible, patient-centered primary care is fundamental to the strength of Brooklyn's delivery system as a whole and to the health of its residents.

Although nursing homes have not been a focus of the Work Group's activities, we recognize that nursing homes play a vital role in meeting the needs of some of our most vulnerable citizens, especially seniors. Nursing homes must be partners with the integrated systems that are recommended by this report, if these systems are to achieve the goals of improving the health of individuals and communities, while lowering costs through improvement.

The Work Group is well aware that any recommendations to improve and strengthen Brooklyn's hospitals and healthcare delivery system must be informed by the particular circumstances of the healthcare facilities and the communities they serve. To help ensure that its deliberations took



full account of community needs and full advantage of the experiences of consumers and providers, the Work Group held a series of public meetings and hearings in Brooklyn. At the first, on July 28, 2011, the Work Group received presentations from State Department of Health (“DOH” or “Department”) staff on demography and community health in Brooklyn, the utilization of hospital services, and opportunities for health system redesign. The Work Group also heard comments from approximately 65 members of the public about Brooklyn’s hospitals and the broader healthcare delivery system.<sup>1</sup>

The second public meeting, on September 21<sup>st</sup>, was comprised of presentations and discussions by a series of experts on a variety of issues, including the financial condition of Brooklyn hospitals, preliminary research findings on Brooklyn’s primary care and emergency room use, different governance models for restructuring hospitals, prospects for private investment in hospital through public-private partnerships, and freestanding emergency rooms as a care setting.<sup>2</sup>

The third hearing on October 19<sup>th</sup>, afforded another opportunity for Brooklyn residents, providers and other stakeholders to comment on the information presented at the prior meetings and on their concerns related to potential restructuring. At that meeting, approximately 25 members of the public presented. In addition, members of the public were invited to submit comments via the DOH public website. The Department received over 25 comments through that medium. Members of the Work Group visited the Brownsville Multi-Service Family Health Center (a federally qualified health center) and each of the fifteen hospitals in Brooklyn. Facilities were reviewed and inspected, and a questionnaire was submitted to leadership at each hospital (the questionnaire is attached as Appendix A). The Work Group interviewed hospital executives, board members, medical staffs, and other experts. The Work Group also met with Primary Care Development Corporation and the Kings County Medical Society to discuss healthcare in Brooklyn.

The Work Group has strived to assure that its deliberations and recommendations are based on an objective and sound analysis of data, as well as the experiences of providers and consumers. To that end, through a grant from the New York State Health Foundation, the Department of Health and the Work Group has worked with Welsh Analytics, LLC to compile and analyze data on population, health status and health care utilization in Brooklyn and finances and trends at each of the facilities. The data sources include the NYS Statewide Planning and Research Cooperative System (SPARCS), institutional cost reports, census data, New York State Medicaid claims and enrollment data, and data developed by the New York City Department of Health and Mental Hygiene. We sought to use the most complete and current data available. Generally, the SPARCS data used in this report was 2010 data obtained in August 2011. However, for prevention quality indicator (PQI) inpatient discharges, we used 2009 SPARCS data.

These data and the comments of consumers, providers, technical experts and other stakeholders at the three public meetings have played a major role in informing the Work Group’s recommendations. The recommendations are intended to provide a process and a policy framework for Brooklyn’s health care providers in restructuring their operations toward a financially-stable, high-performing system of integrated inpatient, outpatient, primary, behavioral health, and long-term care aligned with community needs. We are confident that this report will benefit not only Brooklyn’s hospitals, but also Brooklyn’s communities. Moreover, as many of the issues confronting Brooklyn are also confronting communities around the state, we hope that our findings and recommendations will point the way for similar efforts in other areas of the state.

The Report addresses the Work Group’s charge as follows:

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<sup>1</sup> Meeting materials are available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/brooklyn.htm](http://www.health.ny.gov/health_care/medicaid/redesign/brooklyn.htm).

<sup>2</sup> Meeting materials are available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/brooklyn.htm](http://www.health.ny.gov/health_care/medicaid/redesign/brooklyn.htm).

- Part II provides a demographic profile of Brooklyn and its neighborhoods;
- Part III describes Brooklyn’s health care delivery system;
- Part IV describes the health care emergency in Brooklyn;
- Part V lays out the financial position of the six focus hospitals;
- Part VI outlines the opportunities and challenges posed by reforms at the state and federal levels;
- Part VII offers principles and tools for change of the healthcare delivery system; and
- Part VIII provides specific recommendations for Brooklyn hospitals.

## **II. BROOKLYN AND ITS NEIGHBORHOODS: A DEMOGRAPHIC PROFILE**

A comprehensive analysis of a health care delivery system requires assessment not only of its facilities, services and health care professionals, but also consideration of the people and communities it serves. Health status and factors that impact health care access and patient engagement, such as insurance, English proficiency, educational attainment, and poverty, are all important to the development of sound recommendations for the creation of a high quality, accessible and financially stable health care delivery system.

This report relies on available data to identify and map health status and demographic factors that affect health care access and utilization. However, the Work Group recognizes that a detailed picture of Brooklyn’s neighborhoods and their residents requires in-depth, on-the-ground study and more time than the Work Group was allowed. As noted in Part VII, the Work Group recommends funding for a multi-stakeholder collaborative to conduct that analysis among other activities.

To describe geographic variation in health and socioeconomic status and access to care in Brooklyn, this report uses the neighborhoods defined by the United Hospital Fund for the purpose of research and planning studies. UHF drew 42 neighborhoods across New York City based on boundaries consisting of adjoining zip code areas. These neighborhood designations provide clear and consistent boundaries for the unique demographic, economic, health and delivery system characteristics of small geographic areas. In Brooklyn, the UHF neighborhoods are: Greenpoint, Northwest Brooklyn, Central Brooklyn, East New York-New Lots, Sunset Park, Borough Park, Flatbush, Canarsie-Flatlands, Southwest Brooklyn, Southern Brooklyn, and Bushwick-Williamsburg.

## Brooklyn Neighborhoods and Hospitals



### A. Population, Age, Race and Ethnicity

Current and projected population and the racial and ethnic diversity of a community are important factors in developing plans to redesign its healthcare delivery system. Population growth and decline, as well as distribution of the population by age, affect both the types and amounts of health care capacity needed to serve a community. Race and ethnicity are associated with disparities in health status and health care utilization.<sup>3</sup> Accordingly, any reconfiguration of the delivery system must take into consideration the racial and ethnic composition of the communities to be served in order to promote the development of plans that address health and health care disparities.

With 2.5 million residents, Brooklyn is New York City's most populous borough, comprising 31 percent of the City's population. Its population is, however, growing at a slower rate than the City as a whole – it increased by 1.6 percent between 2000 and 2010, in comparison with a growth rate of 2.1 percent citywide during the same period.<sup>4</sup> Brooklyn's population is projected to grow to 2.59 million by 2030.<sup>5</sup>

Brooklyn's most populous neighborhoods are Southern Brooklyn, Borough Park, Flatbush, and Central Brooklyn with more than 300,000 residents in each. Its least populous neighborhoods are Canarsie-Flatlands, East New York-New Lots, Greenpoint, and Sunset Park.<sup>6</sup>

<sup>3</sup> Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, D.C.: National Academy of Sciences, 2003; Mead, H, Cartwright-Smith, L, Jones, K, Ramos, C, Siegel, B, *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*, The Commonwealth Fund, 2008.

<sup>4</sup> Source: Compilation of 2010 Census at [http://www.nyc.gov/html/dcp/html/census/demo\\_tables\\_2010.shtml](http://www.nyc.gov/html/dcp/html/census/demo_tables_2010.shtml)

<sup>5</sup> Projection by Program on Applied Demographics, Cornell University, available at <http://pad.human.cornell.edu/counties/projections.cfm>

<sup>6</sup> NYC DOHMH, Community Health Survey, 2009.

The median age of Brooklyn residents is 34.4 years, slightly lower than the citywide average of 35.5 years. Currently, residents age 65 and older comprise 11.5 percent of Brooklyn's population. By 2020, the percentage of elderly residents will rise to 13.1 percent.<sup>7</sup> The percentage of the Brooklyn population under age 18 or over age 65, at 35.2 percent, is slightly higher than the citywide percentage.<sup>8</sup>

Nearly 20 percent of Brooklyn's population is Hispanic or Latino, 36 percent is Non-Hispanic White, 32 percent is Non-Hispanic African American, and more than 10 percent is non-Hispanic Asian.<sup>9</sup> Brooklyn's neighborhoods vary based on the distribution of races and ethnicities among their residents. In Central Brooklyn, Bushwick-Williamsburg, Flatbush, and East New York-New Lots, for example, more than 85 percent of the residents are African-American or Hispanic. By comparison, in Greenpoint, Borough Park, and Southwest Brooklyn, more than 50 percent of the residents are White. Sunset Park has the highest percentage of Asian residents at 29 percent.<sup>10</sup>

## **B. Socioeconomic Indicators**

Socioeconomic factors, such as income, health insurance, and education affect health needs and access. In 2010, 23 percent of Brooklyn residents had incomes below the federal poverty level (\$22,350 for a family of four, or \$11,100 for a single person). This compares to 20.1 percent citywide and 14.9 percent statewide.<sup>11</sup> Nearly 15 percent of Brooklyn residents had no health insurance in 2010, compared to nearly 12 percent statewide.<sup>12</sup> Almost 1 million Brooklyn residents, or forty percent of the total, are covered by Medicaid.<sup>13</sup> This compares with 4.7 million and 24 percent statewide.<sup>14</sup>

The following are some additional key socioeconomic indicators for Brooklyn:

- Median household income for all of Brooklyn is \$42,143 in 2010.
- The 2010 unemployment rate for Brooklyn was 10.5 percent, compared to 9.3 percent statewide.
- Of the total population 25 years and older, 12 percent has less than a 9<sup>th</sup> grade education, 29 percent has attained a high school diploma or equivalent and 29 percent has a Bachelor's or higher degree.<sup>15</sup>

The neighborhoods in Brooklyn with the highest poverty rates are: Greenpoint, Bushwick-Williamsburg, Central Brooklyn, and East New York-New Lots, where more than 30 percent of households live below the federal poverty level. By comparison, the poverty rate in Canarsie-Flatlands is 14 percent, in Southwest Brooklyn 16 percent, and Northwest Brooklyn 20 percent.<sup>16</sup>

<sup>7</sup> County population projections by the Program on Applied Demographics, Cornell University, downloaded from <http://pad.human.cornell.edu/counties/projections.cfm>

<sup>8</sup> *Ibid.* This segment of the population is the basis for calculating a locality's "dependency ratio," which reflects the portion of the population not in the workforce and potentially dependent on working age- residents. It is a measure of potential demand for health and human services by vulnerable groups.

<sup>9</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

<sup>10</sup> NYC DOHMH, Community Health Survey, 2009, <http://nyc.gov/health/epiquery>, accessed Oct. 21, 2011.

<sup>11</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

<sup>12</sup> *Ibid.*

<sup>13</sup> NYSDOH/OHIP Recipient Summary Database as of end of 2010.

<sup>14</sup> *Ibid.*

<sup>15</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.

<sup>16</sup> NYC DOHMH, Community Health Profiles, 2006.

Those with the highest percentage of uninsured residents are: Bushwick-Williamsburg and Sunset Part, where more than 25 percent of residents are uninsured.<sup>17</sup>

### **C. Immigration and English Proficiency**

Immigration status affects eligibility for Medicaid and Medicare, as well as other public benefit programs, and thereby can impede access to health care. Limited English proficiency presents communication challenges for the patient and provider which can affect quality of care and outcomes. From the provider's perspective, serving large numbers of uninsured patients generally means that services will be uncompensated, while serving patients with limited English proficiency requires the dedication of resources to interpreter services.

Fully 38 percent of all current Brooklyn residents are foreign-born. Of those foreign-born residents, 45 percent are not US citizens.<sup>18</sup> The majority of immigrants residing in Brooklyn are of Latin-American origin, with 52 percent from South American countries. European and Asian immigrants make up 20 percent and 25 percent of the remaining immigrant population respectively.<sup>19</sup>

All of Brooklyn's neighborhoods have high percentages of foreign-born residents. More than one-third of the residents are foreign born in Borough Park, Canarsie-Flatlands, East New York-New Lots, Greenpoint, Flatbush, Southern Brooklyn, Southwest Brooklyn, and Sunset Park.<sup>20</sup>

The large foreign-born population in Brooklyn naturally leads to a significant percentage of residents with limited English proficiency and a wide variety of spoken languages. Of the total population living in Brooklyn over 5 years old, 46 percent speak a language other than English at home and 25 percent state they speak English 'less than well.'<sup>21</sup>

### **D. Population Health, Disparities, and Brooklyn's Neighborhoods**

Brooklyn faces daunting population health challenges. High rates of chronic disease and premature death exact human and economic costs. On all of the following indices, Brooklyn residents exhibited worse results on health status indicators than New York City residents as a whole:

- 26 percent of adults in Brooklyn were obese in 2009;
- 11 percent of adults had diabetes in 2009;
- 31 percent of adults had high blood pressure in 2009.<sup>22</sup>

Likewise, rates of hospitalization and premature death were higher in Brooklyn than citywide. In Brooklyn, 47 percent of residents who died did so prematurely (before age 75) between 2007 and 2009, as compared to 45 percent citywide. In addition, Brooklyn residents experience a higher rate of:

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<sup>17</sup> NYC DOHMH, Community Health Profiles, 2006.

<sup>18</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.

<sup>19</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>.

<sup>20</sup> NYC DOHMH, Community Health Profiles, 2006.

<sup>21</sup> 2010 estimates from American Community Survey obtained from American Fact Finder website at <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>. The percentage of households characterized as "linguistically isolated" in 2009 (meaning no one in the household speaks English well) varied considerably by geographic area, with the highest rates in southern Brooklyn (32% to 42%), Sunset Park (34%) and Bushwick (33%). Welsh Analytics LLC compilation from American Community Survey data at [www.census.gov/acs/www/data\\_documentation/data\\_via\\_ftp/](http://www.census.gov/acs/www/data_documentation/data_via_ftp/).

<sup>22</sup> NYC DOHMH, EpiQuery, available at: <https://a816-healthpsi.nyc.gov/epiquery/EpiQuery/CHS/index2009.html>.

- heart disease hospitalizations than the citywide average;
- heart disease deaths than the citywide average;
- diabetes hospitalizations than the citywide average;
- diabetes deaths than the citywide average.<sup>23</sup>

Within Brooklyn, significant health disparities are associated with race and ethnicity. Specifically, Black non-Hispanic Brooklyn residents experience a disproportionately high rates of negative health outcomes, including:

- 62.3 percent of Black non-Hispanic residents who died did so prematurely (before age 75), between 2007 and 2009 -- double the rates for White non-Hispanic Brooklyn residents;
- Black non-Hispanic residents experienced the highest rates of obesity (31.8%) and high blood pressure (35.0%) and second highest rate of diabetes (13.2%) as compared to other race/ethnic groups in Brooklyn during 2009;
- Black non-Hispanic children in Brooklyn were hospitalized for asthma at a rate of 70.0 per 10,000 -- almost ten times the rate of their White non-Hispanic (7.6 per 10,000) counterparts.<sup>24</sup>

Hispanics also experience a disproportionately poor health outcomes compared to other racial and ethnic groups residing in Brooklyn. Between 2007 and 2009, in comparison with other racial and ethnic groups residing in Brooklyn, Hispanic Brooklyn residents had the:

- Highest percentage of premature deaths (62.5%)
- Highest prevalence of diabetes (15.5%) and asthma (11.0%);
- Second highest rates of obesity (29.3%) and high blood pressure (31.3%).<sup>25</sup>

Health status indicators among Asian Pacific Islanders and White non-Hispanics residing in Brooklyn are mostly better than the borough average. There are, however, several indicators for which White non-Hispanics had the highest rates, compared to other racial/ethnic groups, including rates of heart disease mortality (262.1 per 100,000), lung cancer incidence (53.2 per 100,000) and hospitalizations for falls (185.0 per 10,000) among persons aged 65 or older.<sup>26</sup>

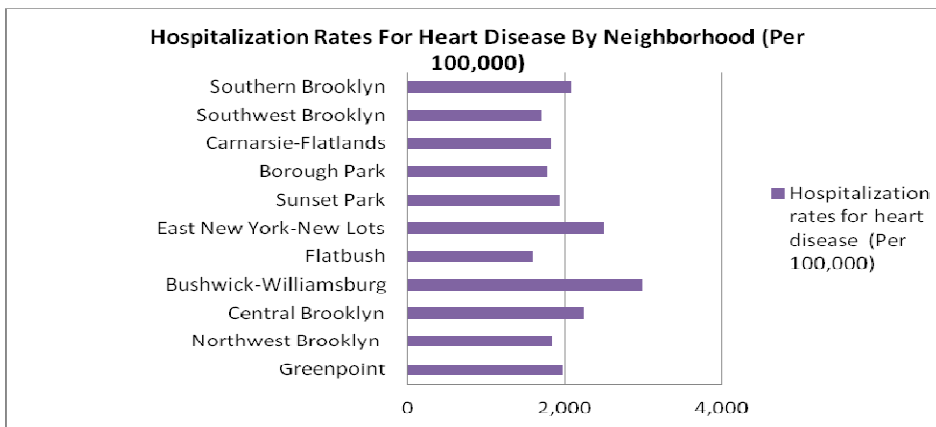
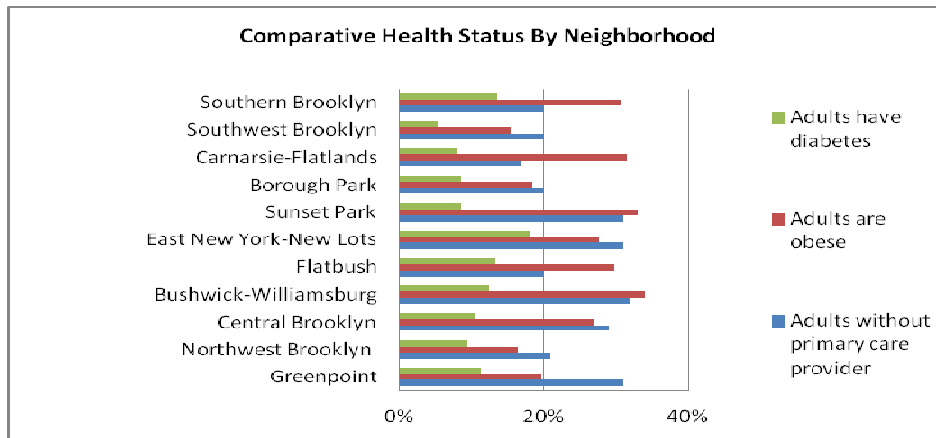
Brooklyn residents and their neighborhoods are socioeconomically, ethnically and racially diverse, and community health data document disparities in health status among neighborhoods. The graphs below show some of the variation in health status. For additional information about some of the key demographic, socioeconomic, and health status characteristics of Brooklyn's neighborhoods, see Appendix B.

<sup>23</sup> NYS Dept. of Health, Office of Public Health, based on NYS SPARCS and Vital Records and U.S. Census data, complete data will be available at <http://cchphig070001/statistics/community/minority/about.htm>.

<sup>24</sup> NYS Dept. of Health, Office of Public Health, based on NYS SPARCS and Vital Records and U.S. Census data, complete data will be available at <http://cchphig070001/statistics/community/minority/about.htm>

<sup>25</sup> *Ibid.*

<sup>26</sup> NYS Dept. of Health, Office of Public Health, based on NYS SPARCS, Vital Records and Cancer Registry data and U.S. Census data, complete data will be available at <http://cchphig070001/statistics/community/minority/about.htm>



Additional analysis of health status, health care needs, and existing capacity by neighborhood is needed to align health care resources with community health needs in Brooklyn and to identify hot spots for disease and sub-optimal utilization. With that information, providers and their communities can respond by developing appropriate health care resources and interventions.

### III. HEALTHCARE DELIVERY SYSTEM PROFILE

#### A. Brooklyn’s Health Care Providers

An inventory of Brooklyn’s health care providers, along with an understanding of its residents and their health needs, is integral to an assessment of its delivery system and recommendations for improvement. There are fifteen general hospitals in Brooklyn which include eleven voluntary hospitals, three municipal hospitals, and one SUNY hospital. In addition, there is one Office of Mental Health certified psychiatric hospital and one Veteran’s Administration Hospital in Brooklyn. Descriptions of Brooklyn’s fifteen general hospitals, their neighborhood locations, licensed beds, and specialized services are set forth at Appendix C. There are also 42 nursing homes and 61 diagnostic and treatment centers (D&TCs) and 83 extension clinics.<sup>27</sup> In addition, there are 69 mental health clinics in Brooklyn with 73 satellites (a total of 142 clinic locations)<sup>28</sup> and 44 chemical dependence treatment outpatient programs in Brooklyn.<sup>29</sup>

<sup>27</sup> NYS Dept. of Health, Health Facilities Information System, accessed October 2011.

<sup>28</sup> NYS Office of Mental Health, OPME OMH Concerts, May 2011; Bureau of Inspection and Certification as of Oct. 2011.

<sup>29</sup> NYS Office of Alcohol and Substance Abuse Services, Division of Outcome Management and System Investment, Oct. 2011; also Welsh Analytics, Mental Health Programs in Brooklyn, Sept. 2011, *citing* NYS Dept. of City Planning.

The D&TCs include 13 organizations that operate federally qualified health centers (FQHCs) in Brooklyn from more than 80 sites (including part-time, school-based, and mobile sites) across the borough.<sup>30</sup> FQHCs are not-for-profit, community-based providers of comprehensive, affordable primary and preventive care services. The foundational concept of the FQHC is to provide a primary care medical home, with enhanced care coordination and enabling services such as interpretation, social services and transportation that encourage patients to remain engaged in care. Financial and non-financial barriers to care are addressed by the comprehensive service model and a requirement that all patients have access to care at the FQHC, regardless of insurance status or ability to pay. FQHCs have been shown to lower significantly the costs associated with treating patients with chronic disease<sup>31 32</sup> and to reduce the rates of avoidable and costly ED visits<sup>33</sup> and preventable hospitalizations.<sup>34 35</sup> In addition, their federally-recognized status provides FQHCs with benefits, such as discounted drug pricing and federal malpractice coverage, that allow them to reduce the operational costs of delivering quality care.

In 2010, FQHCs served 203,000 patients living in Brooklyn, equal to nearly 20 percent of the borough's low-income population. The largest FQHC in Brooklyn is the Sunset Park Family Health Center, an affiliate of Lutheran Medical Center. As a result of federally-funded expansions which began in 2008, nearly all of Brooklyn's neighborhoods are experiencing growth in the number of FQHC patients among their residents, with growth ranging from 7.4 percent between 2008 and 2010 in Sunset Park to nearly 30 percent in Northwest Brooklyn.<sup>36</sup> For a map of Brooklyn's FQHC and D&TC sites, see Appendix D.

The 42 nursing homes in Brooklyn have close to 10,000 beds<sup>37</sup> with an occupancy rate of approximately 94 percent. Hospitals represent the largest source of nursing home referrals, comprising nearly 93 percent of all admissions to Brooklyn nursing homes. Brooklyn nursing homes provide 3.4 million days of care annually, of which 81 percent are reimbursed by Medicaid, which represents 74 percent of net patient revenues. On an average day, about 9,400 residents are living in Brooklyn's nursing homes. Eighty percent are over age 70.<sup>38</sup>

## **B. Collaborative Health Improvement Activities in Brooklyn**

Brooklyn's healthcare delivery system, while facing unprecedented challenges, is also engaged in a variety of innovative activities intended to improve the health of its communities. Three collaborations show promise for supporting integrated systems of care, improving quality, increasing access, and reducing costs.

The Brooklyn Health Improvement Project (BHIP), a HEAL-funded project created in 2009 and led by SUNY Downstate, is a multi-stakeholder collaborative engaged in developing a

<sup>30</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Health Centers and Look-Alikes Data Download, available at [http://datawarehouse.hrsa.gov/Download\\_HCC\\_LookALikes.aspx](http://datawarehouse.hrsa.gov/Download_HCC_LookALikes.aspx).

<sup>31</sup> Costs associated with treating Medicaid beneficiaries in New York who are community health center patients were 24% less per case overall; 36% less for diabetics; and 20% less for asthmatics. Center for Health Policy Studies, "Health Services Utilization and Costs to Medicaid of AFDC Recipients in New York and California Served and Not Served by Community Health Centers," Final Report (November, 1994).

<sup>32</sup> Ku, L., Richard, P., Dor, A., Tan, E., Shin, P. and Rosenbaum, S., "Strengthening Primary Care to Bend the Cost Curve: the Expansion of Community Health Centers Through Health Reform," Geiger Gibson/RCHN Community Health Foundation Research Collaboration, Policy Research Brief No. 19. (Washington, D.C.: The George Washington University School of Public Health and Health Services, June 30, 2010).

<sup>33</sup> Rust, G., Baltrus, P., Ye, J., Daniels, E., Quarshie, A., Boumbulian, P., Strothers, H., "Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties". *J Rural Health* 25(1):8-16 (2009).

<sup>34</sup> Epstein, A., "The role of public clinic in preventable hospitalizations among vulnerable populations" *Health Services Research* 32:2. 405-420 (2001).

<sup>35</sup> Rothkopf, J., Brookler, K., Wadhwa, S., Sajovetz, M., "Medicaid patients seen at federally qualified health centers use hospital services less than those seen by private providers," *Health Affairs* 30:7. 1335-1342 (July, 2011)

<sup>36</sup> Compilation by Community Healthcare Association of New York State from HRSA Uniform Data System ZIP code data available at [www.udsmapper.org](http://www.udsmapper.org).

<sup>37</sup> NYS Dept. of Health, Health Facilities Information System, Oct. 2011.

<sup>38</sup> Continuing Care Leadership Coalition, Oct. 2011.



comprehensive community health planning process. The BHIP is governed by a broad-based coalition that includes representatives of community-based organizations, hospitals, FQHCs, health plans, business, and civic leaders. To ensure that its health planning work is data-driven, it is engaged in data development and analysis activities concerning primary care and emergency department utilization. It is also developing community engagement and primary care access strategies to improve community health.

The Brooklyn Health Information Exchange (BHIX) is a not-for-profit regional health information organization (RHIO) devoted to improving health care through the collection, exchange of and analysis of health information. Its members include 7 hospitals, 10 community health centers, 3 physician practices, 7 community-based and government-sponsored behavioral health providers, 7 nursing homes, 5 home care agencies, and 6 payers. BHIX works in tandem with statewide initiatives to develop common policies, technical standards and protocols for health information technology and exchange. Its information technology architecture enables interoperability through which providers are linked together within BHIX and, in turn, across the Statewide Health Information Network of New York (SHIN-NY). Using advanced decision support systems and patient notification, BHIX will play an active role in improving quality of care and reducing medical errors and oversight. BHIX has funding for various activities under the state's HEAL grant program, including two multi-stakeholder medical home initiatives.

A third initiative funded by a HEAL grant and led by Sunset Park Family Health Center, has enabled the adoption of interoperable electronic health records in 9 diagnostic and treatment centers, including 7 federally qualified health centers (FQHCs). The centers created a Community Health Information Technology Adoption Collaborative ("CHITA") to implement a community-wide electronic health record ("EHR") system, enable the creation of patient-centered medical homes, and support care coordination in Brooklyn. In addition, the CHITA has enabled the exchange of clinical data for quality improvement activities.

The facilities participating in the project, in addition to the Sunset Park Family Health Center, are:

- Association for the Help of Retarded Children (AHRC) (D&TC)
- Bedford Stuyvesant Family Health Center, Inc. (FQHC)
- Brooklyn Plaza Medical Center, Inc. (FQHC)
- Brownsville Multi-Service Family Health Center (FQHC)
- Callen-Lorde Community Health Center (FQHC)
- Community Healthcare Network (FQHC)
- ODA Primary Care Health Center, Inc. (FQHC)
- Planned Parenthood of NYC, Inc. (D&TC).

Each of these facilities has implemented an interoperable EHR with the capacity to share information electronically with other providers, including hospitals.

#### **IV. THE BROOKLYN HEALTH EMERGENCY**

Despite the variety of healthcare facilities and clinicians in Brooklyn, a combination of factors raises serious concerns regarding access to care, quality of care, and population health in Brooklyn. High rates of chronic disease are compounded by socioeconomic barriers to health care, such as lack of health insurance, limited English proficiency, and poverty. Large segments of the population in several neighborhoods live in extreme poverty, have low levels of

educational attainment, and are linguistically isolated.<sup>39</sup> Fully forty percent of Brooklyn residents are on Medicaid and 15 percent are uninsured.<sup>40</sup>

At the same time, it appears to the Work Group, based on interviews, presentations and review of the data, that the delivery system is ill-equipped in some areas to address the complex health issues facing communities. It is dominated by hospitals that are dependent on public monies and, in many cases, weakened by cuts in government programs, intense competition for admissions from within the borough and without, an unfavorable reimbursement environment, and rising costs. Some are managing well on thin margins, while others are struggling to stay afloat and at least three are at risk of imminent financial collapse. Too many of the hospitals have failed to create, and are not organized to partner with, strong primary care and community-based specialty care networks in their communities. Even many well-managed hospitals that are doing good work lack the resources to make necessary investments in physical plant, staff, medical talent, information technology or new models of care.

Health care utilization and capacity data suggest that Brooklyn residents, in several neighborhoods, are not accessing or receiving the types of high-quality health care they need and deserve. Indeed, as discussed later in this report, primary care and outpatient behavioral health providers are unevenly distributed and insufficient in several high-need areas, emergency departments are used heavily for non-emergent or primary care treatable conditions, and too often Brooklyn residents are admitted to hospitals for conditions that could have been prevented through high-quality primary care, community-based specialty care, and care coordination.

An analysis of Brooklyn-related health care utilization data reveals some of the factors that are weakening Brooklyn's hospitals. It also shows in stark terms the failure of the delivery system to engage patients in care in primary care settings, resulting in preventable use of higher cost services and, in all likelihood, poor health outcomes.

## A. Hospital Utilization

Hospital utilization data show a variety of trends and factors that are undermining the financial stability of Brooklyn's hospitals and that suggest inefficiency in the use of their services – declining admissions in several facilities, a low case mix index, high lengths of stay, low occupancy rates, migration of lucrative cases to Manhattan facilities, and high rates of preventable admissions and emergency department visits. In 2010, there were approximately 297,000 inpatient discharges from Brooklyn hospitals, down from approximately 301,000 in 2009.<sup>41</sup> Discharges from Brooklyn hospitals, in 2010, were concentrated heavily in the medical service category:

- Medical: 38%
- Surgical: 26%
- Pediatric: 5%
- Obstetrical: 12%
- Healthy Newborn: 9%
- High Risk Neonate: 1.5%

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<sup>39</sup> Compiled from American Community Survey data at: [www.census.gov/acs/www/data\\_documentation/data\\_via ftp/](http://www.census.gov/acs/www/data_documentation/data_via ftp/). In particular, approximately fifty percent of the residents of the neighborhoods of northeast Brooklyn (Greenpoint, Bushwick-Williamsburg, East New York, Central) have incomes below 200 percent of the federal poverty level. Similarly, close to fifty percent of the residents of Sunset Park and Borough Park also have incomes below 200 percent of the poverty level. There are also large pockets of linguistic isolation in Williamsburg-Bushwick, Coney Island-Sheepshead Bay, Sunset Park, and Borough Park. *Ibid.*

<sup>40</sup> Non-citizens are particularly prominent among the non-elderly uninsured. *Ibid.* This suggests that even after access to health insurance is expanded under the Affordable Care Act, a significant number of Brooklyn residents will remain uninsured.

<sup>41</sup> Welsh Analytics, LLC, NYS DOH SPARCS Inpatient Deidentified File data, obtained Aug. 2011.

- Psychiatric: 5%
- Chemical Dependency: 3%<sup>42</sup>

Although they represented only 8 percent of discharges, more than 15 percent of Brooklyn’s inpatient days in 2010 were attributable to patients with a *principal* diagnosis of “mental illness” (including alcohol- or substance-related disorders) – the largest percentage of inpatient days of all of the clinical categories.<sup>43</sup>

The case mix index (a measure of the acuity of the patients served and resource intensity of their treatments) for medical-surgical patients in Brooklyn overall in 2010 was 1.41 compared with 1.54 in New York City and statewide.<sup>44</sup> Since reimbursement rises with resource intensity, a low case mix is associated with lower revenues.

Average length of stay (ALOS) is a measure of the efficiency of the care process in hospitals. It may also reflect the complexity of the patients treated and difficulties in implementing satisfactory discharge plans. The average length of hospital stays (ALOS) in Brooklyn is 6.12 days overall, and 6.03 days for medical-surgical patients. The 6.12 overall ALOS is also much higher than the national average of 4.8 days.<sup>45</sup> The medical-surgical ALOS is higher than that observed in three of the four other boroughs (the exception being Manhattan which has an ALOS of 6.21 days).<sup>46</sup>

Despite the extended ALOS of Brooklyn hospitals, they are generally not fully occupied. In 2010, excluding healthy newborn admissions, 71 percent of the inpatient beds in Brooklyn, on average, were occupied daily.<sup>47</sup> This is below the medical-surgical planning standard of 85 percent occupancy.<sup>48</sup> However, as the table below illustrates, occupancy rates and ALOS varied by hospital, with some above and many well below the planning standard, but not one with an ALOS that comes close to the national average. Brookdale, Brooklyn Hospital, Interfaith, LICH, Wyckoff, and Kingsbrook Jewish each had an occupancy rate of less than 66 percent in 2010; LICH’s occupancy rate was 45.2 percent.

<sup>42</sup> Welsh Analytics, NYS DOH SPARCS Inpatient Deidentified File data, obtained Aug. 2011.

<sup>43</sup> Welsh Analytics, NYS DOH, SPARCS Inpatient Deidentified File data, obtained in Aug. 2011. The ‘clinical categories’ refer to the Level-1 grouping of diagnostic codes under the Clinical Classification Software provided by the federal Agency for Healthcare Research and Quality (see [www.ahrq.gov](http://www.ahrq.gov)). One category covers behavioral health diagnoses (alcohol or substance abuse and mental disorders) under the term “mental illness.”

<sup>44</sup> *Ibid.*

<sup>45</sup> Derived from weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2009, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States (excludes healthy newborns).

<sup>46</sup> *Ibid.* The overall ALOS of 6.12 excludes healthy newborn discharges.

<sup>47</sup> Welsh Analytics, NYS DOH, SPARCS Inpatient Deidentified File data, obtained in Aug. 2011 and NYS DOH Health Facilities Information System.

<sup>48</sup> The planning standard is set forth in New York State regulations at 10 NYCRR 709.2(d)(14). This is the occupancy level deemed efficient for medical-surgical beds that also provides for additional capacity as a contingency against surges in bed need due to disease outbreaks, disasters, seasonal influxes of patients or population or other eventualities. Although there are lower standards for pediatric and obstetric beds, these represent a much smaller percentage of admissions.

## 2010 Occupancy Rates and ALOS at Brooklyn Hospitals

Hospital	Occupancy Rate	Average Length of Stay*
Beth Israel – Kings	89.5%	6.12
Brookdale	57.9%	6.22
Brooklyn Hospital Center	51.3%	5.51
Coney Island	83.7%	6.60
Interfaith	64.5%	7.13
Kings County	69.4%	7.82
Kingsbrook	63.5%	7.65
Long Island College	45.2%	5.36
Lutheran	78.4%	5.62
Maimonides	84.4%	5.68
New York Community	90.3%	6.19
New York Methodist	84.7%	5.60
University	74.8%	6.14
Woodhull	73.4%	7.12
Wyckoff	65.9%	4.77
<b>Boroughwide</b>	<b>70.8%</b>	<b>6.12</b>
<b>National Average Length of Stay**</b>		<b>4.8</b>

\*Source: Compiled from NYS DoH SPARCS De-identified Inpatient File, obtained Aug. 2011 (ALOS figures exclude healthy newborns).

\*\*Weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2009, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States.

The inpatient payer mix of Brooklyn hospitals is dominated by Medicaid, which paid for 42 percent of the discharges in 2010. Medicare covered 33 percent, and commercial insurance covered 17 percent.<sup>49</sup> The remaining 8 percent are considered “self-pay” patients, who typically include primarily uninsured and charity care patients. With high percentages of patients covered by Medicare and Medicaid (75 percent in 2010), Brooklyn hospitals are particularly vulnerable to the effects of the state and federal budgets.

<sup>49</sup> Welsh Analytics, Brooklyn Hospital Inpatient Discharges by Services and Payer Group, compiled from NYS DOH SPARCS De-Identified Inpatient File, extracted Aug. 2011

## Brooklyn 2010 Hospital Discharges by Payer Group<sup>50</sup>

	Total Discharges	Medicaid	Medicare	Others	Commercial
<b>BI Kings</b>	<b>11,313</b>	14.3%	64.7%	1.7%	19.3%
<b>Bkl Downtown</b>	<b>17,789</b>	50.5%	30.6%	0.2%	18.6%
<b>Brookdale</b>	<b>19,083</b>	53.4%	29.1%	4.7%	12.8%
<b>Coney Island</b>	<b>18,323</b>	36.8%	35.1%	22.8%	5.4%
<b>Interfaith</b>	<b>9,482</b>	52.8%	26.9%	13.7%	6.6%
<b>Kings County</b>	<b>24,637</b>	47.4%	17.0%	30.9%	4.7%
<b>Kingsbrook</b>	<b>9,874</b>	29.2%	57.2%	1.1%	12.5%
<b>LICH</b>	<b>16,972</b>	31.3%	34.1%	2.5%	32.1%
<b>Lutheran</b>	<b>27,678</b>	46.0%	31.6%	7.0%	15.4%
<b>Maimonides</b>	<b>45,658</b>	47.1%	33.5%	1.0%	18.4%
<b>NY Community</b>	<b>7,142</b>	16.4%	68.1%	1.6%	13.9%
<b>NY Methodist</b>	<b>37,223</b>	28.9%	35.5%	1.7%	33.9%
<b>University</b>	<b>17,828</b>	46.5%	33.5%	3.4%	16.6%
<b>Woodhull</b>	<b>16,614</b>	48.0%	9.4%	39.8%	2.7%
<b>Wyckoff</b>	<b>17,627</b>	55.5%	29.5%	1.3%	13.7%
<b>All 15</b>	<b>297,243</b>	41.9%	32.9%	8.5%	16.6%

### *i. Inpatient Trends and Patient Migration*

While total inpatient discharges at Brooklyn hospitals rose slightly (by 1 percent) from 2006-07 to 2009-10, they have declined more recently -- by 2 percent between 2008 and 2010. Discharge trends vary widely by hospital. From 2006-07 to 2009-10, we find a 20 percent decline at Long Island College Hospital, and declines of 8 percent to 11 percent at Brookdale, Woodhull and Wyckoff. During the same period, discharges increased by 5 percent to 9 percent at University, Kings County, Methodist and Beth Israel (Kings), and 11 percent to 15 percent at Kingsbrook Jewish, New York Community and Maimonides.

Discharge trends also vary by payer. Across the 15 Brooklyn hospitals, discharges of Medicaid patients declined by 7 percent between 2008 and 2010, while Medicare and commercially-insured patient volume declined by 1 percent and 7 percent respectively. The sharpest declines in commercially-insured patients were seen at Lutheran (-18%), Coney Island Hospital (-15%), Kings County Hospital (-15%), LICH (-21%) and Woodhull Hospital (-30%).<sup>51</sup> In addition, the number of commercially-insured patients at Brookdale dropped by 33 percent between 2006-07 and 2009-10. Although self-pay inpatients (typically uninsured patients who pay a modest amount or nothing at all for services) are a small percentage overall, the number of self-pay patients discharged from Brooklyn hospitals increased by 56 percent between 2008 and 2010.<sup>52</sup>

Declining discharges are responsible in part for the financial instability of some of Brooklyn's hospitals. As the table below illustrates, rising discharges are associated with a positive operating margin, while reduced or flat discharge trends are correlated with break-even or negative margins.

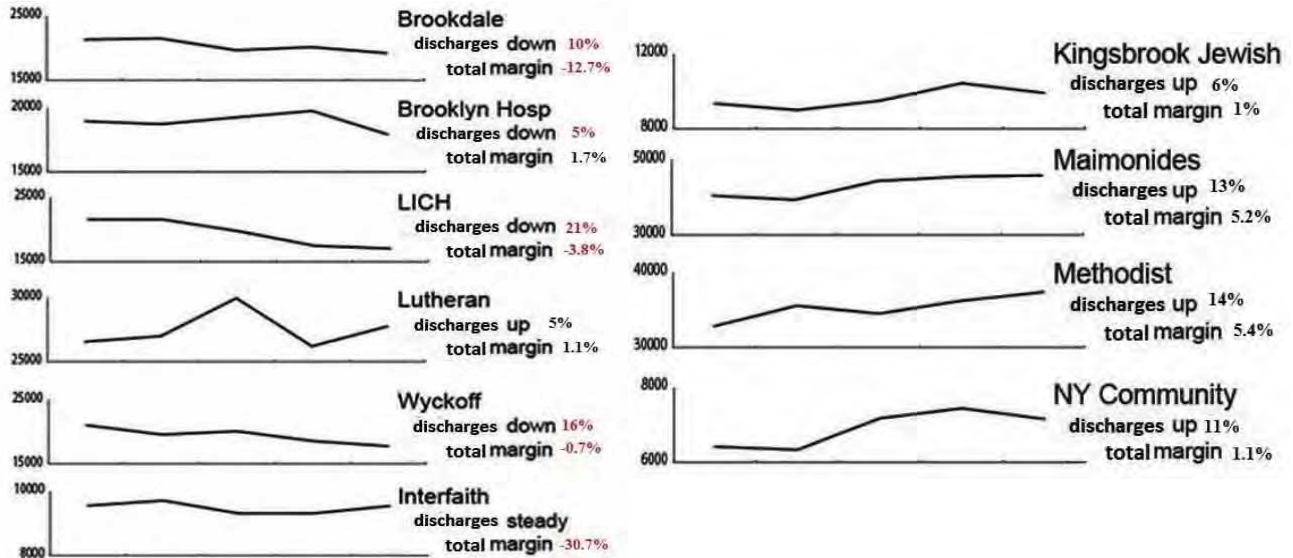
<sup>50</sup> *Ibid.*

<sup>51</sup> Welsh Analytics, LLC, compiled from NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.

<sup>52</sup> Welsh Analytics, LLC, NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.

## Discharge Trends and Total Margin\*<sup>53</sup> (Five-year discharge trend and 2010 total margin)

\*Discharge trend is reflected year-to-year from 2006 through 2010, rather than by comparing the average of 2006-07 to 2009-10. 11.



With declining admissions at many hospitals and little growth overall, competition for patients among hospitals is fierce. Not one Brooklyn hospital commands 40 percent of the inpatient discharges in the zip codes that provide 50 percent or more of its inpatients – its “core market.” Only four hospitals attract more than 30 percent of the inpatient discharges from their core markets: Lutheran (37%), Maimonides (37%), Coney Island (32%), and Wyckoff (31%). In other words, more than 70 percent of the residents of the core market areas of the remaining 11 hospitals go to other hospitals for care. Kingsbrook Jewish and NY Community command the smallest shares of their markets (at 9% and 8%, respectively).<sup>54</sup>

While in many cases the top competitors for Brooklyn patients are Manhattan hospitals (particularly for commercially-insured and surgical patients), Brooklyn hospitals are also competing with each other for patients. For example, Kingsbrook Jewish’s top competitors in its core market are Kings County, Brookdale and University Hospital.<sup>55</sup> Similarly, Brooklyn Hospital Center competes for market share with Woodhull and Methodist, and LICH competes with Brooklyn Hospital and Methodist.<sup>56</sup> (For more information about hospital market shares, see Appendix E)

Low growth in admissions is in part attributable to migration of patients from Brooklyn to other boroughs or counties for care. While more than 90 percent of Brooklyn hospital inpatients are Brooklyn residents, only slightly more than three-quarters (76%) of Brooklyn residents who were admitted to a hospital in 2010 used a Brooklyn hospital in 2010.<sup>57</sup> Nearly one in five (18.4%) went to Manhattan facilities, 2.7 percent to hospitals in Queens, 1.2 percent to Staten Island, 0.6 percent to the Bronx, and 1.4 percent elsewhere.<sup>58</sup> The migration to Manhattan for care has been rising from just over 60,000 patient discharges in 2006-2007 to over 65,000 in 2009-2010.<sup>59</sup> The strongest magnets for Brooklyn patients in 2010 were Beth Israel Medical Center,

<sup>53</sup> *Ibid.*; Heller K, GNYHA Presentation to Medicaid Redesign Team: Brooklyn Work Group, Sept. 21, 20

<sup>54</sup> Welsh Analytics, LLC, NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.

<sup>55</sup> *Ibid.*

<sup>56</sup> *Ibid.*

<sup>57</sup> Welsh Analytics, LLC, NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.

<sup>58</sup> *Ibid.*

<sup>59</sup> *Ibid.*

NYU Langone Medical Center, NY Presbyterian-Weill Cornell Medical Center, and Mt. Sinai Medical Center.<sup>60</sup> Thus, Brooklyn hospitals are not attracting patients from other boroughs, and they are losing a significant portion of their geographic market to Manhattan’s academic medical centers.

The migration of patients to Manhattan was greatest among commercially-insured patients and surgical patients. The number of commercially-insured Brooklyn patients going to Manhattan hospitals increased by 15 percent from 2006-07 to 2009-10. Overall, 35 percent of commercially-insured patients migrated to Manhattan for care, in 2010 whereas 13.5 percent of Medicaid patients did so.<sup>61</sup> While the outflow of patients to Manhattan was highest for surgical patients (drawing 25.1 percent of Brooklyn inpatients) about one in five obstetric patients (21.7 percent) from Brooklyn also went to Manhattan hospitals.<sup>62</sup> Manhattan’s stronger draw of surgical patients is seen both for Medicaid and for commercially-insured groups; its stronger draw for commercially-insured patients is seen for both medical and for surgical patients. By voting with their feet, particularly for services that are reimbursed relatively generously, Brooklyn patients are diverting needed inpatient revenue away from Brooklyn to Manhattan hospitals.

### Out-of-Borough Migration of Brooklyn Hospital Inpatients, 2010<sup>63</sup>

	Brooklyn Residents with Inpatient Admissions	Hospital Destination (%)		
		Brooklyn	Manhattan	Other*
<b>All</b>	356,021	75.8	18.4	5.9
<b>Medical</b>	123,255	83.9	11.3	4.7
<b>Surgical</b>	98,888	70.1	25.1	4.7
<b>Medicaid</b>	140,759	79.6	13.5	6.9
<b>Medicare</b>	112,834	81.5	14.7	3.8
<b>Commercial</b>	73,608	58.6	34.6	6.7

\*This column includes hospital destinations in Queens, the Bronx, Staten Island, and other locations.

#### ii. *Emergency Department Use and Prevention Quality Indicator (PQI) Admissions*

Emergency department utilization and inpatient admissions for conditions that could be treated or prevented through ambulatory care are a starting point for evaluating the overall quality and accessibility of primary and preventive care in an area. In addition, high rates of preventable emergency department or inpatient use are indicators of waste in the health care delivery system – in both cases, the need for higher intensity and expensive health care services could have been averted through the use of lower level, less costly care.

Based on the algorithm developed by John Billings at N.Y.U., approximately 46 percent of all emergency department (ED) visits that do not result in a hospital admission in Brooklyn are either non-emergent or primary care treatable.<sup>64</sup> Similarly, the rate of inpatient admissions that could be avoided with appropriate preventive care or disease management in the community, known as the PQI rate, is also 20 percent higher in Brooklyn hospitals than the statewide average hospital rate (15.4 percent of adult medical-surgical admissions compared to 13.1 percent citywide and 12.9 percent statewide).<sup>65</sup>

<sup>60</sup> *Ibid.*

<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

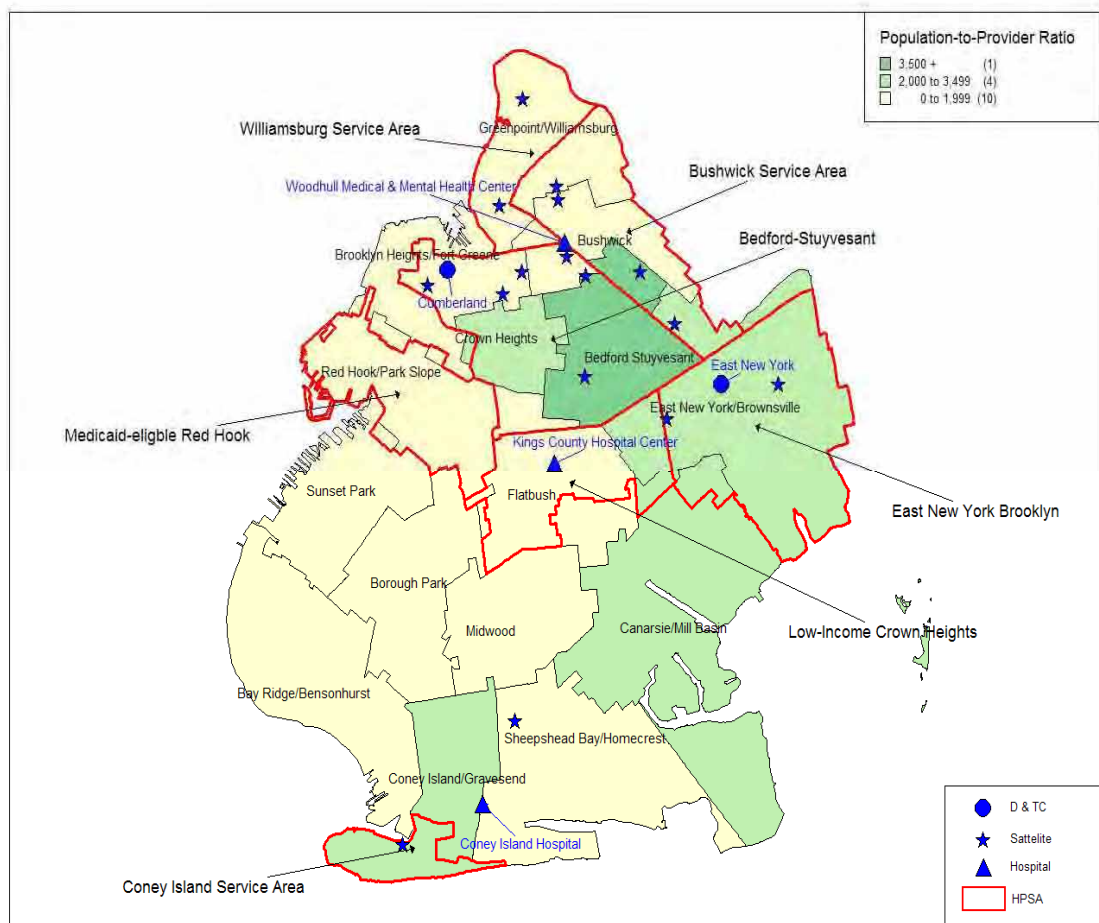
<sup>63</sup> *Ibid.*

<sup>64</sup> Welsh Analytics, LLC, Brooklyn 2010 ED Outpatient Visits as Evaluated by the NYU Algorithm, using NYS DOH SPARCS ED Outpatient File with NYU ED Algorithm, obtained Aug. 2011.

<sup>65</sup> NYS DOH coding of PQIs on 2009 SPARCS Deidentified Inpatient File, obtained Aug. 2011.

Sub-optimal inpatient and emergency department use in Brooklyn vary by neighborhood and correlate with health professional shortage area (HPSA) designations and with poverty. In 2008, East New York-New Lots, Central Brooklyn, and Bushwick-Williamsburg had the highest rates of emergency department visits that did not result in a hospital admission – at 50, 52, and 57 visits per 100 residents respectively.<sup>66</sup> The highest rates of PQI inpatient discharges as a percentage of medical-surgical admissions are found in the neighborhoods of Bushwick-Williamsburg, East New York-New Lots, Central Brooklyn, Northwest Brooklyn and Sunset Park.<sup>67</sup> (See Appendix F for a map of PQI discharges by neighborhood and Appendix G for a table describing Brooklyn HPSAs.) The highest PQI rates by hospital are found at Woodhull Medical Center (24%), Beth Israel-Kings Medical Center (21%), Brooklyn Hospital Center (19%), Brookdale, (19%), Interfaith (20%), and Kings County Hospital Center (19%). This compares to PQI rates of 13 percent at hospitals citywide and statewide.

### Health Professional Shortage Areas in Brooklyn<sup>68</sup>



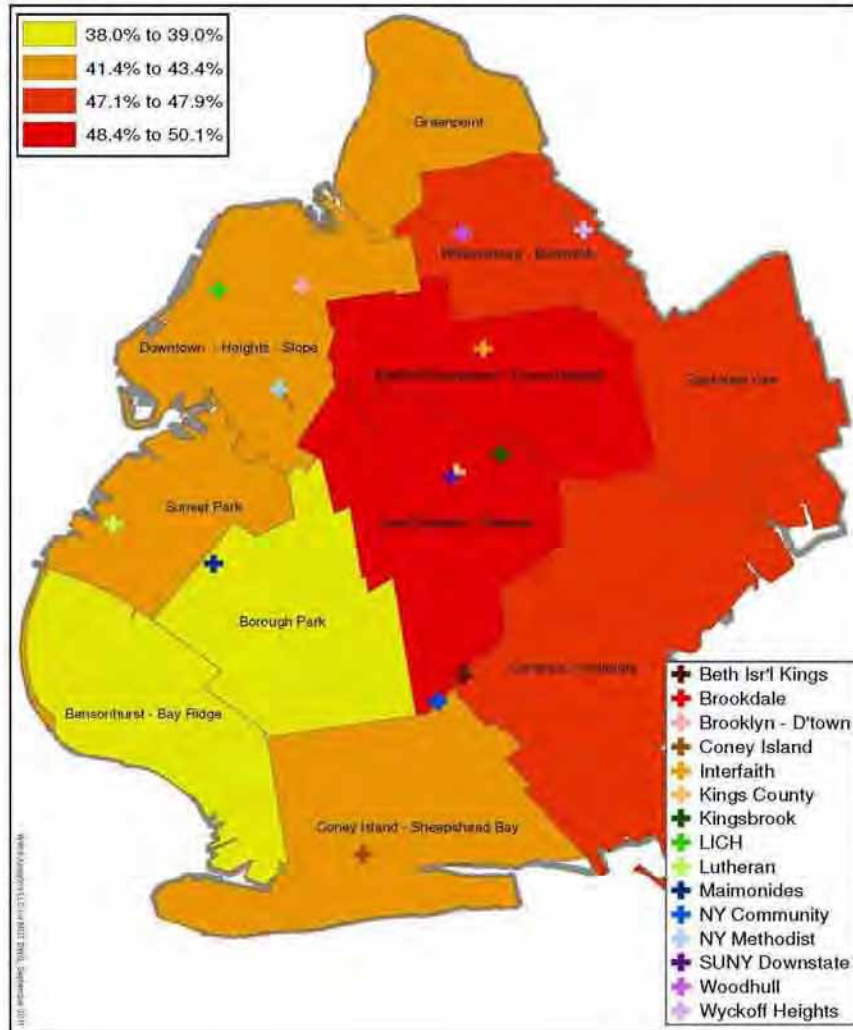
<sup>66</sup> Birnbaum, M, Emergency Department Use in Brooklyn by Neighborhood, United Hospital Fund, Presentation to the Brooklyn Work Group, Sept. 21, 2011, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/2011-09-21\\_brooklyn\\_mrt\\_final.ppt](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-09-21_brooklyn_mrt_final.ppt) #387,1, MEDICAID REDESIGN TEAM: HEALTH SYSTEMS REDESIGN.

<sup>67</sup> Welsh Analytics, LLC, NYS DOH coding of PQIs on 2009 SPARCS Deidentified Inpatient File, obtained Aug. 2011.

<sup>68</sup> Center for Health Workforce Studies, Oct. 2011.



**2010 ED Outpatient Visits by NYU ED Algorithm: UHF Neighborhoods**  
 PERCENTAGE OF VISITS FOUND NON-EMERGENCY OR PC-TREATABLE



High rates of primary care treatable ED use and PQI hospitalizations suggest that patients are not accessing appropriate or effective primary care necessary to keep them healthy and out of the hospital. Similarly, high rates of non-emergent ED use suggest that patients are not connected to a primary care provider who can see them when they are ill.

Since ED care is episodic and typically does not provide the same level of familiarity between the patient and clinician, nor the same level of follow-up care as primary care, it is not an appropriate substitute for primary care. It is also the most expensive alternative to primary care.

These rates further suggest that a significant portion of the effort and resources of Brooklyn's hospitals lies in accommodating the effects of a fragmented healthcare system that both lacks adequate primary and preventive care and encourages patients and the providers themselves to rely inappropriately on emergency departments and hospital-based services.

iii. *Hospital Performance in Patient Satisfaction Surveys*

Further evidence of the weakened condition of some of Brooklyn's hospitals can be found in poor scores on patient satisfaction surveys. To assess patient satisfaction with a hospital, the Work Group used the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey conducted by CMS. Not one Brooklyn hospital reached or exceeded the statewide average score with respect to the percentage of patients who would 'definitely recommend' the facility. On this measure, Brookdale's performance was particularly poor, with less than 40 percent of its patients indicating that they would definitely recommend the hospital. Wyckoff Heights and Interfaith also scored poorly – less than 50 percent of their patients reported that 'they would definitely recommend the hospital.'<sup>69</sup>

Patient satisfaction with the communication and symptom control is also less than ideal in Brooklyn hospitals. The percentage of patients who report that their doctor 'sometimes or always communicates well' with them falls below the state and city averages of approximately 94 and 92 percent respectively in every Brooklyn hospital, with the exception of Maimonides. Significant outliers on this measure are Wyckoff Heights, Brookdale and Interfaith -- each scoring well below the average at approximately 86 percent. This pattern continues for the percentage of patients who report that their pain 'is usually or always well-controlled by Brooklyn hospitals. No Brooklyn hospital reaches the statewide average of 90 percent. Brookdale again falls considerably lower than all other Brooklyn hospitals with a score of approximately 75 percent.<sup>70</sup> For a more complete review of how each Brooklyn hospital rated on these measures please see Appendix H.

iv. *Current and Projected Inpatient Bed Need*

As noted above, on average, only 71 percent of Brooklyn's 6,389 licensed hospital beds are occupied daily.<sup>71</sup> Based on the current population and utilization patterns, Brooklyn needs fewer than 5,400 beds to reach, and not exceed, the optimal 85 percent occupancy medical-surgical planning standard at every Brooklyn hospital.<sup>72</sup> In other words, Brooklyn could shed approximately one thousand beds and still be at or below the 85 percent occupancy standard.

In addition to the relatively low occupancy level of Brooklyn hospitals, flat or downward trends in Brooklyn admissions, high PQI rates, and above-average lengths of hospital stays (ALOS) suggest that inpatient capacity could be reduced even further in Brooklyn. In the context of a reconfigured, high-performing delivery system, in which patient-centered primary care is emphasized, PQI discharges, length of hospital stays, and preventable readmissions will all be reduced. These changes will, in turn, reduce the need for inpatient beds, even after taking into account projected population growth in Brooklyn.

Specifically, modest reductions in PQI discharges and ALOS would yield further reductions in bed need in Brooklyn. If ALOS were reduced by only one day, Brooklyn could reduce its inpatient beds by an additional 869 beds. Taking into account population growth through 2015, if PQI discharges were reduced by 25 percent and ALOS for medical-surgical patients over age 64 were reduced to the average for the other four boroughs, the number

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<sup>69</sup> Hospital Care Quality Information from the Consumer Perspective, Centers for Medicare & Medicaid Services, Baltimore, MD, available at <http://www.hcahpsonline.org>, accessed Apr. 20, 2011

<sup>70</sup> *Ibid.*

<sup>71</sup> See text accompanying note 47.

<sup>72</sup> There are different planning standards for pediatric and obstetric beds, but they allow for even lower occupancy rates than the medical-surgical standard and drive even greater reductions in bed need.

of licensed hospital beds needed in 2015 to achieve (but not exceed) the 85 percent occupancy standard would be 1,235 less than the current number.<sup>73</sup>

## **B. Primary Care Access and Utilization**

Access to effective primary care has the potential to reduce inpatient admissions and emergency department use, while improving health status and reducing costs.<sup>74</sup> Yet, 23 percent of all Brooklyn residents, and nearly one-third of the residents in five Brooklyn neighborhoods, indicate that they lack a primary care provider (Greenpoint, Central Brooklyn, Bushwick-Williamsburg, East New York-New Lots, and Sunset Park).<sup>75</sup>

Generally, in Brooklyn and statewide, there are three distinct settings for primary care – the physician or nurse practitioner office, the hospital-sponsored outpatient clinic, and the freestanding diagnostic and treatment center. As noted above, FQHCs are a type of diagnostic and treatment center that must provide comprehensive primary care and enabling services to patients regardless of their ability to pay.

A scarcity of FQHC sites or other outpatient health care facilities in a neighborhood is not necessarily indicative of insufficient primary care capacity, if physician or nurse practitioner practices are available and affordable to the residents of the community. However, unlike FQHCs and hospital-sponsored clinics, private medical practices rarely offer substantial free care to low-income, uninsured patients. Since 40 percent of Brooklyn residents are on Medicaid and 15 percent are uninsured, medical practices that do not routinely serve Medicaid and uninsured patients cannot satisfy primary care needs in Brooklyn’s economically-challenged communities.

It is difficult to develop a complete picture of primary care capacity and utilization in Brooklyn due to gaps in data – physician practices are not required to report visit data to the Department of Health, and reporting by D&TCs is uneven despite regulatory requirements. Hospital outpatient departments and extension clinics provided a total of approximately 4.2 million outpatient visits in 2010, of which approximately 2.2 million were “general clinic” visits.<sup>76</sup> FQHCs provided approximately 1.1 million visits to Brooklyn residents that year.<sup>77</sup> And, in 2010, Brooklyn’s Medicaid beneficiaries had an average of 6.7 outpatient visits per member per year in Brooklyn, in comparison with an average of 5.3 visits per member per year citywide or 5.2 visits statewide.<sup>78</sup>

While the rate of primary care utilization by Medicaid beneficiaries in Brooklyn may be higher than average overall, rates vary dramatically by neighborhood with the fewest visits per member per year in the neighborhoods located in central and northeast Brooklyn. The availability of primary care also varies by neighborhood in Brooklyn. (See Appendix I for a map of Medicaid

<sup>73</sup> Welsh Analytics, LLC, based on SPARCS Deidentified Inpatient File, obtained Aug. 2011; Population Projections from Cornell University, Program in Applied Demographics.

<sup>74</sup> Starfield, B, L Shi, et al. Contribution of Primary care to Health Systems and Health. *Milbank Q* 2005; 83(3): 457-502. Christakis, DA, Mell, L, Koepsell, TD, Zimmerman, FJ, Connell, FA. Association of Lower Continuity of Care With Greater Risk of Emergency Department Use and Hospitalization in Children. *Pediatrics* 2001, 107(3): 524-29. Gill, JM, Mainous III, AG, Nsereko, M. The Effect of Continuity of Care on Emergency Department Use. *Arch Fam Med.* 2000;9:333-338

<sup>75</sup> NYC DOHMH, Community Health Profiles, 2006, available at <http://www.nyc.gov/html/doh/html/data/data.shtml#bk>; See Appendix B.

<sup>76</sup> NYS Dept. of Health, Institutional Cost Reports, 2010. “General clinic” visits are non-specialty clinic visits. They do not include ambulatory surgery, renal dialysis, mental health or rehabilitation therapy visits.

<sup>77</sup> Compiled from reports to Uniform Data System (UDS), Health Research and Services Administration (HRSA), US Department of Health and Human Services. 2010. These visits include visits by Brooklyn residents to FQHCs outside of Brooklyn, as well as FQHCs within Brooklyn, and include behavioral health, dental, and enabling service visits. Nearly one-third of these visits are also included in the hospital outpatient visit figures, as Lutheran Medical Center’s affiliated FQHC reports its visits on the hospital’s cost reports.

<sup>78</sup> Primary care visits, for this purpose, also include family planning and prenatal/postpartum and physician specialist visits. NYS Dept. of Health, Medicaid OHIP DataMart, updated thru September 2011.

outpatient visit rates by zip code). Although there are dozens of hospital outpatient clinics, diagnostic and treatment centers and extension sites in Brooklyn, and 13 FQHCs, with more than 80 sites, outpatient facilities are unevenly distributed among Brooklyn neighborhoods. Lutheran Hospital through its affiliated FQHC, Sunset Park Health Center, has developed an extensive network of ambulatory care facilities in Sunset Park, northwest Brooklyn and Flatbush. By contrast, there are far fewer FQHC sites in northeast and southeast Brooklyn and outpatient facilities generally appear to be more dispersed in these neighborhoods, leaving many densely populated areas without such facilities.

Similarly, the availability of primary care physicians also varies dramatically by neighborhood. There are 9 federally-designated primary care health professional shortage areas (HPSAs) in Brooklyn – Bedford-Stuyvesant, Bushwick, Coney Island, Crown Heights, East New York, Midwood, Red Hook, Sunset Park, and Williamsburg (see map on p. 30).<sup>79</sup> Overall, there are 85 full-time equivalent (FTE) physicians per population of 100,000 across the borough. Statewide, the rate is 82 per 100,000. However, in Canarsie-Flatlands, Central Brooklyn, Greenpoint and East New York-New Lots, the rate is less than 60 FTEs per 100,000, and in Bushwick-Williamsburg it is 66 per 100,000.<sup>80</sup> In Sunset Park, the rate is 93 per 100,000 and in Northwest, Southwest, and Southern Brooklyn, the rate is more than 115 FTE primary care physicians per 100,000 population.<sup>81</sup>

These statistics do not tell the whole story of primary care availability in Brooklyn. The Brooklyn Healthcare Improvement Project (BHIP) is working to develop a more complete picture. It conducted a block-by-block canvass of primary care sites in 15 contiguous zip codes in Brooklyn (within the UHF neighborhoods of Bushwick-Williamsburg, Flatbush, Central Brooklyn, East New York-New Lots, and parts of Northwest Brooklyn and Canarsie-Flatlands). Preliminary results revealed 307 private physician practice sites, of which 85 percent were accepting new patients regardless of insurance status and 91 percent would schedule an appointment for a new patient within one week. BHIP is still assessing this capacity to determine whether it is appropriate and accessible for this diverse and densely populated area.<sup>82</sup>

BHIP's work has also identified behavioral factors – both on the part of patients and their primary care providers – that play a significant role in determining where patients receive care, not just the availability of a practitioner. Based on nearly 12,000 surveys of ED patients at 6 Brooklyn hospitals (Brookdale, Downstate, Interfaith, Kings County, Kingsbrook, and Woodhull) conducted by the Brooklyn Healthcare Improvement Project (BHIP), 64 percent of ED patients in those hospitals reported that they have a primary care practitioner (PCP), and 45 percent recognized that their reason for visiting the ED was not an emergency. Moreover, the majority of the ED patients surveyed had health insurance. However, of those who acknowledged that their condition was not emergent, 29 percent came to the ED for care because they could not reach their PCP, were instructed to come to the ED by their PCP, or did not want to wait to be seen by their PCP. The single most common reason cited for seeking care in the emergency department was convenience.<sup>83</sup>

The higher than average rate of outpatient visits by Medicaid beneficiaries in Brooklyn, along with the findings of the BHIP, suggest that Brooklyn's high rates of preventable inpatient and emergency department use are products of not only insufficient primary care capacity, but also of the geographic distribution and nature of primary care resources and the patterns of health care

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<sup>79</sup> There are also 5 mental health HPSAs (Kings County Hospital, Northwest Brooklyn, Southwest Brooklyn, Woodhull Hospital), and 2 dental HPSAs (Bedford-Stuyvesant and Coney Island).

<sup>80</sup> New York Physician Re-registration Survey. Center for Health Workforce Studies. University at Albany, State University of New York.

<sup>81</sup> *Ibid.*

<sup>82</sup> See Wong, G., Brooklyn Healthcare Improvement Project, Presentation to the Brooklyn MRT, Sept. 21, 2011.

<sup>83</sup> *Ibid.*

delivery and utilization of physicians and patients. It appears that patients may be making rational choices to use emergency departments, based on convenience and the availability of comprehensive services and free care.

Accordingly, as BHIP's work shows, mere development of additional capacity will not solve the problem of sub-optimal emergency department use or PQI admissions. Rather, a combination of new capacity and new models of patient-centered care must be developed. In order to change patient and physician patterns of relying on emergency departments for non-emergent care, we will have to create a delivery system that changes the cost-benefit analysis for patients and providers, where the benefits of a primary care provider are clearly understood and the disincentives to using primary care are minimized (e.g., cost, scheduling, and lack of one-stop shopping). This will require additional study to understand patient choices and to identify the shortcomings of existing primary care capacity – for example, to assess its availability on an urgent or walk-in basis, geographic accessibility, quality, affordability, and cultural competence.

### C. Behavioral Health Care Capacity and Inpatient Utilization

Brooklyn residents use inpatient psychiatric services at a higher rate than the statewide average (5.8 per 10,000 compared to 5.0 per 10,000).<sup>84</sup> According to the NYS Office of Mental Health's Patient Characteristics Survey (NYS OMH PCS), almost 20,000 adults with serious mental illness and children with severe emotional disturbance were served in all Office of Mental Health licensed settings in the single week in which the survey was administered in Brooklyn in 2009. The NYS Office of Alcohol and Substance Abuse Services' 2011 Service Need Profile reports that over 206,000 Brooklyn residents age 12 and over have a substance use disorder.<sup>85</sup>

Mental illness and substance use disorders are often associated with chronic medical conditions, such as diabetes, obesity, cardiovascular disease and asthma. In Brooklyn, according to the NYS OMH PCS, 50 percent of mental health clients report a chronic medical condition, compared with 44 percent statewide.<sup>86</sup> Managing these complex co-morbidities and medication regimens is difficult, and is further complicated by factors such as homelessness and poverty that disproportionately impact people with mental illness or addictions.

As a result, Brooklyn hospitals are seeing high levels of utilization among people with behavioral health diagnoses. Of all inpatient discharges from Brooklyn hospitals, fully 27 percent involve a patient with a current behavioral health diagnosis, either as the principal diagnosis or as a comorbidity.<sup>87</sup> The portion of discharges with behavioral health diagnoses rises to more than 60 percent at Interfaith Medical Center, with 43 percent of its inpatient days attributable to patients with a principal diagnosis of a behavioral health condition.<sup>88</sup> With the exception of Brookdale, Kingsbrook Jewish, Maimonides, and New York Methodist, 30-day readmission rates to a psychiatric inpatient setting from inpatient psychiatric care in Brooklyn are higher than the statewide average.<sup>89</sup>

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<sup>84</sup> NYS Office of Mental Health, Department of Mental Hygiene Information System; SPARCS; Private Psychiatric Hospital data represent Medicaid eligible residents. Data may be incomplete because Medicaid does not cover individuals from age 22–64; US Census - American Community Survey Estimates for Calendar Year 2008.

<sup>85</sup> NYS OASAS, Service Need Profile – Sept. 2011, Kings County, available at <http://cps.oasas.state.ny.us/cps/secured/countydata/index.cfm?filename=need%5Fkings%5F201109%2Epdf&doctype=necd&year=201109>.

<sup>86</sup> NYS Office of Mental Health, County Dashboard, Wellness and Community Integration, Profile for Kings, 2009, available at: <http://bi.omh.ny.gov/cmhp/dashboard>.

<sup>87</sup> Welsh Analytics, LLC, Diagnosed Behavioral Health Problems among Inpatient Groups at Brooklyn Hospitals, prepared for Brooklyn MRT, Sept. 2011.

<sup>88</sup> Welsh Analytics, Diagnosed Behavioral Health Problems among Inpatient Groups at Brooklyn Hospitals; *ibid.* Major Clinical Categories at Interfaith Medical Center.

<sup>89</sup> NYS Office of Mental Health, County Dashboard, Psychiatric Inpatient Readmissions, Profile for Kings, 2009, available at: <http://bi.omh.ny.gov/cmhp/dashboard>.

The heavy inpatient utilization among people with mental illness and substance use disorders suggests that the management of these conditions, and associated co-morbidities, in the community could be improved. According to the Office of Mental Health, the rate of Medicaid beneficiaries who receive outpatient treatment within 7 days of a psychiatric discharge from a hospital is lower in Brooklyn than statewide (27 percent of Brooklyn adults and 30 percent of Brooklyn children receive outpatient treatment within 7 days, compared to 33 percent and 40 percent respectively statewide).<sup>90</sup>

Like primary care services, outpatient behavioral health services are unevenly distributed among Brooklyn neighborhoods. Brooklyn's 69 mental health clinics and satellites<sup>91</sup> and 44 chemical dependence treatment outpatient programs<sup>92</sup> are concentrated in the Central and Northwest Brooklyn neighborhoods. Although Southern Brooklyn and Bushwick-Williamsburg have higher numbers of residents discharged from the hospital with a behavioral health diagnosis than Northwest Brooklyn, and East New York-New Lots has comparable numbers to Northwest Brooklyn, those neighborhoods have far fewer behavioral health outpatient programs (see Appendix J for maps of OMH-licensed clinics and Appendix K for a map of OASAS-licensed outpatient programs).<sup>93</sup>

Across the state, the health and behavioral health care systems currently in place do not adequately support effective management of behavioral health conditions in the community. There is a heavy reliance on inpatient and emergency department care, segregation of medical and behavioral health care, lack of coordination along the continuum of care, insufficient early intervention, and lack of resources for functional supports such as housing, employment and education. Reimbursement methodologies for providers pay for services, often without any regard for individual outcomes.

However, the state and NYC are involved in a number of initiatives to shift the focus to outpatient care and functional supports, to integrate services across the continuum, and to engage consumers, in Brooklyn and around the state. For example, the Brooklyn Care Monitoring Initiative focuses on high-need individuals with mental illness to ensure that they remain engaged in care. Utilizing managed care techniques and Medicaid claims data to track individuals' patterns of service use, unexpected interruptions in services are identified, and providers of services can then work to re-engage the individual.

In addition, under the leadership of Governor Cuomo's Medicaid Redesign Team, the state is moving to enroll all Medicaid beneficiaries in managed care plans in which mental health and substance use benefits will be managed. The state recently awarded the first phase of Behavioral Health Organization contracts in regions throughout the state (with the exception of Long Island, which will be awarded shortly) with the expectation that this new management capacity will become operational by January 1, 2012. These managed care entities will work with hospitals to review the appropriateness of admissions and the length of stay for mental health and substance use treatment, as well as to assist in identifying appropriate discharges in a timely manner. They will also develop quality outcome metrics and foster the use of data to improve services. This structure will help set the stage for further efforts to improve integration of mental and physical health care.

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<sup>90</sup> NYS Office of Mental Health, Medicaid Data Warehouse,

<sup>91</sup> NYS Office of Mental Health, OPME OMH Concerts, May 2011; also Welsh Analytics, Mental Health Programs in Brooklyn, Sept. 2011, *citing* NYS Dept. of City Planning; *see also* maps at Appendix J and K.

<sup>92</sup> NYS Office of Alcohol and Substance Abuse Services, Division of Outcome Management and System Investment, Oct. 2011; also Welsh Analytics, Mental Health Programs in Brooklyn, Sept. 2011, *citing* NYS Dept. of City Planning, *see also* maps at Appendix J and K.

<sup>93</sup> Welsh Analytics, LLC, Diagnosed Behavioral Health Problems among Inpatient Groups at Brooklyn Hospitals, prepared for Brooklyn MRT, Sept. 2011. Notably, since outpatient behavioral health programs do not have a certified capacity, relative numbers of programs are indicative of geographic accessibility, but not the availability of treatment slots.

The state is also overseeing the creation of “health homes” for Medicaid beneficiaries with multiple chronic conditions. These multi-disciplinary collaborations of community-based services will link individuals with complex health care needs – including mental health and substance use disorders – with health care providers and the community and social supports. Through value-based and risk-based payment reforms, health plans, behavioral health organizations and providers will be held accountable for optimizing the beneficiary’s physical and mental health.

The development of these new models of coordinated and integrated care for Medicaid beneficiaries with behavioral health conditions, together with payment mechanisms that incentivize prevention and outpatient care may also reduce the need for inpatient beds in Brooklyn over the next five to ten years.

## V. HIGH NEED COMMUNITIES AND LOW MARGINS: THE PRECARIOUS CONDITION OF CERTAIN BROOKLYN HOSPITALS

The Work Group is deeply troubled by the health status of Brooklyn residents and the accessibility, sustainability, and quality of medical care in parts of the borough. The borough’s hospitals are major providers of both inpatient and outpatient care, major employers, and engines of economic development. However, many are financially-fragile and, in the worst cases, are in the midst of a financial disaster. Fundamental and wide-ranging changes in governance, organization, clinical care, operations, cost structure, and physical plant are, in the case of many of the hospitals, essential both to their future survival and stability and to the health of the communities they serve.

The Work Group has focused its attention on the three most troubled hospitals in Brooklyn that require immediate intervention to avert financial collapse: **Brookdale Hospital Medical Center, Interfaith Medical Center, and Wyckoff Heights Medical Center**. All of these institutions are located in northern and central Brooklyn. All have unsustainable levels of debt and negative net assets. The Work Group notes that **Long Island College Hospital (LICH)** also falls into this dire category, but with its recent acquisition by SUNY Downstate Medical Center, is of less immediate concern.

Furthermore, the Work Group has also focused its attention on two other key hospitals, **Brooklyn Hospital Center and Kingsbrook Jewish Medical Center**, which do not exhibit the same level of financial distress, nor require the same level of urgent attention as the three most troubled institutions. Brooklyn Hospital Center and Kingsbrook Jewish have effected restructurings that have resulted in stabilization. However, they cannot not remain viable in the long run, as stand-alone facilities under their current business models. They can play a leadership role in creating integrated systems to strengthen health care delivery in the communities served by all six hospitals. This report will refer to these six institutions (Brookdale, Interfaith, Wyckoff, LICH, Brooklyn Hospital Center, and Kingsbrook Jewish) as the “focus hospitals.” The table below summarizes some key facts about the focus hospitals:

## Focus Hospitals: Key Facts

Hospital	Core Market Neighborhoods <sup>94</sup>	Licensed Beds <sup>95</sup>	Specialized Services
Brookdale Hospital Medical Center	Central, East NY – New Lots	530	AIDS, Stroke Center, Level 3 Perinatal Center, and Regional Trauma Center
Brooklyn Hospital Center	Northwest, Central, Bushwick –Williamsburg, Flatbush	464	AIDS, Stroke Center, Inpatient Psychiatric
Interfaith Medical Center	Central, Bushwick – Williamsburg	287	AIDS, Inpatient Chemical Dependency (Detox and Rehabilitation), Inpatient Psychiatric
Kingsbrook Jewish Medical Center	Flatbush, Central, Canarsie – Flatlands	326	AIDS, Stroke Center, Traumatic Brain Injury Center, Inpatient Psychiatric
Long Island College Hospital	Northwest, Central, Bushwick – Williamsburg	506	Stroke Center, Level 3 Perinatal Center, Inpatient Psychiatric
Wyckoff Heights Medical Center	Bushwick – Williamsburg, parts of Queens	324	Stroke Center, Level 3 Perinatal Center

All of these hospitals serve large numbers of Medicaid beneficiaries, and all serve communities affected by poverty and poor health status. The neighborhoods of East New York-New Lots, Bushwick-Williamsburg, and Central Brooklyn have among the highest rates of poverty in Brooklyn. They also have among the highest rates of residents who lack a primary care provider, obesity, hospitalization for heart disease, PQI admissions, and avoidable emergency visits, and among the lowest rates of Medicaid outpatient visits. (See Parts II and IV and Appendices B, F, and I).

The chart below summarizes the performance of the focus hospitals on key financial indicators:

### Key 2010 Financial Indicators for Focus Hospitals

Hospital	Total Hospital Margin	Current Ratio	Long Term Debt Per Bed	Capital Spending	Total Net Assets
Brookdale	-12.7%	0.42	\$210,000	45%	-285,000,000
Interfaith	-30.7%	0.81	\$517,000	66%	-126,000,000
Wyckoff	-0.7%	0.80	\$324,000	39%	-91,000,000
LICH	-3.8%	0.89	\$269,000	31%	-78,000,000
Brooklyn Hospital	1.7%	1.09	\$191,000	85%	59,000,000
Kingsbrook Jewish	1.0%	0.81	\$53,000	82%	16,000,000

Source: GNYHA and DASNY presentations to Brooklyn Redesign Work Group, September 21, 2011; data derived from most current NYS Institutional Cost Reports and audited financial statements. Audit data for Interfaith is draft. Interfaith has cut expenses in 2011 to raise its margin to -18%.

#### A. Factors Contributing to Financial Decline

The financial condition of the three most troubled institutions and LICH is, to a large extent, a product of a long history of weak governance and mismanagement, overwhelming liabilities accumulated on their balance sheets, including debt issued long ago for physical plant

<sup>94</sup> “Core market” refers to the smallest collections of zip codes from which 50 percent of the hospital’s patients are drawn. Welsh Analytics, LLC, analysis of NYS DOH SPARCS 2010 Deidentified Inpatient File, obtained Aug. 2011 (zip codes translated to neighborhoods based on NYC DOHMH Community Health Atlas, 2009).

<sup>95</sup> These figures reflect licensed, not staffed, beds. Many licensed beds are not staffed. The number of staffed beds varies based on occupancy and other factors.



improvements that are now in some cases obsolete, and pension and medical malpractice obligations. However, it is also attributable, in part, to a variety of other factors beyond their control or to which they have not responded effectively:

- Heavy reliance on Medicaid and Medicare and reductions in reimbursement under both programs;
- Intense competition for patients (particularly for commercial and surgical patients) from neighboring hospitals and academic medical centers outside of Brooklyn;
- Advances in medical care that have reduced length of stay and shifted a wide range of services from the inpatient setting to ambulatory settings;
- Managed care penetration (including significant Medicaid managed care growth);
- Prevailing payment methodologies that pay more generously for highly specialized, resource-intensive procedures and less for the core medical and surgical services of a community hospital; and
- Union contracts that require wage and benefit increases in excess of the institutions' revenue growth.

These factors are, in many cases, not unique to these Brooklyn hospitals. Vulnerability to Medicaid and Medicare budget cuts and generally unfavorable reimbursement for core services are facts of life for community hospitals that serve low-income communities nationwide. All of the focus hospitals serve high-need communities, with high rates of chronic disease and poverty and low levels of commercial insurance. These hospitals have been described as safety net hospitals. The term “safety net hospital” has been defined in various ways in different contexts.<sup>96</sup> For purposes of this report, we define a “safety net hospital” by reference to the community it serves, as well as its services and source of revenue. In this report, a safety net hospital:

- Is situated in and serve a high need community, often characterized by poverty, public health challenges, low levels of educational attainment, and other psychosocial demands, like drug and alcohol abuse and inadequate housing;
- Fulfills otherwise unmet health care needs in a community;
- Serves a high volume of Medicaid and medically-indigent patients;
- Serves comparatively few commercially-insured patients;
- Is typically located in a federally-designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA);
- Principally provides core medical and surgical services, such as obstetrics, pediatrics, and internal medicine, and behavioral health services.

More recently, Governor Cuomo's Payment Reform Work Group has coined the term, “vital access provider” to describe health care providers with similar characteristics. The Brooklyn Work Group would like to stress that it is the level of community need, the hospital's mission to address it, and its location that determine the hospital's safety net or “vital access” status -- not the hospital's need. Today's vital access hospital may play a less crucial role in the integrated health care delivery system of the future. In the long run, it may need to assume new roles within more compact facilities.

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<sup>96</sup> In a 2000 Report, the Institute of Medicine defined the health care safety net as those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid and other vulnerable patients. *America's Health Care Safety Net* (2000).

The focus hospitals are not just safety net hospitals – they are also community hospitals.<sup>97</sup> They provide medical, surgical and emergency care to vulnerable residents. They are not, and should not try to be, quaternary care centers with a high volume of subspecialty care. Nor are they academic medical centers (although they sponsor medical training programs) engaged in substantial clinical research. As a result, they do not have the leverage to negotiate more lucrative managed care contracts, to attract sizeable philanthropic donations, or to cross-subsidize their core services and charity care with highly-specialized services provided to well-insured patients.

It is also important to note that, although safety net hospitals are often characterized as serving health care needs that would otherwise be unmet, this is not necessarily true for the focus hospitals. As the inpatient utilization and market share data in Part IV demonstrate, residents of the communities served by these hospitals are voting with their feet and choosing to use hospitals outside of their immediate neighborhoods and outside of Brooklyn.

Clearly, these hospitals are not, and should not be, the sole health care providers that serve their communities. Many of the services they provide could be offered in a cost-effective manner by other types of providers, such as freestanding ambulatory care facilities, physician practices, or even nursing homes and home care agencies. Restructuring will necessarily require new and changed relationships among all manner of providers to serve patients in the best and most cost-effective way possible. Unless we address the financial crisis for these hospitals by restructuring, we cannot hope to take advantage of the emerging care models and payment reforms that seek to improve quality of, and access to, care in their communities.

## **B. Financial Position of Selected Hospitals**

Although all six of the hospitals under discussion provide important health care services to vulnerable patients in high need communities, they lack a business model that will allow them to survive in the long run, and in three cases, even short-term survival is in jeopardy. Common to the financial circumstances of these hospitals are insufficient operating revenue and an unsustainable cost structure. The three most troubled hospitals (Brookdale, Wyckoff, and Interfaith) are struggling week-to-week to make payroll and are working with vendors and creditors for forbearance. Most cannot access capital markets to make the necessary investments in physical plant, human resources or technology necessary to maintain an acceptable level of quality or access. As the discussion below illustrates, none of the three exhibits a favorable position on any of the key indicators of financial stability: operating margin, current ratio, debt-to-bed ratio, and net assets.

According to national hospital industry standards, a margin of operating revenues over expenses of at least 3 percent is necessary to assure financial stability and the capacity for reinvestment.<sup>98</sup> However, four of the institutions under discussion (Brookdale, Wyckoff, Interfaith and LICH) have a negative margin, and only two (Kingsbrook Jewish and Brooklyn Hospital Center) have slightly positive margins. None has a margin approaching 3 percent. While few hospitals in New York State meet this standard, the margins of Brookdale and Interfaith are outliers.<sup>99</sup> Interfaith lost approximately \$57 million in 2010, and Brookdale lost nearly \$43 million.<sup>100</sup> While insufficient operating margins may be ameliorated through improvements in services, management and operational efficiency, rarely can such measures compensate for a lack of reliable, predictable revenue corresponding to the costs of delivering care.

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<sup>97</sup> Not all safety net hospitals are also community hospitals. Some safety net hospitals may also be academic medical centers providing quaternary care.

<sup>98</sup> Heller, K, Greater New York Hospital Assoc., Medicaid Redesign Team: Health Systems Redesign, Presentation to the Brooklyn Work Group, Sept. 21, 2011.

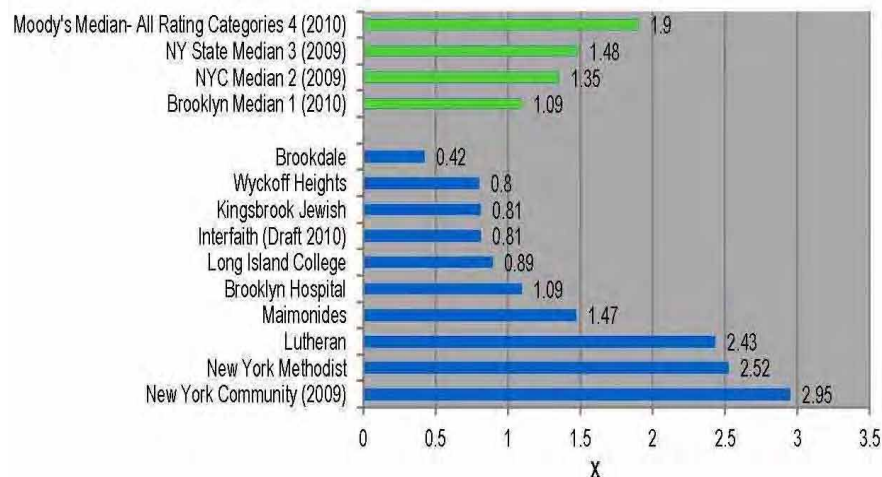
<sup>99</sup> The average total margin for New York State hospitals is 2.2 percent. *Ibid.*

<sup>100</sup> Selected audit data from 2010 DASNY supplemental form. Interfaith report is preliminary.

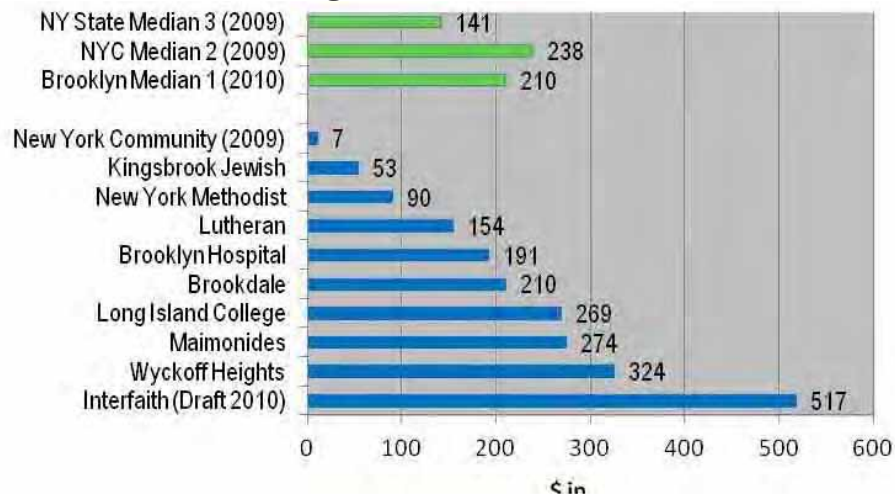
The absence of revenues sufficient to support day-to-day operations forces facilities to consider reliance on managing cash flow or borrowing to help cover expenses. This may be the only practical course when a facility's current ratio of current assets to current liabilities is 1.0 or lower. All of the hospitals under discussion, except Brooklyn Hospital Center, have current ratios of less than 1.0.

With the exception of Brooklyn Hospital Center, the ratios for the focus hospitals do not compare favorably to the other hospitals in Brooklyn, all of which have current ratios above 1.0.

### Current Ratio\*



### Long-Term Debt / Bed\*



Sources: Hospital Audited financial statements and DASNY supplemental survey.

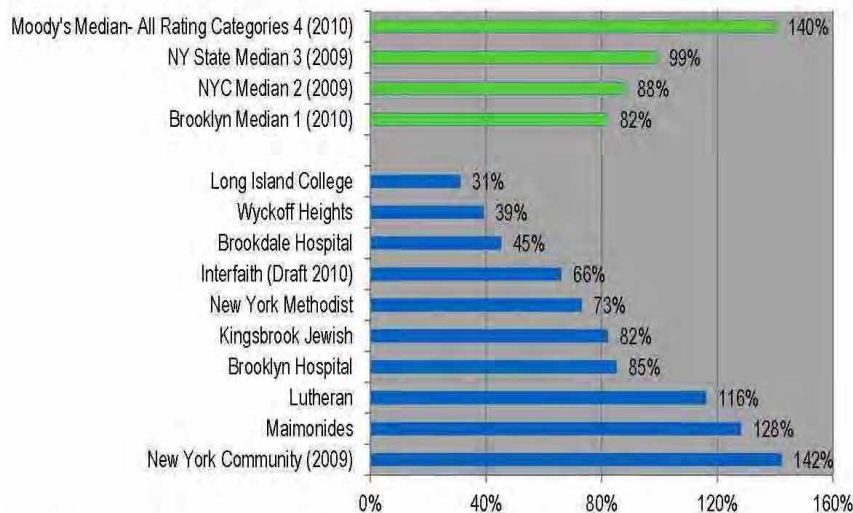
- 1 Median includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospitals Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for BI-Kings Highway is from consolidated audit for system. Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home. Excludes the three public Health and Hospitals Corporation hospitals and the State hospital.
- 2 2009 Audit data. Includes 31 Article 28 hospitals/hospital systems located in the five boroughs and excludes major publics and specialty hospitals.
- 3 2009 Audit data. Includes 148 Article 28 hospitals/hospital systems in the State and excludes major publics and specialty hospitals.
- 4 Moody's Fiscal Year 2010 Not-for-Profit Hospital Medians, August 2011. Includes 401 freestanding hospitals & single state systems that have an underlying rating from Moody's across all rating categories.

\* Excludes Beth Israel – Kings Highway because its data are reported in a Consolidated Audit for the system. LTD / BED is defined as the current and long-term portion of debt from the audit balance sheet divided by licensed beds.

The facilities' low current ratios are compounded by high levels of long-term debt. A hospital's ratio of long-term debt per bed is an indicator of the facility's capacity to leverage. As the chart above indicates, with the exception of Kingsbrook Jewish, all of the selected hospitals have levels of long-term debt to bed ratios above the median (\$141,000 per bed) for hospitals statewide. At Interfaith, this ratio reaches an extreme of \$517,000 per bed, more than double the median for all Brooklyn hospitals and more than three times the statewide median.

Low operating margins at the selected hospitals, combined with high levels of long term debt and low levels of current assets relative to current liabilities, preclude the formation of adequate capital for investment in physical plant and depreciable medical and nonmedical equipment. This is reflected in the individual capital spending ratios (ratio of annual purchases of property, plant and equipment to current year depreciation expense) of the facilities. All of the focus facilities have capital spending ratios below 100 percent. This indicates that the hospitals are disinvesting — spending less in new capital than is being incurred in the depreciation of old capital. Over time, this will make it difficult for these facilities to maintain quality of care and keep abreast of advances in the organization and delivery of inpatient and outpatient services.

### Capital Spending – 5 year averages



Sources: Hospital Audited financial statements and DASNY supplemental survey

- 1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospital Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the Consolidated Audit which includes the Kings Highway division in Brooklyn. 2010 Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home. Excludes the three public Health and Hospitals Corporation hospitals and the State hospital; excludes Beth Israel – Kings Highway because its data are reported in a Consolidated Audit for the system.
- 2 2009 Audit data. Includes 31 Article 28 hospitals/hospital systems located in the five boroughs and excludes major public and specialty hospitals.
- 3 2009 Audit data. Includes 148 Article 28 hospitals/hospital systems in the State and excludes major publics and specialty hospitals. Moody's Fiscal Year 2010 Not-for-Profit Hospital Medians, August 2011. Includes 401 freestanding hospitals & single state systems that have an underlying rating from Moody's across all rating categories.

Finally, the difficult financial position of the selected hospitals is illustrated by their net asset positions. The net asset position of a hospital is the difference between its total assets and total liabilities. It is a measure of equity and the ability of lenders to recover in the event of a default. Four of the hospitals have negative net asset positions, ranging from minus \$91 million at Wyckoff Heights to minus \$285 million at Brookdale.

## Net Assets

Hospital	Total Net Assets (\$ millions)	Total Assets (\$ millions)	Total Long-Term Debt <sup>2</sup> (\$ millions)	Total Other Liabilities (\$ millions)
Brookdale	-285	184	112	357
Long Island College	-78	308	136	250
Interfaith (Draft 2010)	-126	184	148	162
Wyckoff Heights	-91	140	114	117
Kingsbrook Jewish	16	115	17	82
New York Community (2009)	27	60	1	32
Brooklyn Hospital	59	255	89	107
Lutheran	69	289	72	148
New York Methodist	135	491	53	303
Maimonides	185	759	195	379

Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Excludes the three public Health and Hospitals Corporation hospitals and the State hospital; excludes Beth Israel – Kings Highway because assets are reported in a Consolidated Audit for the system. 2010 Audit data unless otherwise noted. 2010 Audit data for Interfaith Medical Center is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

2 Total long-term debt includes the current and long-term portions of all debt including bond/mortgages, capital leases, notes and other loans.

The negative net assets of these facilities would make it difficult for them to initiate the restructuring of services and physical plant that would be necessary for any significant improvement in efficiency or increases in revenues necessary for their longer term viability and for the delivery of quality care appropriate to the identified health care needs of their communities.

## **VI. OPPORTUNITIES AND CHALLENGES IN A CHANGING HEALTHCARE ENVIRONMENT**

To create a financially viable health care delivery system in the communities served by the focus hospitals, the clinical, organizational and financial paradigm for these institutions must change. As discussed above, Brooklyn hospitals are heavily reliant on Medicaid and Medicare. Reforms in Medicaid and Medicare at the state and national levels create opportunities to achieve fundamental change. While these may also impose additional stresses on Brooklyn’s hospitals, they also create a call for immediate action so these hospitals can take advantage of new delivery models and payment structures.

Federal health care reform promises to reduce dramatically the numbers of uninsured people and to provide support for health information technology adoption and new models of care that emphasize care coordination and improved outcomes. On the other hand, Medicare and Medicaid reimbursement are in flux. Longstanding sources of Medicare revenue will be reduced under the Affordable Care Act (ACA). Federal Medicare disproportionate share (DSH) payments will be

cut substantially beginning in 2014,<sup>101</sup> which will have a particularly significant impact on hospitals, like those in Brooklyn, that serve large numbers of low-income Medicare and Medicaid beneficiaries. In addition, Medicare inpatient rates will be reduced by 3.9 percent to offset case-mix growth. To close the federal budget deficit, the Congressional Deficit Reduction Committee is reviewing additional cuts, with a default outcome of a 2 percent set-aside of all Medicare payments.<sup>102</sup>

At the same time, Governor Cuomo's Medicaid Redesign Team (MRT) is working to make the health care delivery system more affordable and efficient, while improving health outcomes. Under its guidance, the state has implemented a global cap on Medicaid spending, which will limit Medicaid spending growth to the inflation rate. According to the MRT global cap report, the reforms are on track to save money. In addition, through the work of the MRT, the state is shifting all Medicaid beneficiaries, including individuals with disabilities, mental illness, and long-term care needs, into managed care plans. This will virtually eliminate Medicaid fee-for-service payments for hospitals, and require them to rely almost entirely on their ability to leverage adequate reimbursement from managed care plans and to manage their costs.

We have not calculated the cumulative effects of these changes on the bottom lines of the six focus hospitals, but acknowledge that, under their current configurations and cost structures, significant reductions in Medicare and Medicaid revenue would be devastating, absent changes in organization, services and costs. With their heavy reliance on Medicaid and Medicare, these hospitals cannot expect commercial payers to fill in the gaps.

Given the pending reductions in Medicare and possible reductions in Medicaid revenue, the prospects for financial success for any hospital depend in large part on its ability to participate effectively in reforms introduced by the federal ACA and Governor Cuomo's MRT. The federal ACA has launched, and the MRT embraced, new strategies for delivering and paying for care that emphasize care coordination, prevention, and performance, such as accountable care organizations, patient-centered medical homes and health homes. Under these models, providers along the continuum of care must integrate or collaborate with each other to improve the health of Medicare and/or Medicaid beneficiaries and accept payment arrangements that reward positive outcomes and efficiency and/or penalize negative outcomes and inefficiency. Similarly, both the ACA and the state's Medicaid Redesign Team seek to promote improvements in care coordination and outcomes through reimbursement penalties for potentially preventable readmissions related to certain conditions. In New York, these initiatives will be supported by recently approved funding under the state's Medicaid waiver -- the Hospital Medical Home Demonstration which will provide up to \$345 million over 3 years to teaching hospitals that become accredited patient-centered medical homes and \$20 million in grants to hospitals to develop strategies to reduce potentially preventable readmissions.

Safety net, community hospitals can play an important role in this new world of coordinated care and performance-based reimbursement, but must be proactive in adapting to it. Because these new models emphasize prevention and deploy performance- and risk-based payment mechanisms, they demand a fundamental reconfiguration of Brooklyn's health care delivery system from a strategic, organizational, physical, and financial perspective.

Accordingly, in the long run, the institutions under consideration are not viable with their current bed complement, in their current configuration. Most are experiencing declining admissions, and all are experiencing a low average daily census. In the short run, their revenues cannot support

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<sup>101</sup> Medicare disproportionate share payments are reimbursement adjustments to hospitals based on their services to low-income Medicare and Medicaid beneficiaries.

<sup>102</sup> Heller, K., Greater New York Hospital Assoc., Medicaid Redesign Team: Health Systems Redesign, Presentation to the Brooklyn Work Group, Sept. 21, 2011.

expenses, much less provide needed capital investments. In the long run, under Medicare and Medicaid reforms, length of stay, PQI admissions, emergency department use, and readmissions are expected to decline, further reducing revenue from inpatient services. While the Work Group is committed to striking the right balance of inpatient and primary care to ensure access to needed services along the continuum in Brooklyn, these reforms will drive a reduction in the need for inpatient beds and conversely incentivize the development of integrated systems of care with comprehensive, high quality primary care services.

## **VII. BUILDING HIGH-PERFORMING SYSTEMS OF CARE ALIGNED WITH COMMUNITY HEALTH NEEDS**

The Work Group observes, based on interviews and presentations, that since the inception of the Medicaid program, which is more than four decades ago, the service delivery model in Brooklyn has not changed dramatically. Although there have been isolated efforts to enhance primary care (most notably by Lutheran and its associated FQHC) and develop health systems, health care delivery in Brooklyn remains heavily-invested in inpatient and emergency care. The predominant care model in Brooklyn is built around the four walls of the hospital and perpetuates the use of medical services that tend to be fragmented, uncoordinated, and often accessed in the most expensive setting at the point when health care problems are acute or emergent. As the state and the nation implement health care reforms that incentivize coordination and prevention, integrated systems of patient-centered care comprised of providers along the continuum must be created.

To support the development of a high-performing, high-quality health care delivery system in Brooklyn that is responsive to community needs, this report describes a set findings<sup>103</sup> and a series of principles for restructuring derived from those findings. Restructuring guided by these principles will not only stabilize Brooklyn's health care delivery system, it will also advance CMS's "Three Part Aim" – better care for individuals, better health for populations, and lower costs through improvement. We believe that these principles are applicable to health systems in other communities as well. In addition to identifying sound principles to drive restructuring, the report also recommends a set of tools that can be used to carry out those principles in particular communities. Finally, it explains how the principles and tools should be applied to some of the more troubled hospitals in Brooklyn.

### **A. Restructuring Principles:**

The Work Group recommends that the following principles drive the restructuring of the delivery system:

- **In order to improve the health status of Brooklyn residents and to succeed under emerging payment methodologies, health care providers must create integrated systems of care and service delivery models, comprised of hospitals, physicians, federally qualified health centers, nursing homes, home care agencies, behavioral health providers, and hospice programs.**

To confront Brooklyn's health and health care challenges, we need to reduce the fragmentation of the delivery system, eliminate waste, support coordination, and reduce inappropriate utilization of services, while building access to efficient and effective community-based systems of care. These integrated systems may or may not necessarily unite providers under the auspice of a single entity, but they must be comprised of providers linked by formal relationships (operational and perhaps financial) that are able to coordinate patient care, have the capacity to transmit patient information electronically, and jointly engage in quality, performance, and population health

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<sup>103</sup> The Work Groups findings can be found at pp. 3-4.

improvement activities. At the core of these systems, there must be accessible, high-quality primary care services.

- **New models of delivery will require a rethinking of the hospital-based bricks and mortar pattern of health care.**

Reliance on the “big box” institution as the place to access all health care is rapidly becoming obsolete. Hospital services should be rationalized within integrated systems to create regional centers of excellence and to respond to community needs. Some hospitals should be closed, and some may need to be replaced by more compact inpatient hubs surrounded by primary care, urgent care, and other ambulatory care sites.

- **Patient-centered primary care services, strategically-located and linked to acute and long-term care providers, must be developed.**

For patients in Brooklyn and elsewhere, primary care is where patients begin their first encounter with the health care system, and where they form supportive relationships that guide them throughout their interaction with the health care system. But over the past three decades, primary care has failed to thrive, due to the payment incentives, especially in Medicare and Medicaid, increased specialization; under-funding; and inattention in medical training and practice. In particular, the high cost of medical education together with the lower salaries paid to primary care physicians have discouraged medical students from pursuing careers in primary care.

Primary care and urgent care facilities should be established with hours and availability that match emergency departments and with walk-in capacity. In order to strengthen patient engagement and effectively address community health needs, development of new primary care capacity, either in clinics or physician practices, must be strategically planned, based on health status, utilization, and demographic data. Development of new capacity must be based on intimate knowledge of the communities to be served, including cultural, language, transportation, education and lifestyle issues that affect health care access and utilization. They must be designed in conjunction with reconfigured systems to support care coordination and participation in emerging risk-based and performance-based reimbursement.

The Work Group recognizes that hospitals are rarely the best operators of primary care services. Primary care tends to be a low priority for many hospitals and often does not receive strong leadership or substantial investment under their management. To assure that effective primary care capacity is developed and integrated with other hospital services, hospitals should affiliate with FQHCs and/or networks of physicians. In all cases, hospital management must be reconfigured to include a senior executive, reporting to the board, who is responsible for outpatient development and partnerships with community-based physicians and facilities. The focus of these activities must be clinical integration, prevention and care coordination, not maximizing inpatient market share.

- **Restructuring must reduce waste and improve the quality of care, the settings for care, the engagement of patients in care, the way clinicians deliver care, and ultimately community health.**

This entails changing the model of care to promote prevention, patient engagement and self-management. It means making hospitals, health centers, and physician practices more responsive to patient needs, so that sub-optimal ED and inpatient use is reduced. It also involves actions to reduce waste generated by excessive lengths of stay, by failures in care processes that cause delays and complications for patients, by ineffective care coordination particularly at care transitions, and by administrative excesses. And, it means working with community-based



organizations, the local health department, faith-based organizations, and local business to encourage more optimal patient engagement and to improve community health.

- **Strong institutional governance and experienced leadership are needed to stabilize Brooklyn’s most troubled hospitals and to steer them into new integrated healthcare systems.**

Hospitals must be led by engaged boards composed of dedicated and objective members with the skills and expertise needed to govern effectively. Boards must also be representative of, responsive to, and responsible for, the health needs of the community served by the hospital. Boards must be able to assess key indicators of financial and clinical performance, and to evaluate management’s plans to address those indicators. Boards must establish strategic goals and hold management accountable for implementation of those goals. This responsibility includes assuring that the institution builds productive relationships with other providers. In those situations in which building collaborations, merging or affiliating with other institutions is in the best interests of the community, it is incumbent upon the boards to assume an active leadership role in achieving those ends.

- **Academic medical centers from outside Brooklyn that seek to establish affiliations or ambulatory care facilities in the borough must partner with local hospitals and other providers and strive to serve Brooklyn residents in Brooklyn.**

Utilization data show that nearly 20 percent of Brooklyn inpatients choose to travel to Manhattan for hospital care – principally to academic medical centers. The most lucrative (surgical and commercially-insured) patients tend to migrate at a higher rate than others. The effect of this migration is to weaken Brooklyn hospitals financially and operationally.

The Work Group is also aware of efforts by academic medical centers to affiliate with Brooklyn hospitals and, in some cases, their desire to construct free-standing ambulatory care facilities in Brooklyn. Such efforts by academic medical centers to establish a presence in Brooklyn may stimulate further patient migration outside the borough and weaken Brooklyn providers. In order to ensure that the entrance of new providers, including academic medical centers, is a positive step for Brooklyn communities, the state should require providers that apply for Certificate of Need (CON) approval to:

- Propose a program consistent with the principles set forth in this report;
- Invest in clinical and executive leadership and direct care staffing for any facility it seeks to establish; create opportunities to attract and retain new physicians committed to primary care to the community; and provide active oversight of the training, recruitment and retention of staff.
- Partner with Brooklyn hospitals and other Brooklyn-based providers to offer comprehensive care, including a range of specialists, and foster integrated delivery models consistent with medical homes, in order to provide as much patient care in the borough as possible and minimizing the need to refer patients to facilities outside of Brooklyn for care.
- Commit financial and human resources to promoting quality through health information technology and implementing evidence-based practices and clinical protocols.
- Implement an electronic health record system that facilitates sharing of information in a seamless manner with Brooklyn hospitals and other health care providers in the borough.

- Promote credentialing and privileging of its primary care providers and specialists at Brooklyn hospitals to facilitate continuity of care and retention of admissions in Brooklyn.
- Participate in strengthening Brooklyn hospitals and other Brooklyn providers through joint healthcare programs, including new lines of services offering new revenue sources. It is expected that a financial model would include an advantageous payer mix to sustain and support these programs and practices.
- **Restructuring support, whether in the form of debt relief or restructuring, grants, loans or reimbursement adjustments, must be conditioned on the creation of a sound governance and management structure, and the development of viable strategic, financial, and operational plans consistent with the principles set forth in this report, and the achievement of quality benchmarks and savings. Any support must be revenue neutral.**

Support offered by the state to troubled facilities can no longer be provided in the form of unrestricted bail-outs. Public dollars cannot be squandered on one-time infusions that do not fundamentally drive restructuring and integration. The state cannot be a passive payer, allowing poorly managed institutions to slip into deeper levels of dysfunction.

State support must be based upon a viable plan for long-term sustainability, subject to enforceable conditions and ongoing monitoring. In addition, the plan must demonstrate long-term savings, and any support must be revenue neutral.

To qualify for support, the Brooklyn hospitals' restructuring plans must be consistent with the principles outlined in this report. The state must not accept or support any plan in which a facility attempts to "go it alone." Restructuring plans should also leverage the hospitals' unique strengths. In the course of our public hearings, we have been impressed by the strengths of these institutions in many areas, including:

- Ties to the community, CBOs, and faith-based institutions;
- Loyalty of businesses, consumers, workers;
- Ample health care workforce;
- Proximity to academic medical centers, FQHCs, community behavioral health providers;
- Active and engaged civic organizations and academic institutions;
- Existing EHR penetration;
- Opportunities to benefit from Medicaid and Medicare reforms.

All of these factors can help to shape a successful vision for a high-performing health care delivery system.

- **The Brooklyn crisis and the state's response highlight the need for more oversight of troubled facilities and structured collaborative health planning.**

To ensure the success of restructuring plans, DOH, either directly or working with the Brooklyn Healthcare Improvement Board described below, must provide active oversight of their approval and implementation over the long term

In addition to this financial and operational oversight by DOH, broad and structured input from the communities is needed to ensure that community needs are addressed. Effective health planning is needed to tackle both supply of, and demand for, health care services. Careful study at a neighborhood level of needs and resources is needed to develop plans to align resources with needs and to work with the community to promote the best uses of health care resources. This

requires the engagement of a variety of community stakeholders, including consumers, health care providers, health plans, business, government, civic organizations and others. A community-based, multi-stakeholder collaborative, like BHIP, should be engaged actively in ongoing efforts to assure that the health system is aligned with needs. The New York City Department of Health and Mental Hygiene can be a valuable partner in this effort.

- **Innovative options for capital formation, including private investment, are needed to support capital and operational improvements in Brooklyn hospitals; but private investment must not be allowed to undermine a facility’s commitment to the community or its accountability for the quality of care.**

As a general matter, healthcare facilities in New York State must be owned by not-for-profit corporations or entities owned by “natural persons.” In other words, healthcare facility operators may be for-profit companies, but they cannot be publicly-traded or owned by a private, multi-investor entity. The exception to this rule is dialysis facilities, which may be owned by publicly-traded or similar entities. This exception was created several years ago in face of rapidly shrinking dialysis capacity, when only the large chains were able to survive with the prevailing Medicare payments. While dialysis facilities are the only health care facilities that may be owned by a publicly-traded corporation in New York, other health care industry actors may also be publicly-traded, such as health insurers and home care agencies.

Today, given extremely limited state and federal resources, opportunities to encourage private investment in Brooklyn’s hospitals must be explored. However, such investments should be allowed only under a governance and regulatory structure that would assure accountability for quality, community involvement in governance, and an enforceable commitment to addressing community needs.

- **The cost structure of healthcare facilities in Brooklyn must be rationalized.**

The Work Group has focused this report on revenue limits and opportunities affecting community hospitals in Brooklyn. However, we are acutely aware that there is a need to examine carefully and change cost structures in all areas. In particular, the real financial impact of medical education programs must be examined. In addition, the largest cost center for all of the facilities is labor, including executive and physician compensation and workforce costs. A particularly large component of this cost center is fringe benefits, which are disproportionately high. The need for this level of fringe benefit expense should be examined and proposals should be developed to reduce it.

- **The state should support the participation of nursing homes in emerging systems of care.**

Nursing homes play a vital role in meeting the needs of some of Brooklyn’s most vulnerable citizens, especially its seniors. While the Work Group did not conduct an in-depth review of nursing homes, as it did of some of the most troubled hospitals, the Work Group recognizes that there are signs of financial stress at some Brooklyn nursing homes. With major health reforms at the federal and state levels, the combined impact on hospitals and nursing homes will be significant, especially in nursing homes with over 90 percent of admissions coming from hospitals.

Care coordination among hospitals, nursing homes, and community-based primary and specialty care providers is essential to improving the health status of nursing home residents and avoiding costly hospitalizations. In particular, the financial penalties attached to hospital readmissions will directly impact nursing homes, which will be pressured to retain residents who might in prior years have been transferred to hospitals. Avoiding readmission penalties will demand stronger

collaboration between hospitals and nursing homes and will require an enhanced capability to provide medical care in the nursing homes. Similarly, participation in emerging risk-based payment mechanisms will also require collaboration between hospitals and nursing homes. The Work Group recommends further analysis by the Department of Health of nursing home finances and consideration of mechanisms to support the participation of nursing homes in emerging systems of care.

## **B. Tools for Restructuring:**

The Work Group recommends that following tools be developed and deployed, where applicable, to support change in Brooklyn:

### **Expand the State Health Commissioner's Powers over Healthcare Facility Operators**

Effective governance of healthcare facilities and systems will be essential to the future of health care in Brooklyn. To ensure that the commissioner has the necessary power to protect the public health, the Commissioner should be granted expanded authority over healthcare facility operators as follows:

- Legislation should be enacted to give the Commissioner authority, at his or her discretion, to appoint a temporary operator for health care facilities that present a danger to the health or safety of their patients; or have operators that have failed in their obligations; or are jeopardizing the viability of essential health care capacity, absent intervention by the state.
- Legislation should be enacted to give the Commissioner authority, at his or her discretion, to replace health care facility board members who are not fulfilling their duties to the organizations they are charged with governing.

### **Appoint a Brooklyn Healthcare Improvement Board**

The Commissioner should appoint a Brooklyn Healthcare Improvement Board (BHIB) to advise the Commissioner and, under his or her direction, oversee, initiate where necessary, manage and ensure the implementation of this report's recommendations. The Board may include the Department of Health, DASNY, Office of Mental Health, Office of Alcohol and Substance Abuse Services, members of the Brooklyn Redesign Work Group, community leaders, and other experts. Its functions should include:

- Assistance with Department of Health evaluation of applications for restructuring support (see below);
- Assessment of healthcare facility and system governance and management;
- Coordination of debt restructuring activities with DASNY or a DASNY subsidiary;
- Quarterly reviews of restructuring plan development and implementation with providers and stakeholders;
- Consideration of data and recommendations of the multi-stakeholder collaborative health planning entity (see below);
- Recommendation of actions to be taken by DOH and DASNY concerning the continuation or termination of restructuring support based on performance;
- Coordination with the Public Health and Health Planning Council concerning restructuring activities in Brooklyn.

## **Provide Financial Support for Restructuring through an Application Process**

This application process, as envisioned by the MRT Proposal 67 and the MRT Payment Reform Work Group, will provide a vehicle for supporting and overseeing implementation of the recommendations in this report as they apply to particular facilities or collaborations. The application will require feasible and actionable plans for restructuring, as well as strong governance, and long-term oversight.

To qualify for support, plans must include integration and collaboration with other providers for the purpose of rationalizing services, improving quality, coordinating care, improving access, increasing efficiency, and reducing unnecessary health care costs. The plan must be based on community need and be developed in consultation with community stakeholders. Plans may include, but not be limited to, closure, merger or redesign of providers, and appropriate alternate uses of facilities and identification of sources of capital to facilitate such reuse. Plans must demonstrate substantial, long-term cost savings to the delivery system that can be reinvested in the community, so that any support will be revenue neutral.

In exchange for the benefits awarded under the program, successful applicants will be subject to oversight by the Brooklyn Healthcare Improvement Board to monitor governance, performance, administrative and operational efficiencies, provision of essential services, responsiveness to community need, cost savings, and collaboration with other entities. The facilities will be further evaluated according to a core set of performance measures for quality, including those being applied in New York in Medicaid managed care and additional measures currently being developed by the MRT for application to all sectors of health care (e. g., managed care, ACOs, BHOs, health homes).

Approved applications for support will be subject to contractual conditions that may require replacement of provider boards and management. Any request for temporary or long-term rate enhancements will be subject to the recommendation of the Brooklyn Healthcare Improvement Board. And, any rate enhancements will be financed through savings derived from the restructuring and through implementation of new care models. Successful applicants would be eligible for:

### **Transitional and Long-Term Payment Adjustments**

The needed restructuring of these hospitals will require adjustments in Medicaid reimbursement and Medicare payments that enable facilities to reconfigure and operate their buildings and services in a manner that will reduce unneeded inpatient capacity and strengthen primary and preventive care and disease management services appropriate to identified community health needs. Consistent with the “Vital Access Provider” (VAP) principles outlined by the MRT Payment Reform Work Group, short-term operational payment adjustments will be needed to support the transition to integrated systems of care and reconfiguration of services, including adjustments that will achieve:

- Expanded and effective primary care;
- Reduced use of emergency department services for non-emergent and primary care treatable conditions;
- Clinical integration with non-hospital providers (primary care and community-based specialty care providers, skilled nursing facilities and others) to improve quality, outcomes and efficiency; and
- Capital improvements to modernize and downsize outdated physical plants and expand EHR implementation.

In the longer term, innovative payment methodologies that incentivize care coordination, prevention, and optimal outcomes, including bundled and performance-based payments, and that recognize the special circumstances of safety net providers and the complexity of the patients they serve may be appropriate. All of these adjustments will be revenue neutral and financed through substantial, long-term health care savings.

### **Debt Restructuring**

The financial rehabilitation of these institutions will also require the refinancing and restructuring of mortgages and other borrowings, as well as the reduction or forgiveness of other obligations, including pension and medical malpractice liabilities. Successful applicants would be supported in negotiating agreements to restructure debt, which may or may not involve the use of bankruptcy protection. In addition, DASNY, in its capacity as secured creditor, may, subject to its obligations to bondholders, be able to facilitate appropriate restructuring efforts and, in appropriate instances, utilize its ability to create a subsidiary to assist in the implementation of such a restructuring plan. This legislation sunsets in July of 2012 and should be extended so that work outs can be effectuated without exposing DASNY to liability. The law should also be expanded to allow the subsidiary to issue new debt, if is justified by the plan.

To support this process, legislation should be enacted to provide these focus hospitals and others that qualify, under the principles outlined in this report, with access to capital and/or the means of reducing existing debt burdens that substantially impair the hospitals' ability to restructure.

### **Capital Formation**

For the longer term, payment reform measures should be accompanied by mechanisms that grant better access to capital for the selected facilities and other essential providers. Sources could include private lending by commercial banks or other private interests and tax-exempt bonds issued by DASNY and other lenders, such as the Primary Care Development Corporation and models that use public funds to leverage private sector capital, particularly in patient-centered primary care facilities.

It is appropriate for the state to undertake a broad review of restrictions on private investment in health care facilities, and it should consider a pilot or demonstration project to relax such restrictions. A possible model for such investment could be the structure created by a proton beam facility recently approved by the Department of Health and Public Health Council. That facility will be operated by a not-for-profit clinical consortium and managed by a for-profit entity jointly owned by five academic medical centers and a national investor-owned company with a minority stake.

A further source of capital may be available through the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL). As with the HEAL and F-SHRP programs, these funds may be viewed as a reinvestment of savings to be generated from reforms and downsizing in Brooklyn and elsewhere throughout the State.

### **Rationalize Distribution of DSH/Indigent Care Pool Funds**

Brooklyn's hospitals serve significant numbers of uninsured and Medicaid patients and will be affected by pending changes in the distribution of federal Medicaid disproportionate care (DSH) funds. The MRT Payment Reform Work Group's has articulated the following principles for reform of the allocation of these funds, which should be adopted:

- Develop a new allocation methodology consistent with CMS guidelines to ensure that New York State does not take more than its share of the nationwide reduction;
- Adopt a fair and equitable approach to allocate funds across hospitals, with a greater proportion of funds allocated to those hospitals that provide services to uninsured and underinsured;
- Simplify the allocation methodology and consolidate the Indigent Care pools.

### **Support Involvement of Private Physician Practices in Integrated Health Systems**

The Work Group encourages the state to support the development of physician practices in under-served areas and the involvement of physician practices in integrated systems of care, particularly through electronic health records and payment arrangements. We acknowledge that steps have already been taken in this regard through enhanced Medicaid payments for physician practices that have received patient-centered medical home accreditation and Doctor Across New York practice support and loan repayment assistance grants. The expansion of Medicaid managed care has also driven additional physician participation in the Medicaid program and promoted primary care for Medicaid beneficiaries. Nevertheless, more can be done to support physicians seeking to practice in under-served areas.

The state should also consider working with Medicaid managed care plans, commercial payers and foundations to fund embedded care managers or social workers in physician practices, who can help to prevent hospitalizations and readmissions and assist in addressing health-related needs such as transportation to appointments and housing. Tax credits for physicians who provide significant charity care should also be considered. To the extent that physician practices receive enhanced support from the state, however, the funding should be tied to the satisfaction of quality standards, like patient-centered medical home accreditation, and to services to Medicaid beneficiaries and uninsured patients. Physicians who receive enhanced support and do not serve a specified percentage of uninsured patients should be subject to an assessment to subsidize services to the uninsured by other providers.

### **Develop New Alternatives for Capital Support of Primary Care Providers**

Primary care providers are often undercapitalized and have difficulty securing affordable capital financing necessary to expand and build facilities. To expand primary care in the communities most in need, the state should explore new programs that use public support to leverage outside investment in high quality primary care projects.

### **Provide Funding for a Multi-Stakeholder Planning Collaborative in Brooklyn**

To assure that the restructured hospitals and the new systems under development address community health needs, a data-driven, multi-stakeholder health planning collaborative, like BHIP, should be created or expanded with state and other support. The collaborative would include a diverse array of community stakeholders, including consumers, providers, payers, labor, and business. The New York City Department of Health and Mental Hygiene should be a partner in this effort. This collaborative would provide input into the hospitals' restructuring plans and make recommendations to the Brooklyn Healthcare Improvement Board concerning the alignment of healthcare resources with community needs and develop a primary care plan for Brooklyn. It would also develop and support the implementation of data-driven interventions, developed with the input and consensus of the community, to improve care coordination, primary care utilization, and community health. It could also engage in activities to curb unnecessary health care spending, such as the creation of a community advisory board for major investments in medical technology, like the CTAAB in the Finger Lakes Region.

## **VIII. PROPOSALS TO RESTRUCTURE THE DELIVERY SYSTEM**

The Work Group firmly believes that where there are home-grown restructuring plans, developed by the affected institutions, they should be given highest priority. As the Work Group has proceeded with its reviews, several of the institutions that are the focus of this report have begun to develop their own restructuring plans.

### **A. Brookdale Hospital Medical Center and Kingsbrook Jewish Medical Center**

#### **Actions:**

The Work Group recommends that Kingsbrook Jewish take the lead in establishing an integrated system with Brookdale, either under a common active parent or other accountable governance structure. The Work Group recommends new executive leadership at Brookdale and a separation from MediSys. A viable plan would require the creation of a new governance structure and a new board of directors for the integrated system.

#### **Discussion:**

Any assessment of Brookdale's future must begin with an acknowledgment that Brookdale cannot continue to survive with its current clinical services, physical plant, revenue stream, and cost structure. It experienced approximately \$42 million in operating losses in 2010, and has unsupportable debt, pension, and medical malpractice liabilities. To compound the problem, patient volume has declined significantly in recent years. In 2006, Brookdale discharged an estimated 21,000 patients, while in 2010 it discharged 19,000 patients — a 10% decline.<sup>104</sup> If dramatic action is not taken soon, the inevitable result will be financial collapse and, in all likelihood, the closure of the facility. A substantial, unrestricted state bail-out of the facility in its current configuration, under current leadership, is neither feasible, nor rational. It does not make sense to invest large sums of public money or heavily subsidize an institution that should change dramatically in the context of the new delivery system and reimbursement paradigm.

The Work Group is seeking to identify a solution that will avoid a precipitous slide into financial collapse and will allow the hospital to remain open, while a long-term restructuring plan is implemented. We have been informed that Brookdale and Kingsbrook Jewish have begun discussions to create an integrated system that provides the most promising response to the health needs of the community and the long-term viability of its hospital services. By combining the resources, clinical expertise, physical assets and market shares of the two facilities, there is potential to improve quality, while reducing costs. We believe that these discussions should be accelerated, under the guidance of the Brooklyn Healthcare Improvement Board, with input from the communities served.

This arrangement should benefit not only Brookdale, but also Kingsbrook Jewish. While strong leadership has stabilized Kingsbrook Jewish for the moment, in the long run it must expand its reach in order to generate efficiencies, increase volume, and develop the capability to participate in new models of care and payment mechanisms.

Short-term survival will require the restructuring of Brookdale's debt and other obligations. It will also require the elimination of unnecessary expenses and sources of operating losses, such as its various teaching programs. In the longer term, the Kingsbrook/Brookdale system should consider further reducing its bed complement and investing in additional ambulatory care services.

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<sup>104</sup> Welsh Analytics, LLC, NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.



Any restructuring would require the implementation of a plan to strengthen primary care in the communities served by the two institutions. This could be achieved most easily through a partnership with an existing FQHC and/or physician practice groups. Regardless of the organizational structure adopted, primary care and community-based specialty services must be integrated clinically with the hospitals' inpatient and other ambulatory care services.

The new system should pursue collaborations with other providers in addition to FQHCs and physician practices (e.g., nursing homes, behavioral health providers, home care agencies, and hospice programs) to position itself to benefit from impending health system reforms like ACOs, health homes, and risk-based payment methodologies. Kingsbrook Jewish's existing relationship with its affiliated nursing facility will serve as a platform for expanded clinical relationships with long-term care providers.

Any restructuring plan would have to be reviewed by the Brooklyn Healthcare Improvement Board, and approved by the Department of Health. To improve the health of the community, and to maximize its revenues under performance-based payment reforms and new models of care, the new system must also consult with the multi-stakeholder health planning collaborative about community needs and effective ways to engage patients in care.

## **B. Brooklyn Hospital Center, Interfaith Medical Center, and Wyckoff Heights Hospital**

### **Action:**

The Work Group recommends the integration of these three institutions into a single system under an active parent, or other accountable governance structure, led by Brooklyn Hospital Center. In light of the precarious financial positions of Interfaith and Wyckoff, the Work Group would like to ensure that Brooklyn Hospital, which has recently emerged from bankruptcy and is demonstrating sound financial practices, is not brought down by this plan. Indeed, we recommend that Brooklyn Hospital be given the support to lead the transformation to restructure the operations at Interfaith and Wyckoff.

### **Discussion:**

Wyckoff Heights Medical Center and Interfaith Medical Center are in weak financial positions. It is clear that, absent a dramatic change in its operations, Interfaith cannot continue to survive even in the short run. It lost in excess of \$57 million in 2010, has a negative net asset position of \$126 million and \$148 million in long-term debt.<sup>105</sup> Wyckoff, while marginally more stable than Interfaith, is also in jeopardy of failure. Its discharges have declined by almost 19 percent since 2005.<sup>106</sup> It has a negative net asset position of \$91 million and \$114 million in long-term debt.<sup>107</sup> Brooklyn Hospital Center is the strongest of the three, with a positive margin and a positive net asset position. However, it bears a heavy long-term debt burden of \$89 million and is not seeing growth in discharges.<sup>108</sup> In the long run, it cannot survive as a stand-alone facility.

The three facilities have brought to the Work Group a proposal to combine the hospitals into a single hospital system. When fully developed and implemented, this proposal should streamline inpatient and tertiary care in a manner that is both sustainable and aligned with the community's health needs. Restructuring the existing liabilities of the three institutions is also necessary and can be supported by enhanced operating margin projections. Enhanced margins will also provide capital for reinvestment in programs and infrastructure.

<sup>105</sup> Draft 2010 audit data.

<sup>106</sup> Welsh Analytics, LLC, NYS DOH SPARCS Deidentified Inpatient File, obtained Aug. 2011.

<sup>107</sup> 2010 audit data.

<sup>108</sup> 2010 audit data

A critical element of their restructuring plan must be enhanced access to high quality primary care and outpatient services. The plan must include the development of strong and integrated primary care services or a close partnership with one or more strong primary care providers. A partnership with an existing FQHC and/or physician practice groups would facilitate this effort. Regardless of the organizational structure adopted, primary care and community-based specialty services must be integrated clinically with the hospitals' inpatient and other ambulatory care services in order to promote quality and efficiency.

Development, approval and implementation of the plan should proceed under the guidance of the Healthcare Improvement Board with input from the communities served.

In order to support improvements in community health and to maximize its ability to benefit from performance-based payment reforms and new models of care, the new system must also consult with the multi-stakeholder health planning collaborative about community needs and effective ways to engage patients in care.

### **C. SUNY Downstate Medical Center and Long Island College Hospital**

#### **Action:**

In light of the recent acquisition of LICH, SUNY Downstate should consider consolidating inpatient services at the LICH campus, thereby eliminating excess capacity and permitting the medical center to focus its inpatient resources and expertise on one location.

#### **Discussion:**

Downstate Medical Center and Long Island College Hospital (LICH) completed a consolidation earlier this year in which SUNY created subsidiary corporations to hold LICH's assets and employ its staff. The physical plant is leased back to LICH and the staff is provided to LICH through a contract. The SUNY trustees serve as the governing body for LICH. Downstate Medical Center also operates services (primary care and ambulatory care) at the former Victory Memorial Hospital site.

Although LICH is located in a comparatively affluent area of Brooklyn, it continues to struggle with a negative margin, a current ratio of less than 1, substantial long-term debt, and low occupancy and low market share. More than half of its beds are vacant on an average day. University Hospital's physical plant is small and outdated. It relies heavily on Kings County Hospital for clinical space. With the availability of the new LICH campus and the pending expansion of services at the neighboring Kings County Hospital, SUNY Downstate should reconsider any planned expansion of beds at the site formerly occupied by Victory Hospital and any development of an ambulatory facility in the vicinity of University Hospital. Any request by SUNY Downstate to open additional inpatient beds at the Victory Hospital site should be denied.

### **D. Kingsboro Psychiatric Center**

#### **Action:**

The Office of Mental Health (OMH) should close the inpatient service of KPC and, working with the Department of Health, redirect resources to community-based behavioral health services that would function in collaboration with Brooklyn hospitals. Intermediate psychiatric hospital care for Brooklyn residents and court referrals would be provided primarily by South Beach Psychiatric Center, which currently serves a large section of Brooklyn. KPC's existing array of community-based services should remain within the community. These include two clinics, two transitional residences, a crisis residence in partnership with Kings County Hospital, intensive case management and a family care program.

**Discussion:**

Kingsboro Psychiatric Center (KPC) provides intermediate psychiatric hospital care for fewer than 240 admissions each year. The length of treatment for patients at KPC is the longest in the state for this level of care. The median LOS for KPC is 183 days, versus the statewide adult median LOS of 79 days.<sup>109</sup> Conversion of a majority of the high cost KPC inpatient beds into intensive community treatment and support services would be well-timed with the implementation of the Medicaid health home initiative in the borough. Improved coordination, coupled with expanded service availability, will significantly reduce the burden on Brooklyn's emergency rooms and inpatient services.

**E. Woodhull Hospital, Kings County Hospital and Coney Island Hospital****Action:**

These hospitals are operated by the New York City Health and Hospitals Corporation (HHC). The Work Group has had discussions with NYC leaders and visited the three sites.

**Discussion:**

Historically, HHC hospitals have been linked principally with the other institutions in the HHC system, rather than with local facilities. It is now essential that they add a new dimension to their approach by working with other providers in their geographic vicinity and becoming integral parts of emerging regional healthcare delivery systems. Initial discussions have begun, and while there are a variety of complex issues, it is obvious to all parties that HHC will have to become a more active partner in developing regional healthcare solutions for Brooklyn.

**IX. CONCLUSION**

The financial crises facing Brookdale, Interfaith and Wyckoff require immediate intervention and concerted action by stakeholders and the state. Brooklyn Hospital, Kingsbrook Jewish, and LICH may be stable at the moment, but will need to reconfigure their organizations and services, based on sound strategic plans, in order to survive in the long run. Given the high rates of chronic disease and the heavy reliance on hospital services in the communities served by all six hospitals, steps must be taken to assure access to high-quality primary care in those communities.

The recommendations in this report are intended to begin a process of reshaping the healthcare delivery system in Brooklyn. In addition to specific recommendations dealing with hospitals in financial crisis, the principles, tools, and structural recommendations of this report should be seen as the framework and first stages of a multi-year process designed to strengthen primary care, improve care coordination and chronic disease management, and reduce wasteful utilization and provider inefficiency. The shape of our healthcare delivery system is changing partly as a result of new federal legislation, as well as the efforts of the state's MRT. With these changes in mind, we have focused on promoting integrated systems of care that, in order to succeed, must involve collaborations with providers all along the health care continuum.

The monumental task in front of us will require redefining the roles and relationships among health care providers and between providers and patients. Primary care, acute care, behavioral health care and long-term care must all be linked in a patient-centered system, with the ultimate goal of better health care for individuals, better health for communities, and lower costs through improvement. To accomplish these ends, in an environment of necessary revenue neutrality, will require creativity, compromise and the willingness of many groups and institutions to work together in ways they never have before. For Brooklyn, managing these changes in the years

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<sup>109</sup> NYS Office of Mental Health, Management Indicator Reports, Nov. 2011.

ahead is essential, if we are to improve access and quality, particularly for the large number of people facing barriers to care in communities throughout the borough.

While the mandate set by the commissioner for this Work Group was Brooklyn, it is clear that the issues of health care access, quality and cost affect many other communities throughout New York State. In fact, for most communities, whether urban, suburban, rural, affluent or low-income, truly coordinated, accessible and affordable care remains more theory than reality. We therefore believe that the recommendations we have made have applications far beyond the borders of Kings County.

## APPENDIX A

### Brooklyn Healthcare Redesign Workgroup Site Visit Questions

#### **Governance and Management**

- Describe your corporate governance and management structure.
- How do you select members of the board, define the work of the board and how they are working to improve the quality and performance of the organization through their governance process?
- What are your hospital's greatest strengths/weaknesses?

#### **Business Model**

- Does your Board have a Strategic plan?
- How does it deal with proposed federal actions on DSH and GME reductions?
- How do you define your market?
- Has it changed over the past 5 to 10 years?
- Who are your key competitors?
- Description or even a copy of community service report Are there unique problems in patient mix that we would not pick up from analyzing the data?
- How do you define "safety net" and what role do you play in the ongoing evolution of the safety net?
- What strategies do you have to generate capital for reinvestment? What would be your top capital reinvestment priority?

#### **Physicians**

- What is the arrangement and organization of physicians that practice at your hospital? How many physicians on staff? Do you use hospitalists? Do you know whether and where physicians' have admitting privileges at other institutions?
- Do you have medical education in the facility? Clerkships, residencies, etc.

#### **Provider Relationships**

- Do you have a network of services and what is included and how are they connected? Is it fully integrated in terms of quality measures, coordinated care, referrals, etc.
- What is your relationship with other providers in the community, including hospitals, clinics and FQHCs, nursing homes?
- Do you have relationships with behavioral health providers?

#### **Health Information Technology**

- Are you electronically linked with other providers?
- How far along are you on internal electronic records progress?

#### **Quality Initiatives**

- What initiatives have you put in place to control preventable admissions and manage people with chronic conditions?
- Have you instituted protocols to deal with hospital acquired infections?

**APPENDIX B**  
**Brooklyn Neighborhoods – Key Socioeconomic and Health Status Factors**

	Population*	Poverty <sup>1</sup> (% below FPL)	Race/ Ethnicity*	Education <sup>1</sup> (HS Diploma or Equivalent)	Immigration <sup>1</sup>	Uninsured <sup>1</sup>	Health Status <sup>1</sup>
Greenpoint	140,099	34%	63.43% White 29.84% Hispanic 2.60% African-American 3.29% Asian 0.84% Other – Non-Hispanic	26%	34%	20%	<ul style="list-style-type: none"> <li>• 31% adults w/o primary care provider</li> <li>• 19.8% adults are obese*</li> <li>• 11.4% adults have diabetes*</li> <li>• 1,983 per 100,000 – hospitalization rates for heart disease</li> <li>• 33% mothers receive late or no prenatal care</li> <li>• 8% residents suffer from SPD (serious psychological distress)</li> </ul>
Northwest Brooklyn	236,982	20%	49.09% White 23.05% Hispanic 20.43% African-American 5.41% Asian 2.02% Other – Non-Hispanic	15%	17%	13%	<ul style="list-style-type: none"> <li>• 21% adults w/o primary care provider</li> <li>• 16.5% adults are obese*</li> <li>• 9.4% adults have diabetes*</li> <li>• 1,840 per 100,000 – hospitalization rates for heart disease</li> <li>• 19% mothers receive late or no prenatal care</li> <li>• 5% residents suffer from SPD</li> </ul>
Central Brooklyn	314,013	31%	5.98% White 11.44% Hispanic 79.46% African-American 1.45% Asian 1.67% Other – Non-Hispanic	29%	29%	21%	<ul style="list-style-type: none"> <li>• 29% residents w/o primary care provider</li> <li>• 26.9% adults are obese*</li> <li>• 10.6% adults have diabetes*</li> <li>• 2,256 per 100,000 – hospitalization rates for heart disease</li> <li>• 35% mothers receive late or no prenatal care</li> <li>• More than twice the HIV-related death rate in NYC overall</li> <li>• Elevated rates of other STDs, such as chlamydia and gonorrhea</li> </ul>

	Population*	Poverty <sup>1</sup> (% below FPL)	Race/ Ethnicity*	Education <sup>1</sup> (HS Diploma or Equivalent)	Immigration <sup>1</sup>	Uninsured <sup>1</sup>	Health Status <sup>1</sup>
Bushwick-Williamsburg	202,549	38%	5.24% White 52.97% Hispanic 36.22% African-American 4.37% Asian 1.19% Other – Non-Hispanic	25%	27%	27%	<ul style="list-style-type: none"> <li>• 32% adults w/o primary care provider</li> <li>• 34% adults are obese*</li> <li>• 12.5% adults have diabetes*</li> <li>• 2,991 per 100,000 – hospitalization rates for heart disease</li> <li>• 34% mothers receive late or no prenatal care</li> <li>• 10% residents suffer from SPD</li> <li>• High HIV-related death rate than in Brooklyn and NYC overall</li> </ul>
Flatbush	307,274	21%	10.02% White 9.51% Hispanic 76.38% African-American 2.65% Asian 1.44% Other – Non-Hispanic	29%	51%	21%	<ul style="list-style-type: none"> <li>• 20% adults w/o primary care provider</li> <li>• 29.8% adults are obese*</li> <li>• 13.3% adults have diabetes*</li> <li>• 1,605 per 100,000 – hospitalization rates for heart disease</li> <li>• 33% mothers receive late or no prenatal care</li> <li>• 6% residents suffer from SPD</li> </ul>
East New York-New Lots	177,819	34%	2.88% White 40.17% Hispanic 50.31% African-American 4.70% Asian 1.94% Other – Non-Hispanic	29%	33%	21%	<ul style="list-style-type: none"> <li>• 31% adults w/o primary care provider</li> <li>• 27.6% adults are obese*</li> <li>• 18.1% adults have diabetes*</li> <li>• 2,505 per 100,000 – hospitalization rates for heart disease</li> <li>• 39% mothers receive late or no prenatal care</li> <li>• 7% residents suffer from SPD</li> <li>• 21% residents currently smoke; 62% of smokers trying to quit</li> </ul>
Sunset Park	128,725	28%	20.45% White 46.90% Hispanic 2.43% African-American 29.09% Asian	25%	49%	26%	<ul style="list-style-type: none"> <li>• 31% adults w/o primary care provider</li> <li>• 32.9% adults are obese*</li> <li>• 8.5% adults are</li> </ul>

	Population*	Poverty <sup>1</sup> (% below FPL)	Race/ Ethnicity*	Education <sup>1</sup> (HS Diploma or Equivalent)	Immigration <sup>1</sup>	Uninsured <sup>1</sup>	Health Status <sup>1</sup>
			1.13% Other – Non-Hispanic				diabetes* <ul style="list-style-type: none"> <li>• 1,940 per 100,000 – hospitalizations rates for heart disease</li> <li>• 16% mothers receive late or no prenatal care</li> <li>• 7% residents suffer from SPD</li> <li>• Foreign-born residents (27%) less likely to be insured than US-born residents (13%)</li> </ul>
Borough Park	347,062	25%	64.93% White 10.80% Hispanic 4.75% African-American 18.33% Asian 1.19% Other – Non-Hispanic	28%	45%	15%	<ul style="list-style-type: none"> <li>• 20% adults w/o primary care provider</li> <li>• 18.5% adults are obese*</li> <li>• 8.5% adults have diabetes*</li> <li>• 1,782 per 100,000 – hospitalization rates for heart disease</li> <li>• 23% mothers receive late or no prenatal care</li> <li>• 6% residents suffer from SPD</li> <li>• 30% hospitalizations for hip fractures among older adults</li> </ul>
Canarsie-Flatlands	197,108	14%	35.92% White 8.79% Hispanic 49.19% African-American 4.73% Asian 1.38% Other – Non-Hispanic	29%	37%	14%	<ul style="list-style-type: none"> <li>• 17% adults w/o primary care provider</li> <li>• 31.5% adults are obese*</li> <li>• 7.9% adults have diabetes*</li> <li>• 1,826 per 100,000 – hospitalization rates for heart disease</li> <li>• 28% mothers receive late or no prenatal care</li> <li>• 5% residents suffer from SPD</li> <li>• 25% women not getting timely mammograms</li> </ul>
Southwest Brooklyn	210,906	16%	72.02% White 8.27% Hispanic .65% African-American 17.89% Asian 1.16% Other – Non-Hispanic	28%	40%	13%	<ul style="list-style-type: none"> <li>• 20% adults w/o primary care provider</li> <li>• 15.5% adults are obese*</li> <li>• 5.5% adults have diabetes*</li> <li>• 1,705 per 100,000 –</li> </ul>



	Population*	Poverty <sup>1</sup> (% below FPL)	Race/ Ethnicity*	Education <sup>1</sup> (HS Diploma or Equivalent)	Immigration <sup>1</sup>	Uninsured <sup>1</sup>	Health Status <sup>1</sup>
							hospitalization rates for heart disease <ul style="list-style-type: none"> <li>• 15% mothers receive late or no prenatal care</li> <li>• 5% residents suffer from SPD</li> <li>• 21% residents smoke; 52% trying to quit</li> <li>• 33% foreign-born women less likely to get Pap test</li> </ul>
Southern Brooklyn	304,561	22%	67.58% White 9.74% Hispanic 6.82% African-American 14.78% Asian 1.08% Other – Non-Hispanic	28%	47%	14%	<ul style="list-style-type: none"> <li>• 20% adults w/o primary care provider</li> <li>• 30.8% adults are obese*</li> <li>• 13.5% adults have diabetes*</li> <li>• 2,074 per 100,000 – hospitalization rates for heart disease</li> <li>• 20% mothers receive late or no prenatal care</li> <li>• 6% residents suffer from SPD</li> <li>• 23% residents smoke; 62% trying to quit</li> <li>• Women less likely to get timely Pap tests than in NYC overall</li> <li>• 37% hospitalizations for hip fractures among older adults</li> </ul>

Source: \* New York City Department of Health and Mental Hygiene (NYC DOHMH). Epiquery: NYC Interactive Health Data System - Community Health Survey 2009. Accessed October 21, 2011; <http://nyc.gov/health/epiquery>.

Population data: NYC DOHMH. Epiquery: NYC Interactive Health Data System - NYCDOHMH neighborhood population estimates, modified from the US Census Bureau vintage population estimates, 2009. Accessed October 21, 2011; <http://nyc.gov/health/epiquery>.

<sup>1</sup> Data from the NYC DOHMH, Community Health Profiles, 2006 (except where indicated by \*)

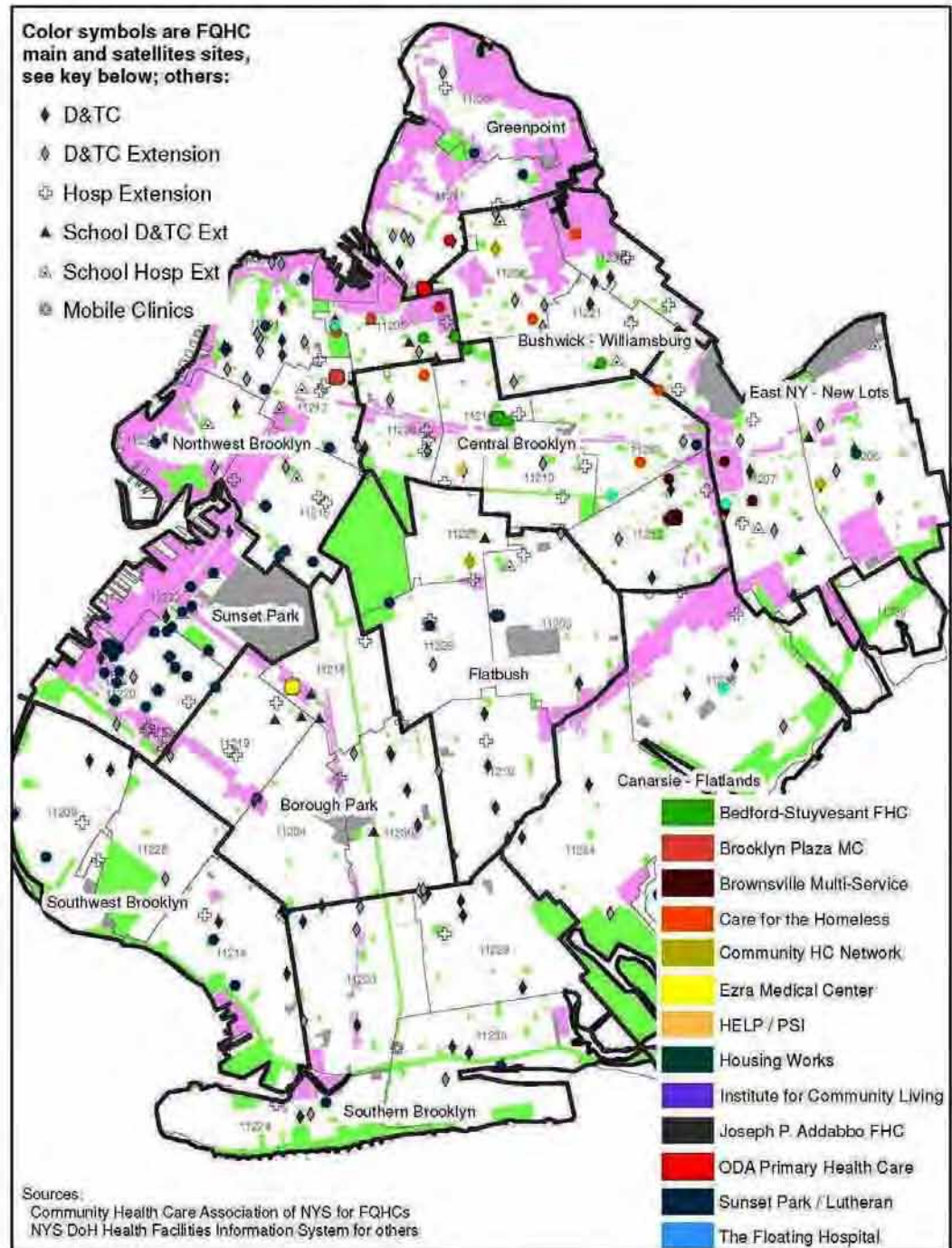
**APPENDIX C**  
**Hospitals in Brooklyn: Key Facts**

<b>Hospital</b>	<b>Neighborhood</b>	<b># of Licensed Beds<sup>110</sup></b>	<b>Specialized Services</b>
Beth Israel-Kings Highway	Canarsie-Flatlands	212	Stroke Center
Brookdale Hospital Medical Center	Canarsie-Flatlands	530	AIDS, Stroke Center, Level 3 Perinatal Center, and Regional Trauma Center
Brooklyn Hospital Center	Northwest	464	AIDS, Stroke Center, and Inpatient Psychiatric
Coney Island Hospital	Southern	371	AIDS, Stroke Center, SAFE, Level 2 Perinatal Center, Inpatient Chemical Dependency (Detox and Psychiatric)
Interfaith Medical Center	Central	287	AIDS, Inpatient Chemical Dependency (Detox and Rehabilitation), Psychiatric
Kings County Hospital	Flatbush	695	AIDS, Stroke Center, Regional Trauma, SAFE, Level 3 Perinatal Center, Inpatient Chemical Dependency (Detox and Psychiatric)
Kingsbrook Jewish Medical Center	Flatbush	284	AIDS, Stroke Center, Traumatic Brain Injury Center, Inpatient Psychiatric
Long Island College Hospital	Northwest	506	Stroke Center, Level 3 Perinatal Center, Inpatient Psychiatric
Lutheran Medical Center	Sunset Park	468	AIDS, Stroke Center, Regional Trauma Center, Level 2 Perinatal Center, Inpatient Chemical Dependency (Detox and Psychiatric)
Maimonides Medical Center	Borough Park	705	Stroke Center, Regional Perinatal Center, Inpatient Psychiatric
New York Methodist Hospital	Northwest	591	Stroke Center, Level 3 Perinatal Center
New York Community Hospital of Brooklyn	Canarsie-Flatlands	134	Stroke Center
University Hospital of Brooklyn	Flatbush	376	AIDS, Stroke Center, Regional Trauma Center, Level 3 Perinatal Center, Inpatient Psychiatric
Woodhull Medical Center	Bushwick-Williamsburg	394	AIDS, Stroke Center, SAFE, Level 3 Perinatal Center, Inpatient Chemical Dependency (Detox)
Wyckoff Heights Medical Center	Bushwick-Williamsburg	324	Stroke Center, Level 3 Perinatal Center

<sup>110</sup> These figures reflect licensed, not staffed, beds. Many licensed beds are not staffed. The number of beds that is staffed varies based on occupancy and other factors. However, the overhead costs associated with a bed are the same, whether or not it is staffed.

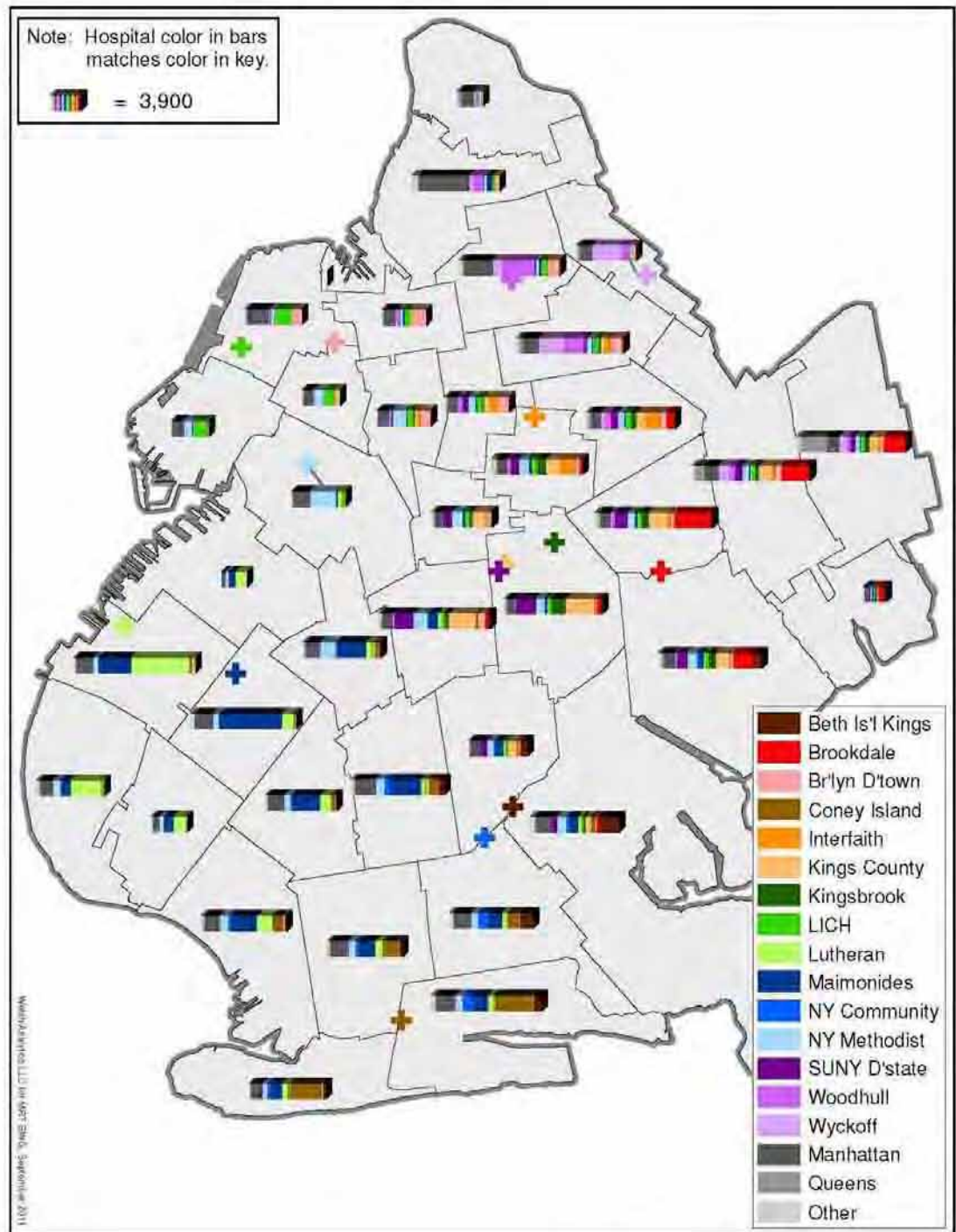
## APPENDIX D

### FQHCs and Other Clinic Sites in Brooklyn (with UHF Neighborhood Boundaries)



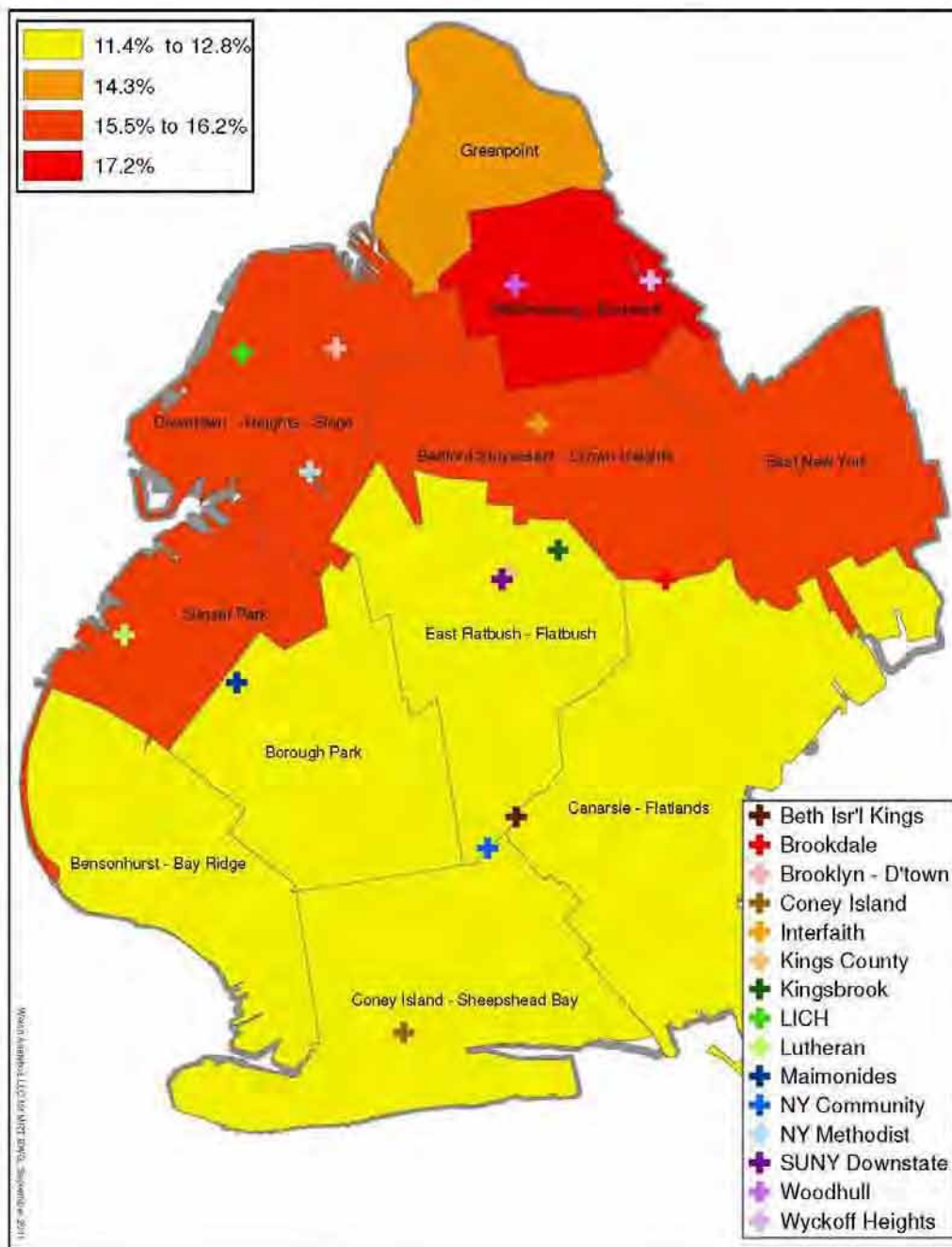
## APPENDIX E

### Hospital Shares of 2010 Patient Discharges by ZIP Code of Residence



## APPENDIX F

### 2009 PQI Hospitalizations as Percentage of Adult Medical-Surgical Hospitalizations Among Residents of UHF Neighborhoods



<sup>111</sup> Some neighborhood names have changed since this map was produced. Downtown-Heights-Slope is known as Northwest Brooklyn; Bedford Stuyvesant-Crown Heights is known as Central Brooklyn; East New York is known as East New York-New Lots; East Flatbush-Flatbush is known as Flatbush; Bensonhurst-Bay Ridge is known as Southwest Brooklyn; and Coney Island-Sheepshead Bay is known as Southern Brooklyn.

## APPENDIX G

### Brooklyn Health Professional Shortage Areas

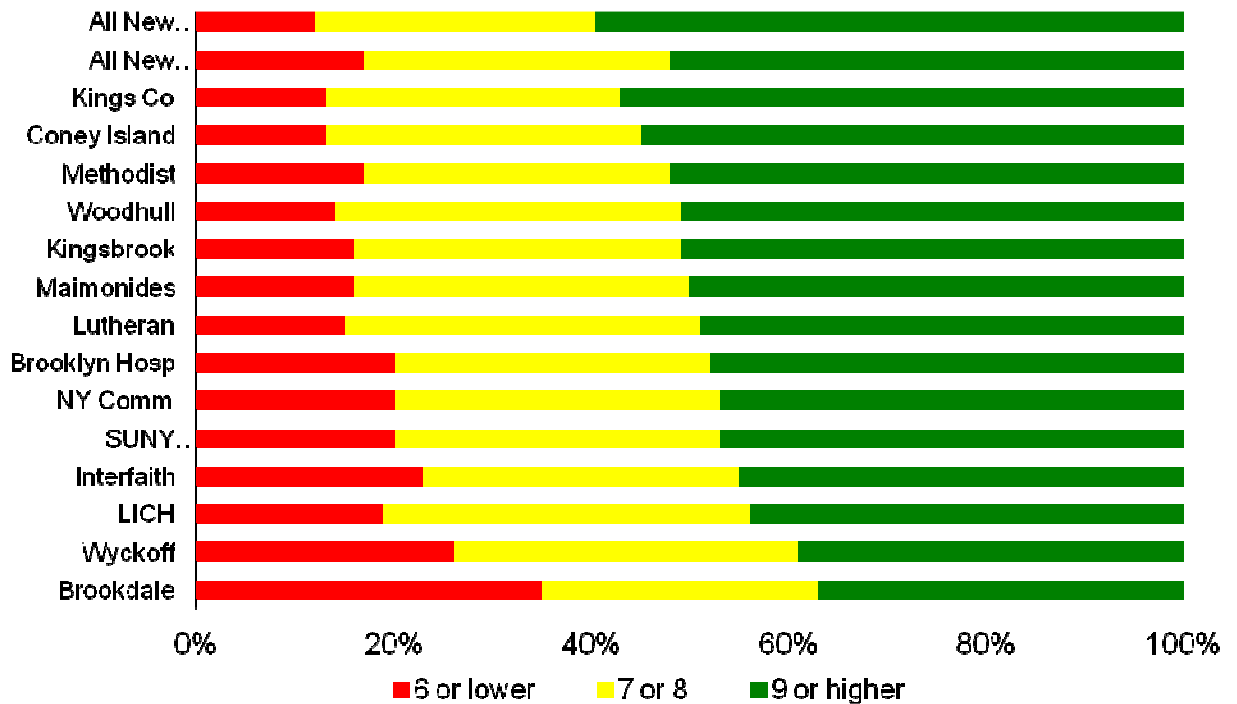
Discipline	Name	Type
<b>Primary Care</b>	Bedford-Stuyvesant	Geographic
	Bushwick	Geographic
	Coney Island	Geographic
	Crown Heights	Pop – Low Income
	East New York	Geographic
	Midwood	Pop – Medicaid Eligible
	Red Hook	Pop – Medicaid Eligible
	Sunset Park	Pop – Medicaid Eligible
	Williamsburg	Geographic
	<b>Mental Health</b>	Coney Island/Gravesend
Kings County Hospital		Facility
Northwest Brooklyn		Pop – Homeless
Southwest Brooklyn		Geographic
Woodhull Hospital		Facility
<b>Dental</b>	Bedford-Stuyvesant	Pop – Medicaid Eligible
	Coney Island	Pop – Medicaid Eligible

Source: Center for Health Workforce Studies, Oct. 2011.

## APPENDIX H

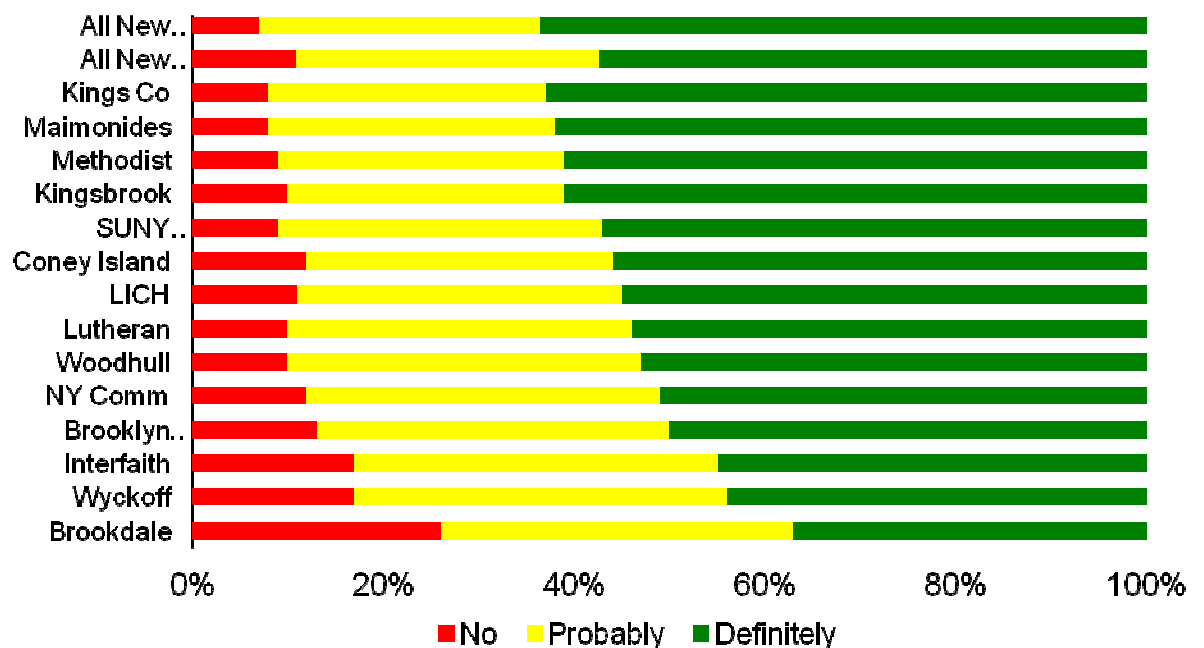
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

**Overall hospital rating on a scale from 0 (lowest) to 10 (highest)**



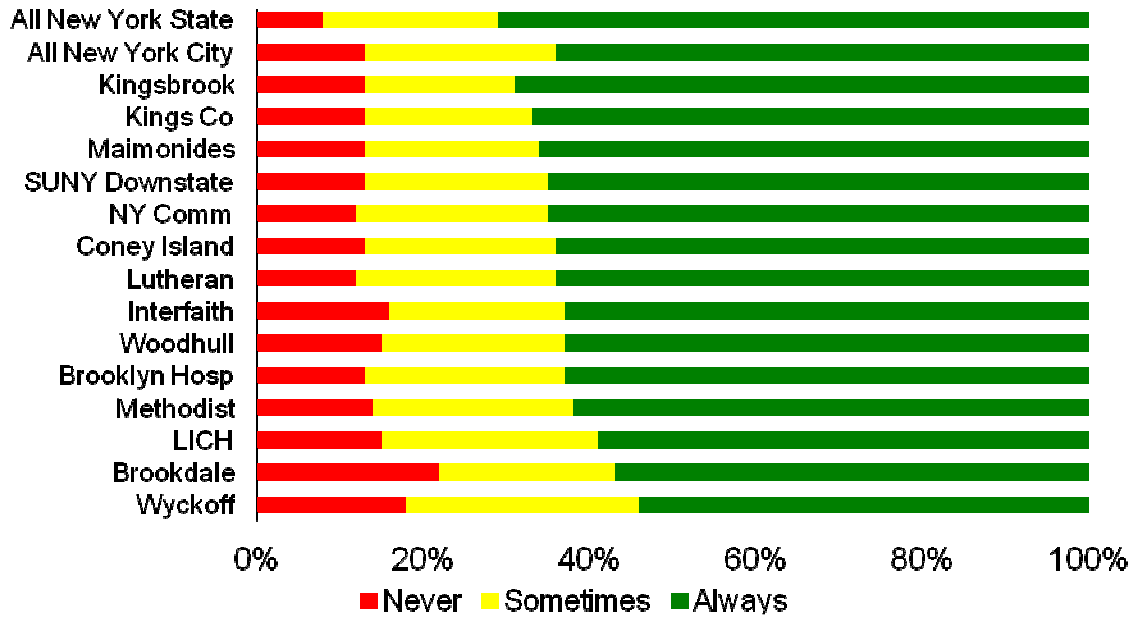
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

**Percent of patients who reported they would recommend the hospital**



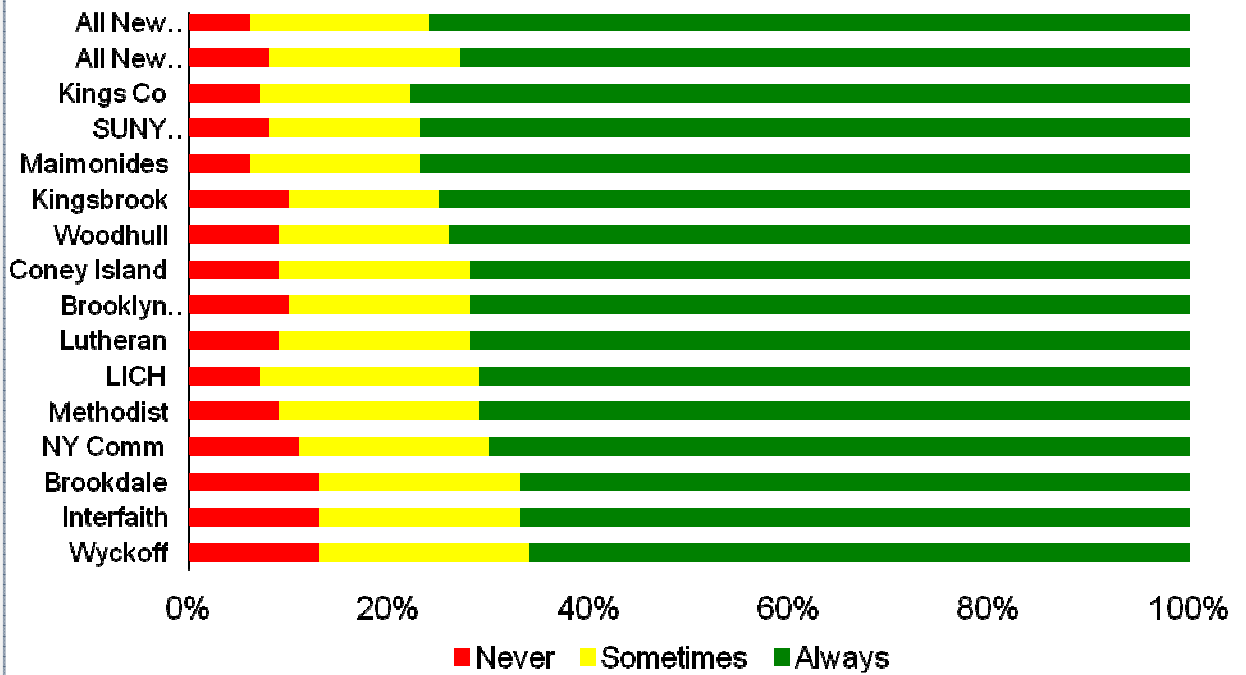
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that their nurses communicated well



Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

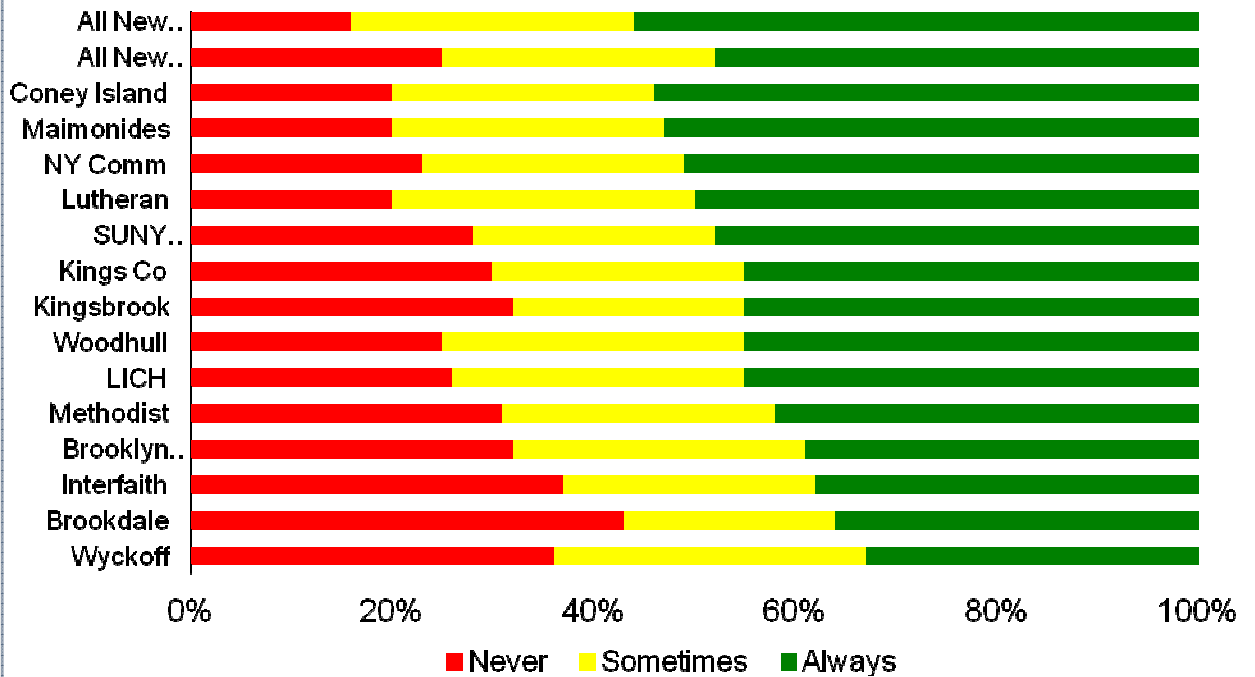
Percent of patients who reported that their doctors communicated well





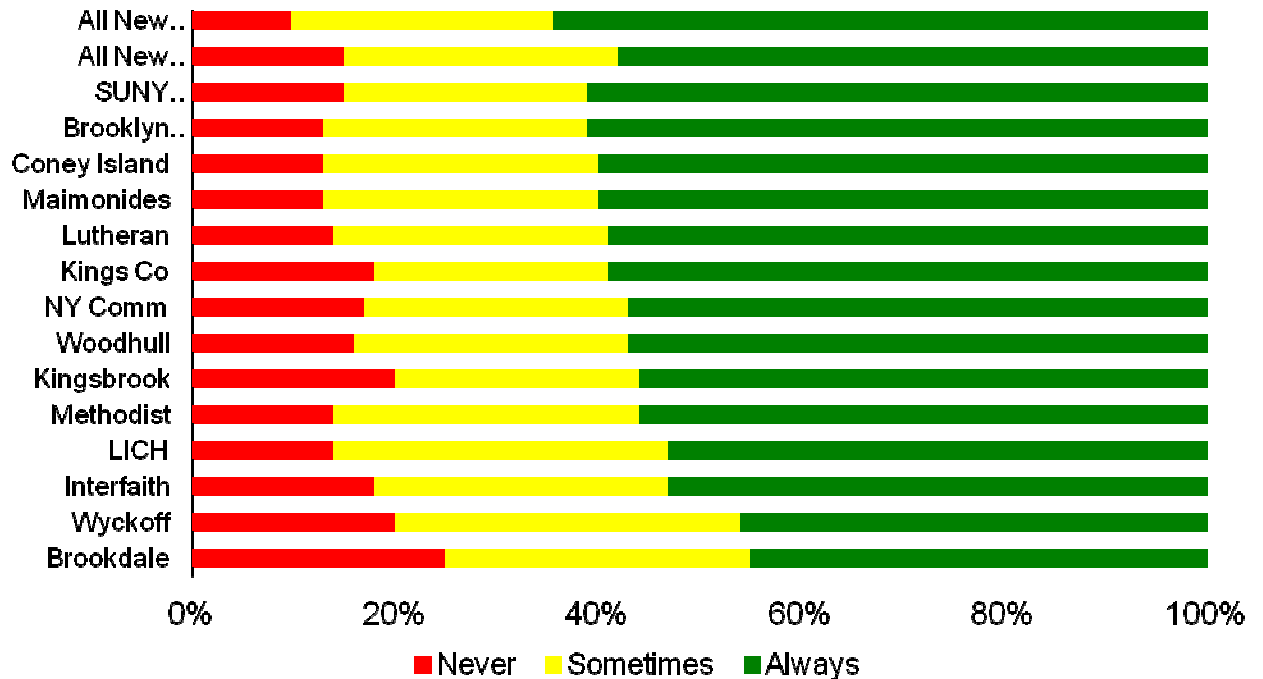
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that received help as soon as they wanted



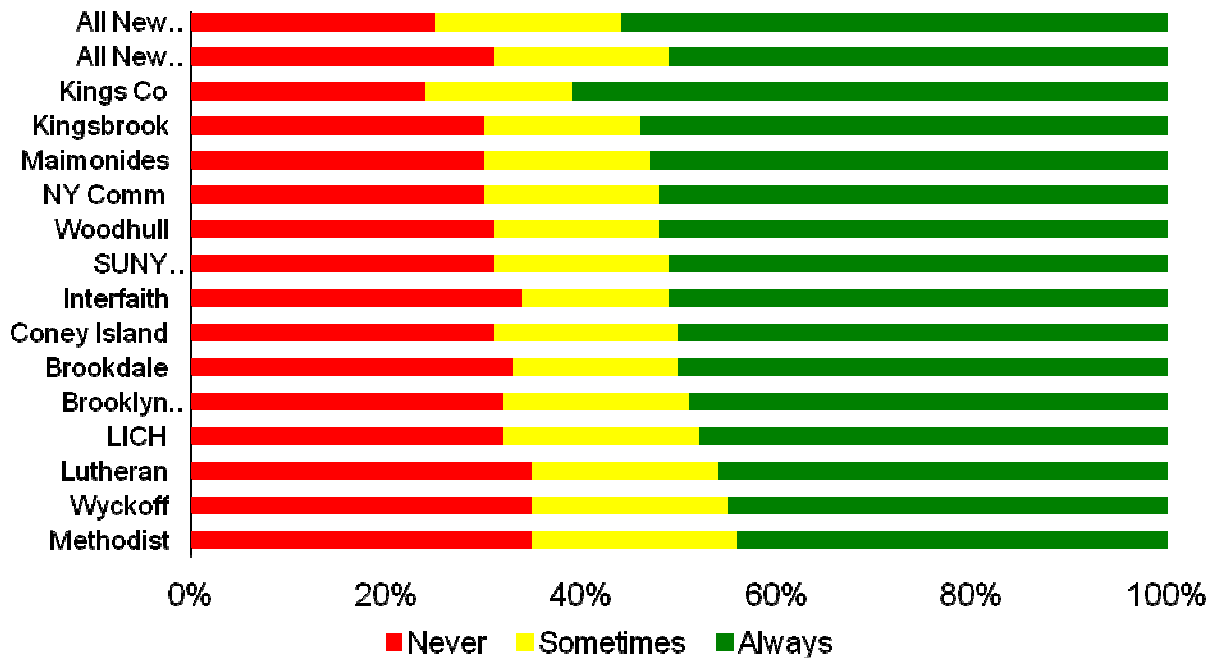
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that their pain was well controlled



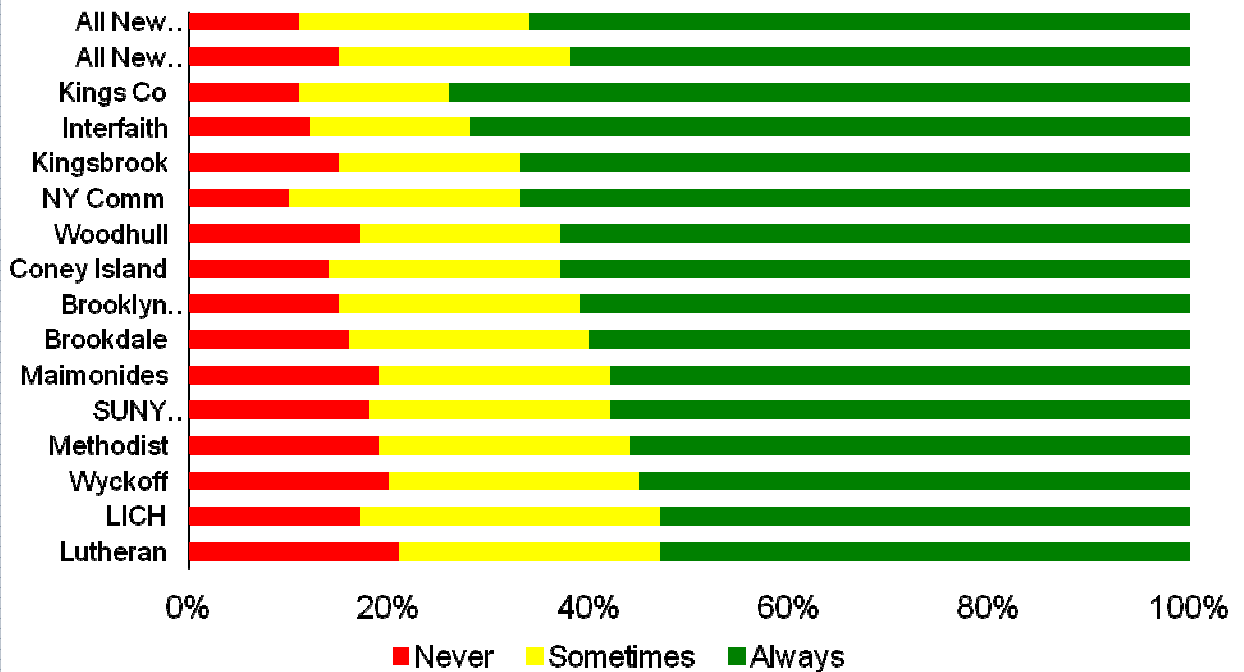
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that staff explained about medicines before giving it to them



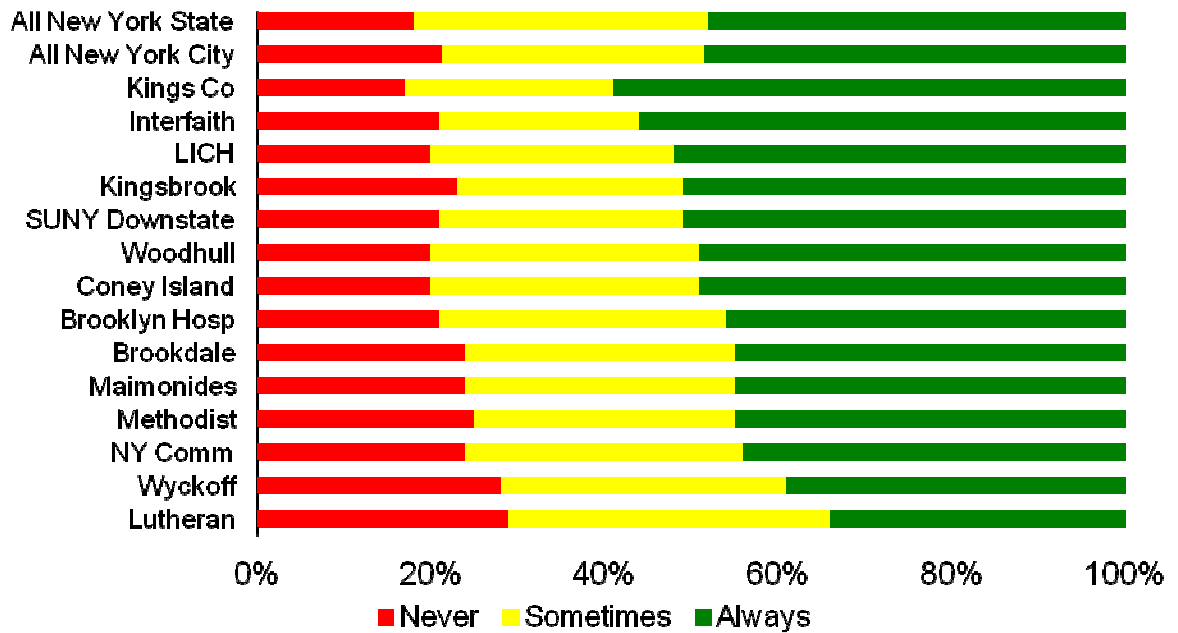
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that their room and bathroom were clean



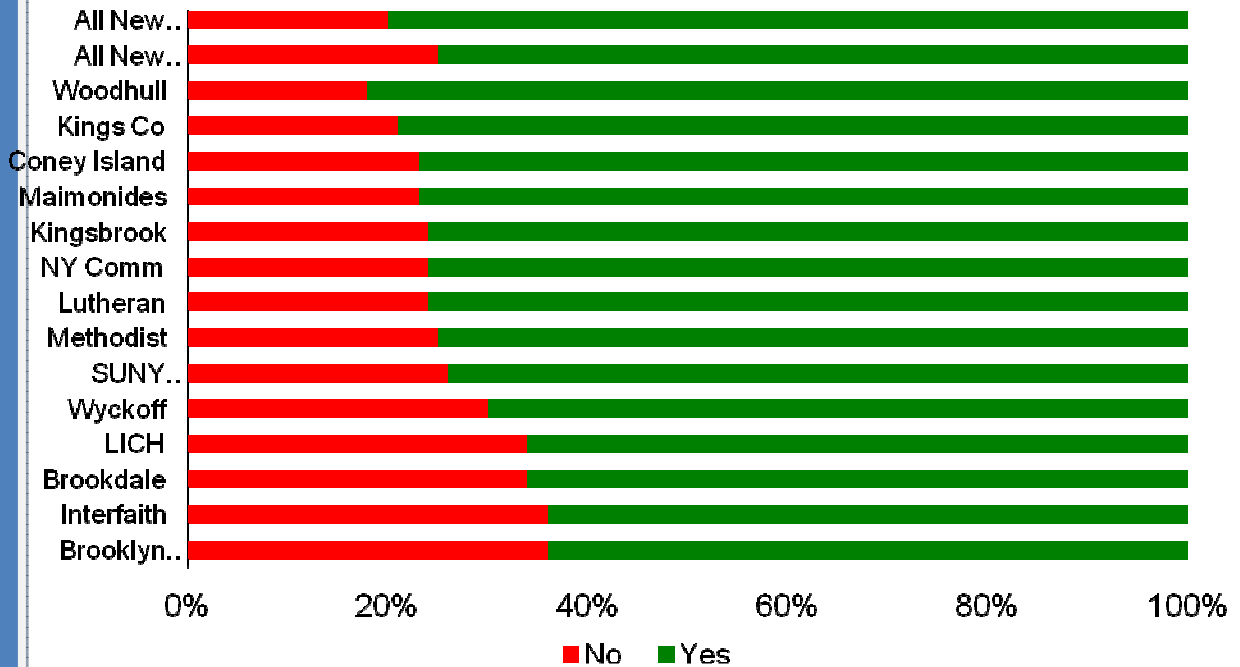
Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities

Percent of patients who reported that the area around their room was quiet at night



Hospital Care Quality Information from the Consumer Perspective (HCAHPS), 7/2009-6/2010  
Brooklyn Facilities<sup>112</sup>

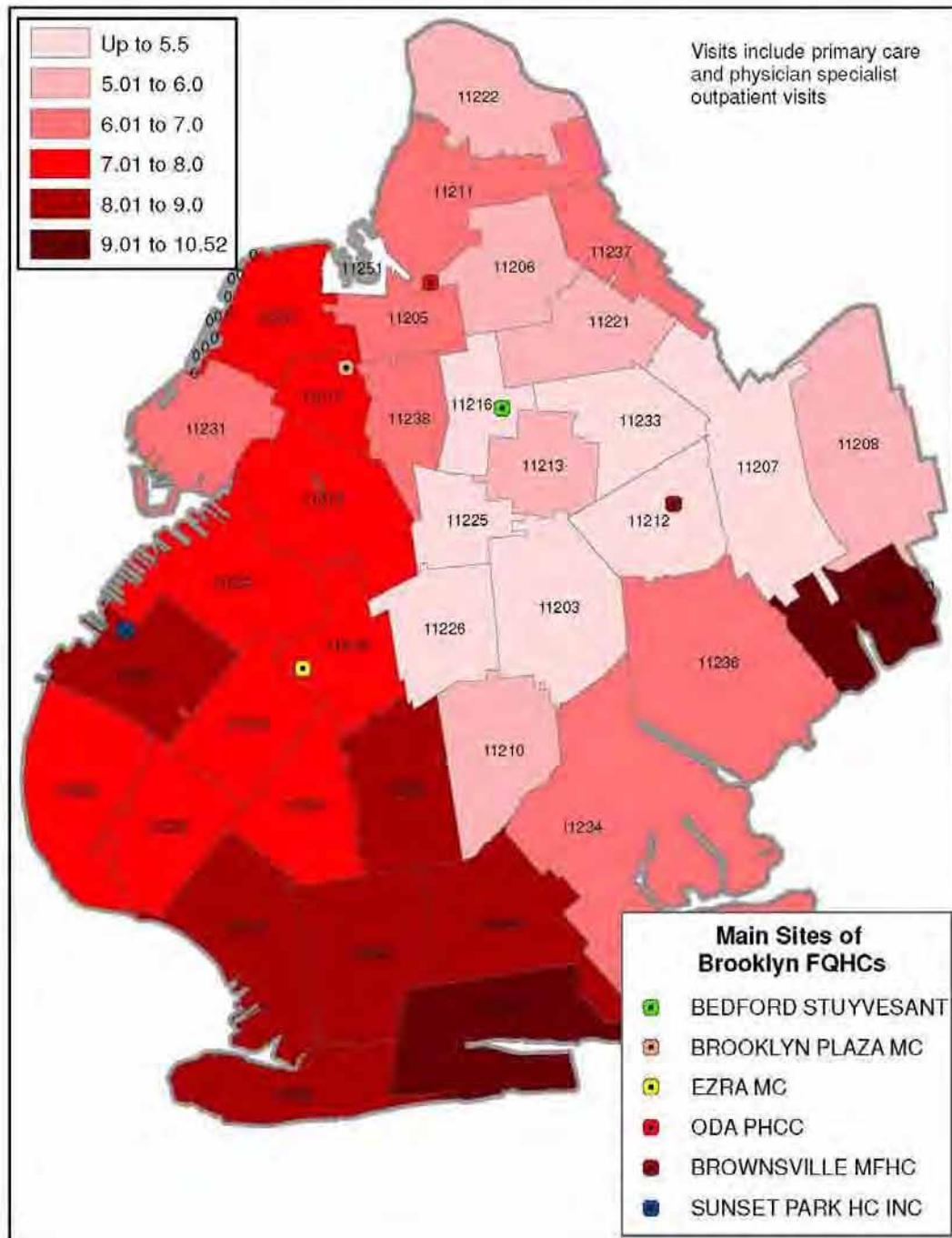
Percent of patients who reported they were given information about what to do during recovery



<sup>112</sup> Hospital Care Quality Information from the Consumer Perspective, Centers for Medicare & Medicaid Services, Baltimore, MD, available at <http://www.hcahponline.org>, accessed Apr. 20, 2011

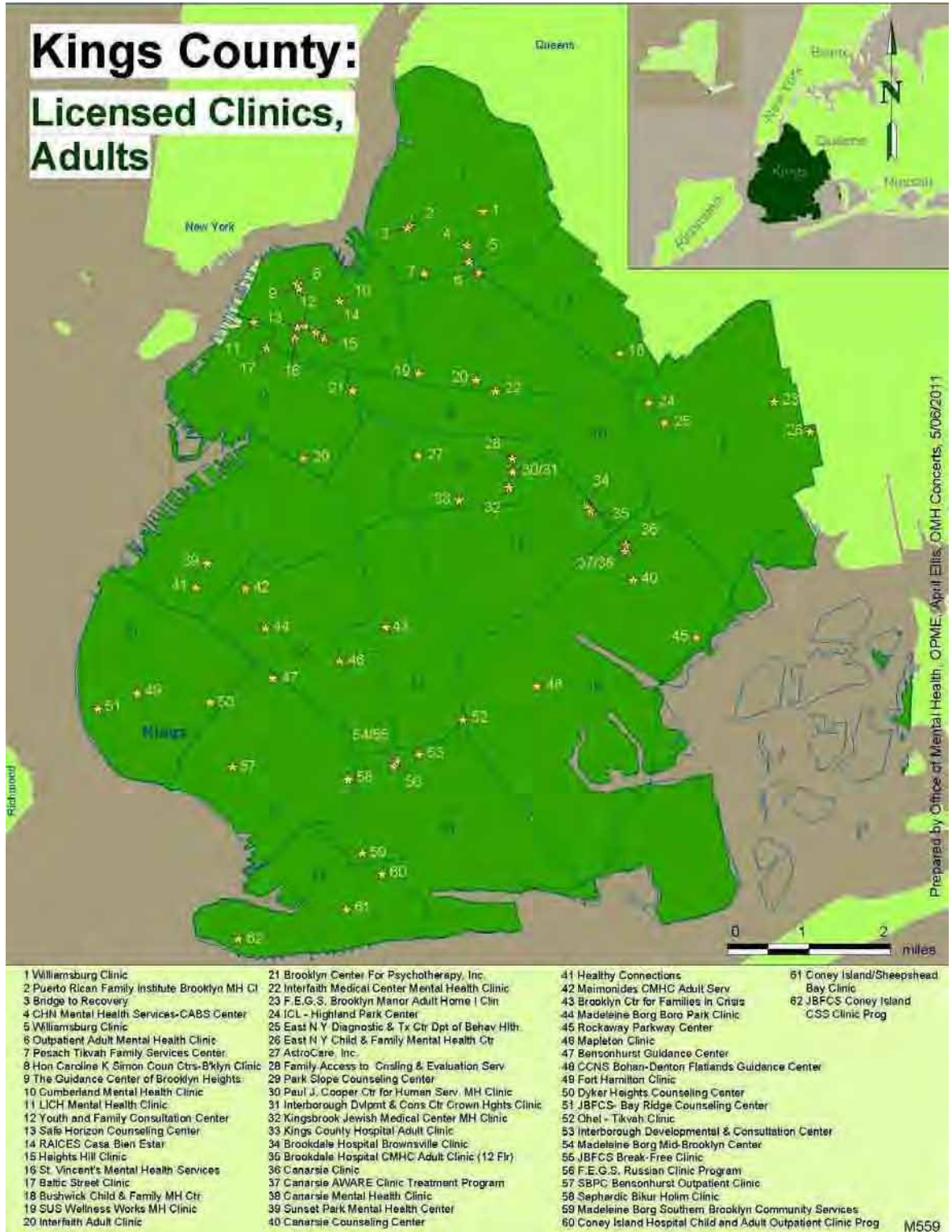
## APPENDIX I

### Outpatient Visits per Member per Year by Medicaid Fee-for-Service and Managed Care Enrollees in 2009



# APPENDIX J

## Office of Mental Health (OMH) Licensed Clinics - Adults



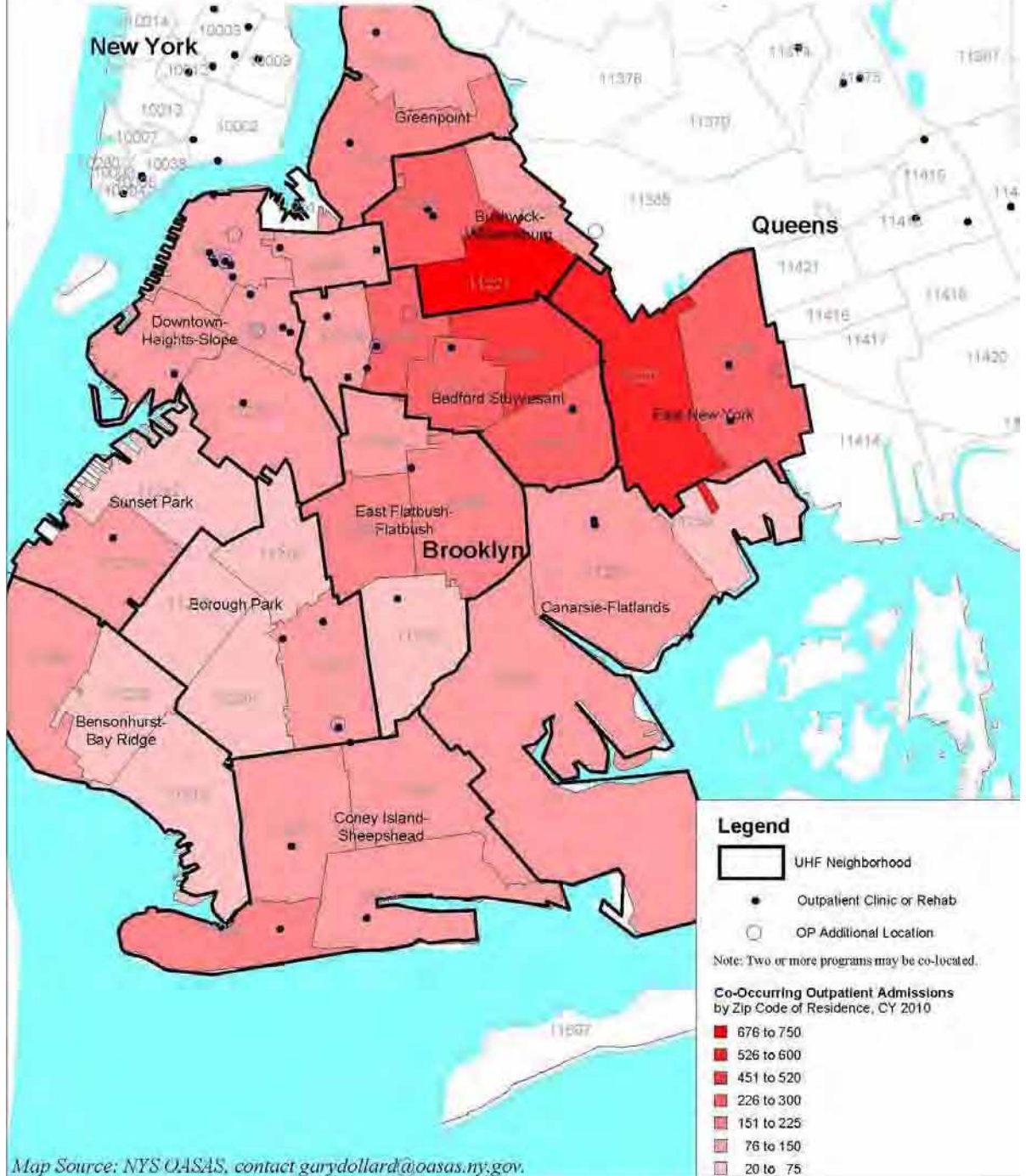
## Office of Mental Health (OMH) Licensed Clinics - Children



## APPENDIX K

### NYS OASAS Part 822 Outpatient Programs and Additional Locations in Kings County by United Hospital Fund Neighborhood

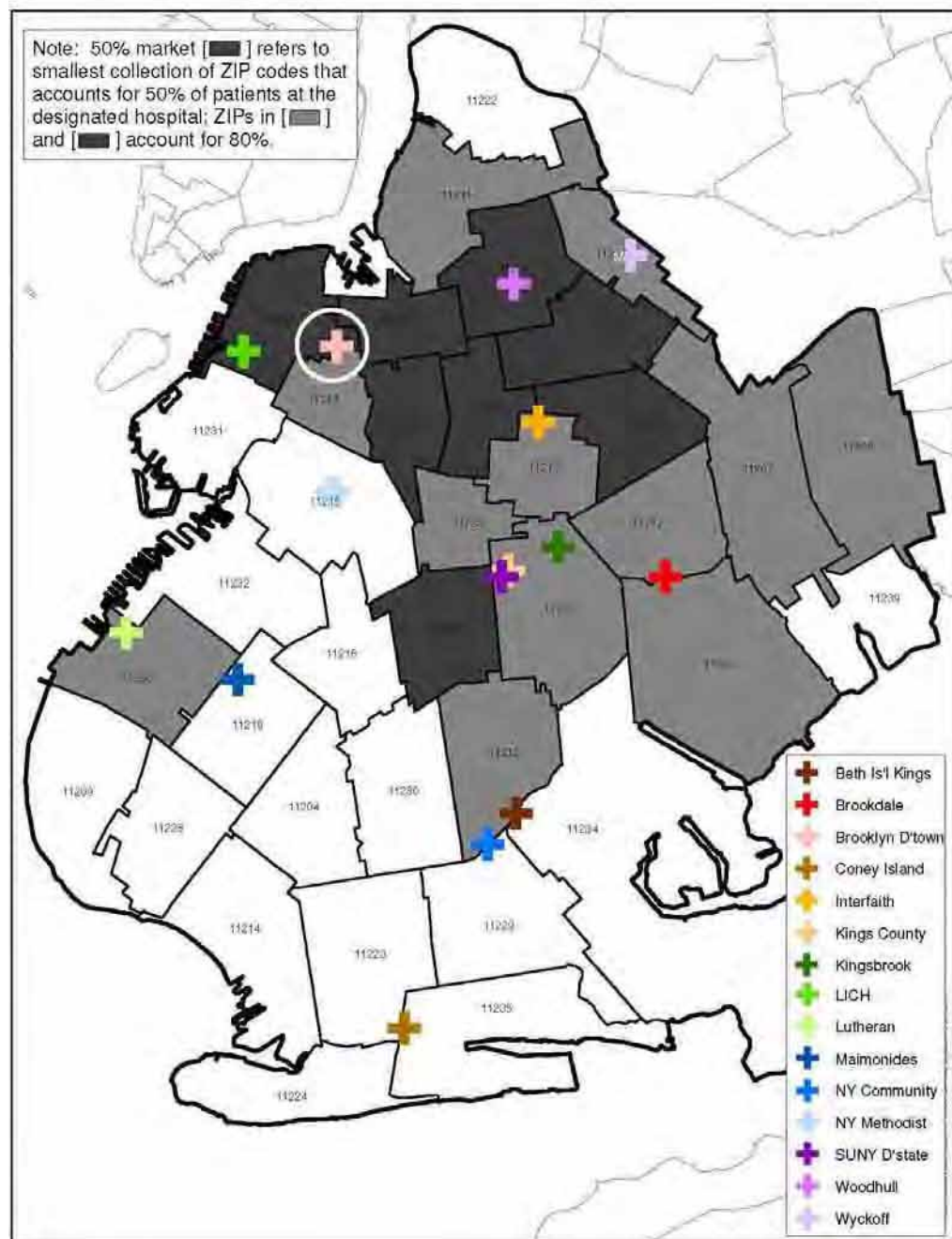
*Data Source: NYS OASAS Data Warehouse, geocoded extract of 9/13/2011.*



## APPENDIX L

### CORE MARKET MAPS FOR 6 FOCUS HOSPITALS<sup>113</sup>

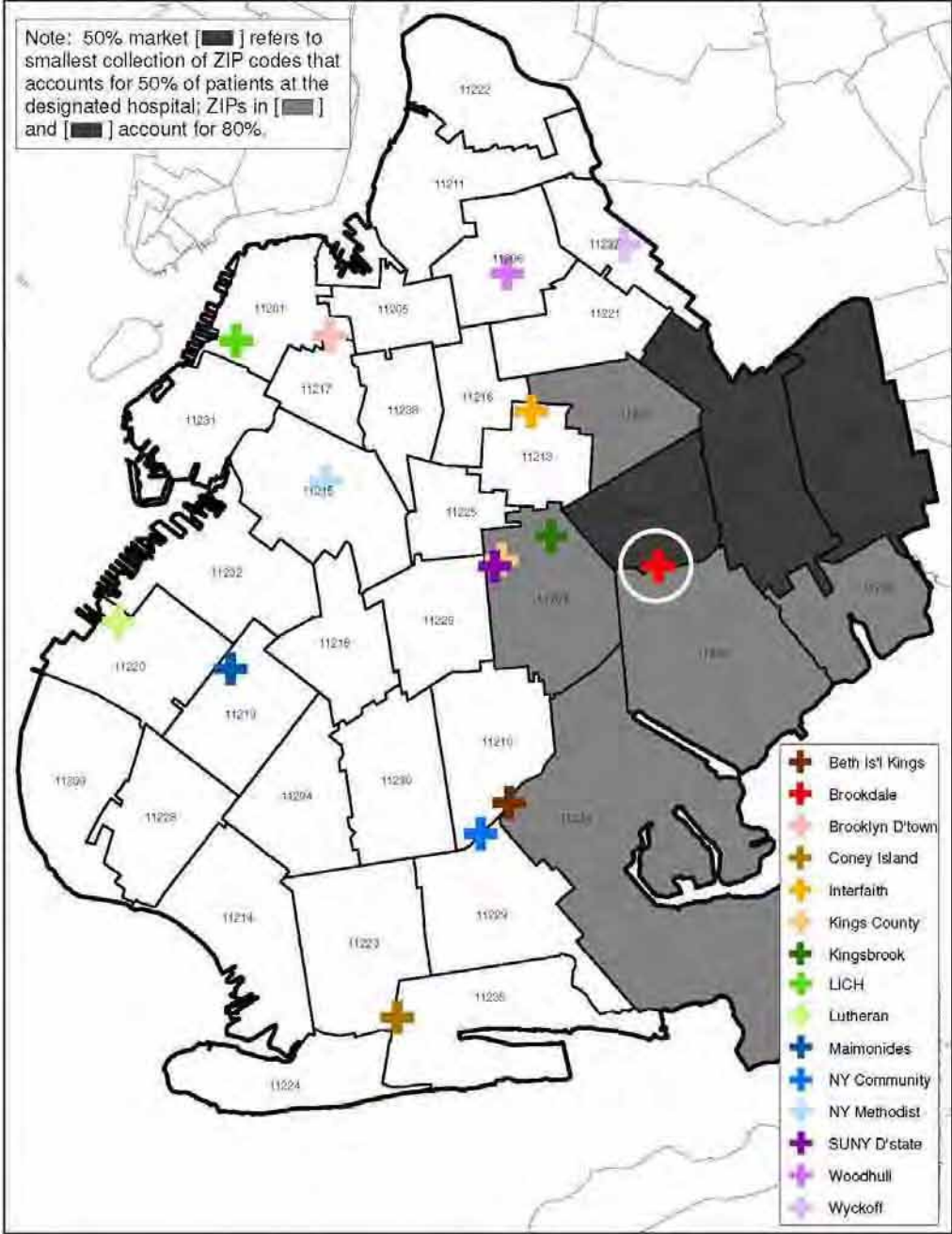
Boundaries for 50% and 80% Markets for All Patients  
at Brooklyn Downtown Hospital Center in 2010



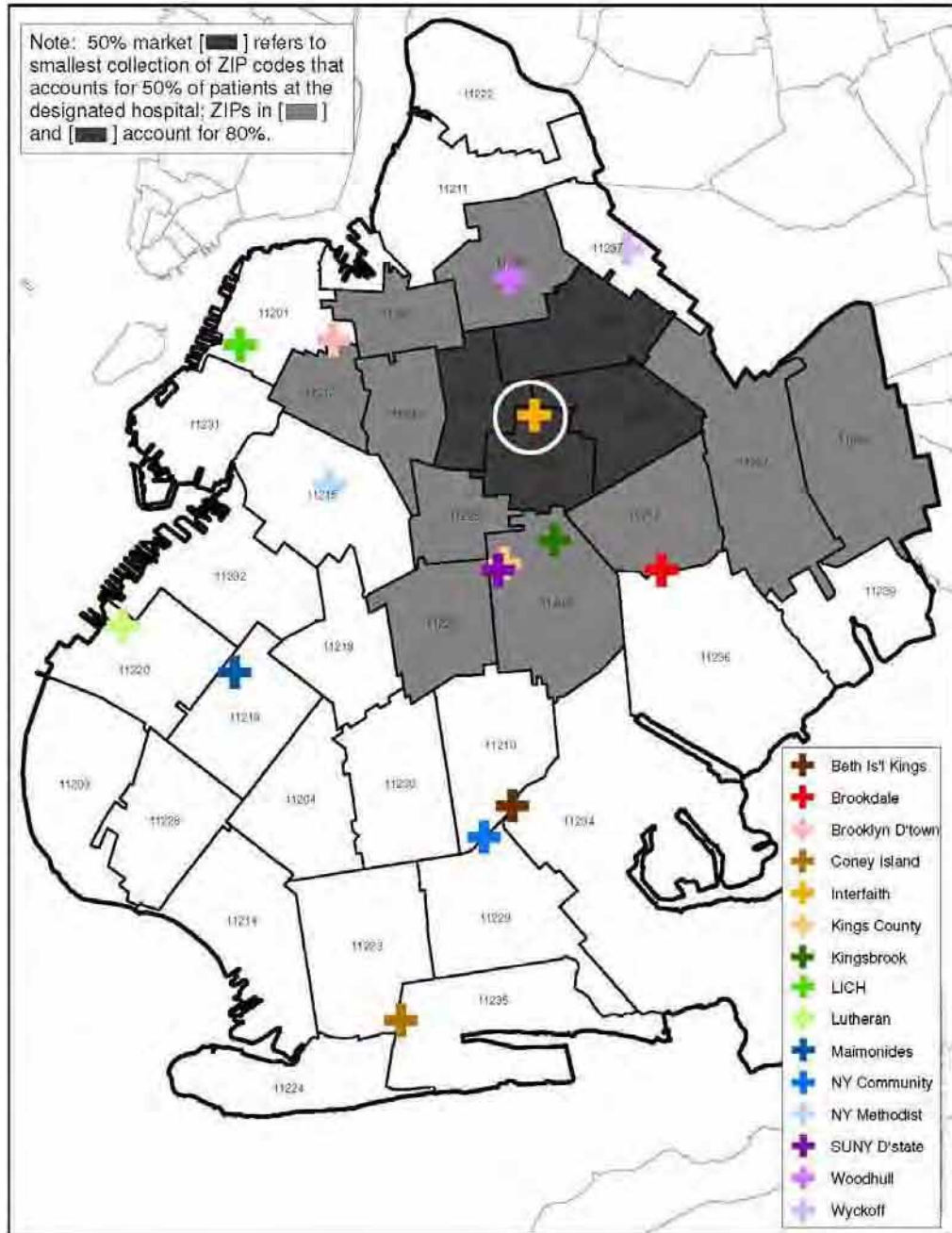
<sup>113</sup> Welsh Analytics, LLC, NYSDOH SPARCS Deidentified Inpatient File, obtained August 2011.



### Boundaries for 50% and 80% Markets for All Patients at Brookdale Medical Center in 2010

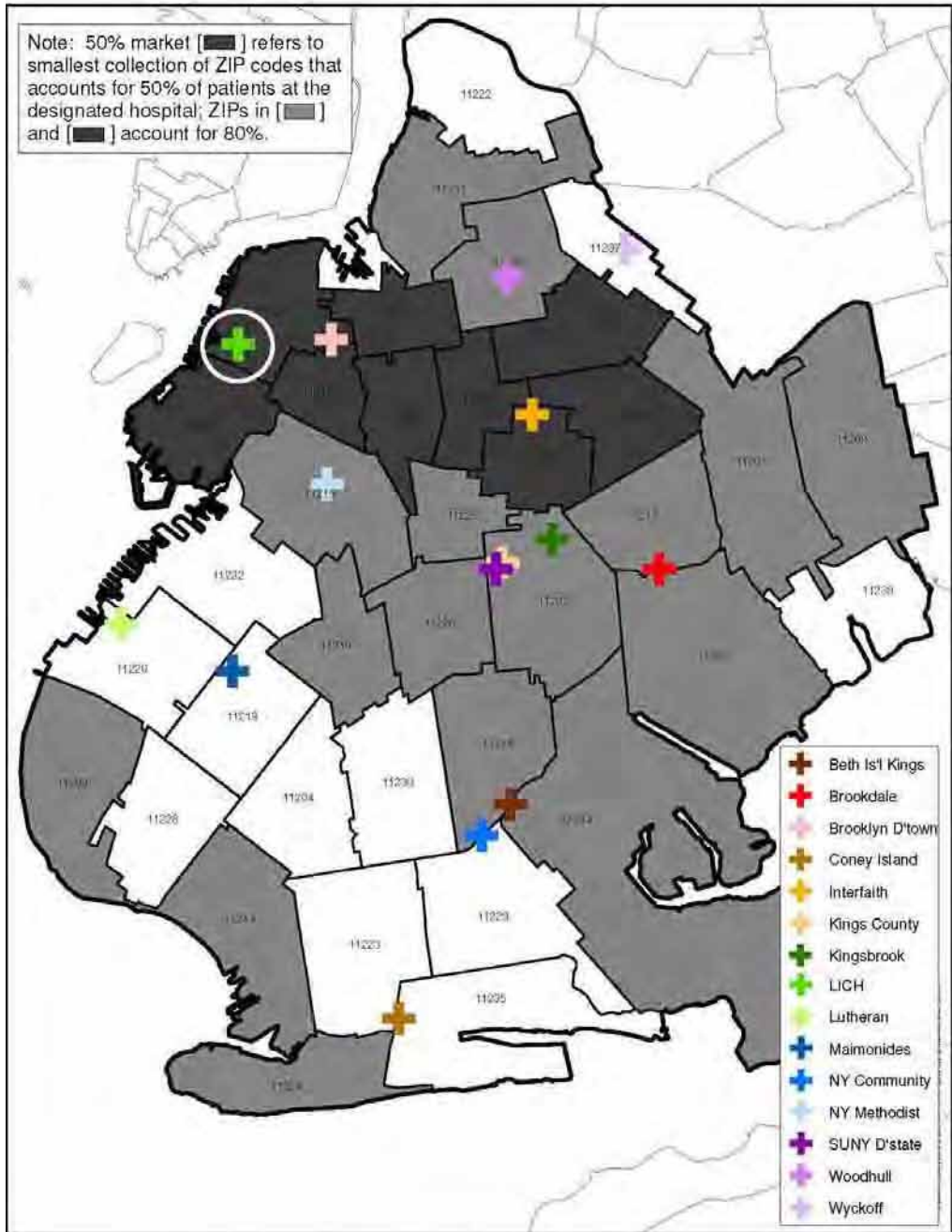


## Boundaries for 50% and 80% Markets for All Patients at Interfaith Medical Center in 2010





## Boundaries for 50% and 80% Markets for All Patients at Long Island College Hospital in 2010





## APPENDIX M

### Charge to Chair/Work Group from Health Commissioner Nirav Shah



Nirav R. Shah, M.D., M.P.H.  
Commissioner

Sue Kelly  
Executive Deputy Commissioner

June 15, 2011

Stephen Berger  
Odyssey Investment Partners  
280 Park Ave, 38th Floor - West Tower  
New York, New York 10017

Dear Mr. Berger:

I am inviting you to lead a Medicaid Redesign initiative to evaluate the hospital system in Brooklyn, New York. As a member of Governor Cuomo's Medicaid Redesign Task Force, you are well aware the Task Force was concerned with the future financial strength and viability of the state "safety net" providers. A specific initiative was established (MRT 67) to provide the state financial and programmatic tools to assure the communities served by "safety net" providers are protected.

The hospital system in Brooklyn is today particularly challenged. Many have witnessed a drop or leveling of inpatient volume; revenue growth and capital investment has been curtailed; debt capacity limited by existing financial weakness and debt load. Yet, the communities served continue to need access to appropriate high quality and cost effective health care.

Your charge is to assess the strength and weaknesses of the Brooklyn hospitals and their future viability to deliver appropriate health care services throughout the many communities that comprise Brooklyn. Secondly, to make specific recommendations that will lead to a high quality, financially secure and sustainable hospital system that can meet the needs of all patients.

I look forward to working with you in this critical Medicaid Redesign initiative. If you should have any questions or concerns please don't hesitate to contact Richard M. Cook, Deputy Commissioner, Office of Health Systems Management at (518) 474-7028.

Sincerely,

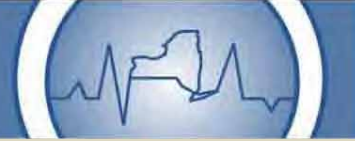
A handwritten signature in black ink that reads "Nirav R. Shah".

Nirav R. Shah, M.D., M.P.H.  
Commissioner of Health

cc: Mr. Cook

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**Redesigning**  
THE MEDICAID PROGRAM

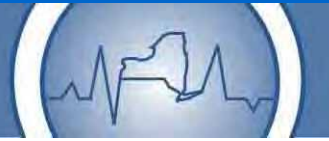


NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Medical Malpractice Reform Work Group

**FINAL RECOMMENDATIONS**



## **Medicaid Redesign Team Medical Malpractice Work Group Final Recommendations**

### **Work Group Charge:**

To review the cost of malpractice coverage, including the identification of significant cost drivers of coverage, review the available data (insurance and other relevant data), and develop recommendations on reducing the cost.

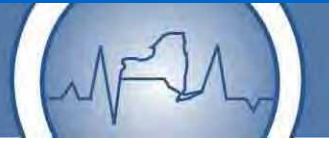
### **Work Group Membership:**

Joseph W. Belluck, Co-chair  
Kenneth E. Raske, Co-chair  
Edward J. Amsler  
John Bonina, Jr.  
Arthur Fougner  
Matthew Gaier  
Joel Glass  
Lee Goldman  
Fred Hyde  
Hon. Douglas E. McKeon  
Christopher Meyer  
Nicholas Papain

### **Meeting Dates and Focus:**

October 17, 2011-The costs of adverse events and medical malpractice and the impact of these costs on providers, the State's Medicaid program, and the delivery of health care in general in New York State.



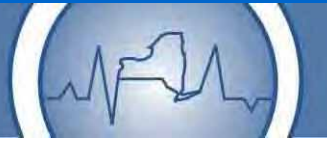


**Brief Summary of Discussions: Presentations were made on the following subjects, with a question and answer/discussion period following each presentation:**

- 2011 Medical Practice Initiatives –The New York State Medical Indemnity Fund and the Agency for Healthcare Research & Quality Grant to the Unified Court System
- Cost of medical malpractice insurance in New York State
- The impact of Medical Malpractice Costs on Providers, the State Medicaid Program, and the Delivery of Health Care
- The impact of Adverse Outcomes on Provider Malpractice Cost
- Practices Being Undertaken to Reduce the Number of Adverse Events, the Success of such Practices; and the Impact of these Practices on Malpractice Coverage Expenses
- The Non-economic Impact of Medical Malpractice Claims on Providers.

**Outside Experts Consulted with:**

- Geoff Taylor, Senior Vice President for Corporate communications and Public Policy, Excellus BlueCross;
- Donald Faber, Vice President and Assistant Secretary, Medical Liability Mutual Insurance Company;
- Susan Waltman, Executive Vice President and General Counsel, Greater New York Hospital Association;
- Michelle Mello, Professor of Law and Public Health, Harvard School of Public Health;
- Arthur Levin, Director, Center for Medical Consumers;
- Lorraine Ryan, Senior Vice President, Legal, Regulatory and Professional Affairs, Greater New York Hospital Association;
- Arthur Kleinman, President of the New York State Plastic Surgeons Society and Treasurer of the Medical Society of the State of New York.



**Meeting Date and Focus: October 27, 2011-** The Effectiveness of the Tort System in Resolving Medical Malpractice Claims and Promoting Patient Safety

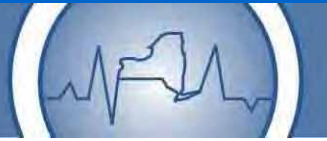
### **Brief Summary of Discussions:**

Presentations were made on the following subjects, with a question and answer/discussion period following each presentation:

- Effectiveness of the Tort System in Resolving Medical Malpractice Claims and Promoting Patient Safety
- Analysis of Key Medical Malpractice Insurance Issues in New York State
- The Tort System's Cost to New York City and Recommendations for Medical Malpractice Reform;
- The Patient Safety Role of the Tort System; A judicial Perspective on the Tort System for Resolving Medical Malpractice Claims;
- The Positives and Negatives of the Tort System for Resolving Medical Malpractice Claims.
- Medical Malpractice Insurance Rates; PRI's Actuarial Approach to Claims;
- Analysis of the Impact of California's Insurance Regulatory Law;
- CIRCO's Experience in Using Closed Claims as a Tool in Implementing Patient Safety Measures.

### **Outside Experts Consulted with:**

- J. Robert Hunter, Director of Insurance, Consumer Federation of America; Former Federal Insurance Administrator; Former Commissioner of Insurance for the State of Texas; actuary
- Michael Cardozo, Corporation Counsel for the City of New York
- Nicholas Papain, Partner, Sullivan, Papain, Block; McGrath & Cannavo, PC
- Hon. Anne Pfau, Coordinating Judge of the New York State Medical Malpractice Program and former Chief Administrative Judge for New York State
- Hon. Eileen Bransten, Justice, Supreme Court, Civil Branch
- Brian J. Noonan, Vice President, Claims & Litigation, Management New York-Presbyterian Hospital
- Gregory V. Serio, Consultant to PRI and former New York State Insurance Superintendent, Physicians' Reciprocal Insurance
- Harvey Rosenfield, Founder, Consumer Watchdog; Author of Prop. 103, California's 1988 Insurance Regulatory Reform Law
- Robert Hanscom, Senior VP CIRCO Strategies, (Insurer for Harvard Medical System)

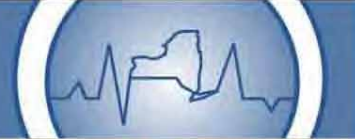


### **Statement of the Medical Malpractice Work Group In Lieu of Third Meeting and Recommendations**

The Medical Malpractice Work Group has worked diligently over the last month to address its charge. In addition, the co-chairs have had multiple good faith conversations regarding the information shared at the Work Group meetings as well as potential recommendations. Notwithstanding the discussions that have taken place, there remain significant differences of opinion regarding the recommendations that should be supported. As a result, we have concluded that the Work Group is unable, at this time, to support any recommendations.

We thank the Executive for empanelling the Work Group, which has been of value in learning about individual members' views and perspectives, and for the time and commitment of all involved.

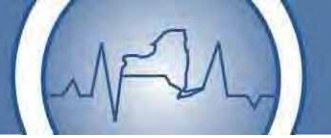
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NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Additional Recommendation  
Approved December 13, 2011



## **Medicaid Redesign Team Recommendation – Approved December 13, 2011**

In addition to approving the recommendations developed by the Medicaid Redesign Team (MRT) Work Groups, an additional recommendation was put forward and approved at the December 13, 2011 MRT Meeting.

The MRT would like to praise the staff effort put forward to implement Phase 1 initiatives and assist with the work groups developing Phase 2 initiatives. The MRT cannot recommend such an ambitious action plan without noting successful implementation of the Phase 2 work group recommendations requires adequate resources. Additional staff will allow the department to focus on priority functions, and secure a maximum return for the invested dollars.

The MRT formally recommends that a provision be made in the 2012-13 Executive Budget that enhances the capacity and staff of the Department of Health.