Redesigning
THE MEDICAID PROGRAM

Medicaid Redesign Team Meeting

February 9, 2011 – New York City

Working together to build a more affordable, cost-effective Medicaid program

WELCOME

Dennis Rivera, Team Co-Chair

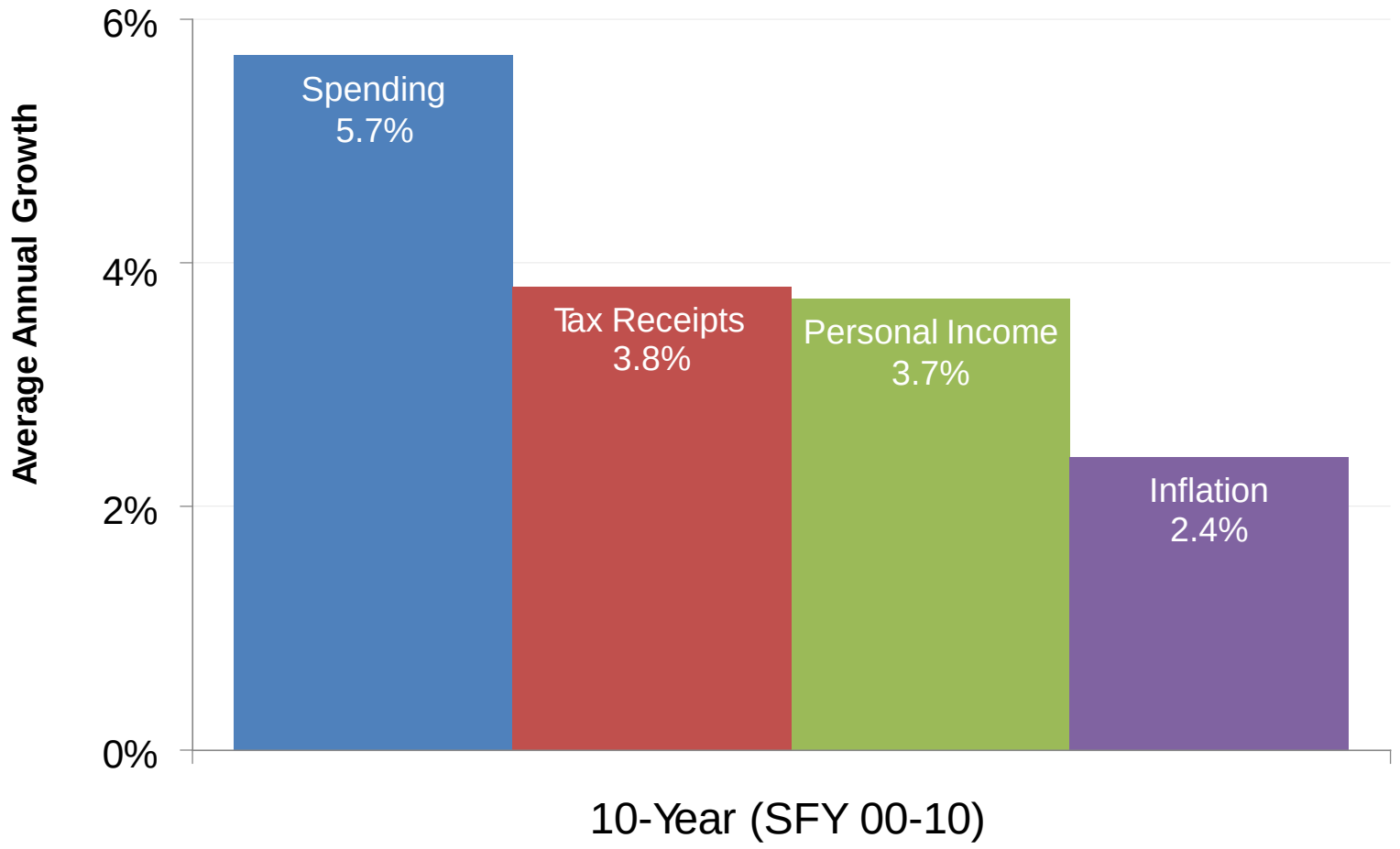
Meeting Agenda

- Budget Update
- Updated Timeline
- Hearing Feedback Summary
- Public Website Feedback
- Summary of Ideas Received
- MRT Member Feedback Tool
- Discuss Key/Complex Issues

BUDGET UPDATE

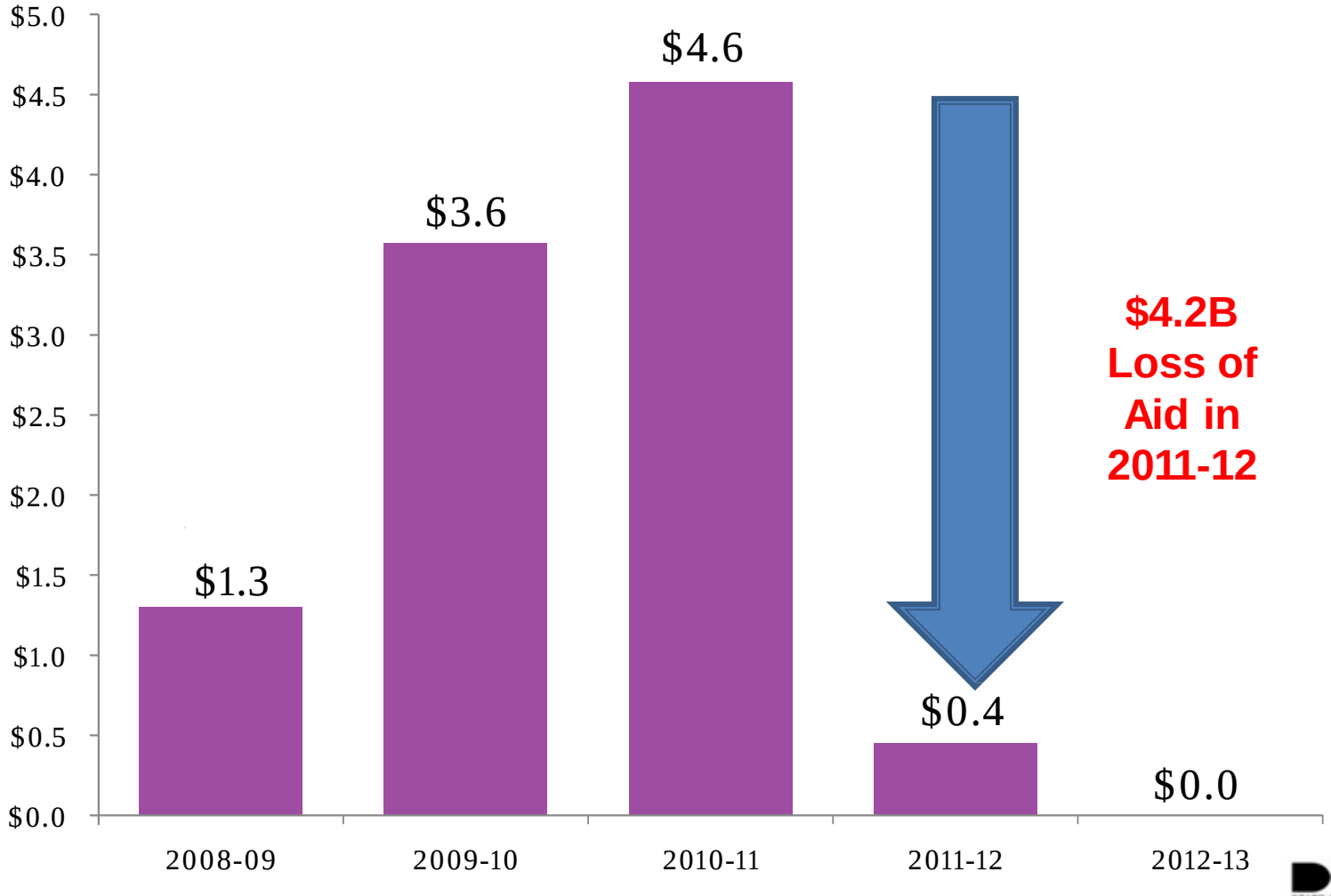
Robert Megna, State Budget Director

Spending Growth Has Outpaced State's Resources

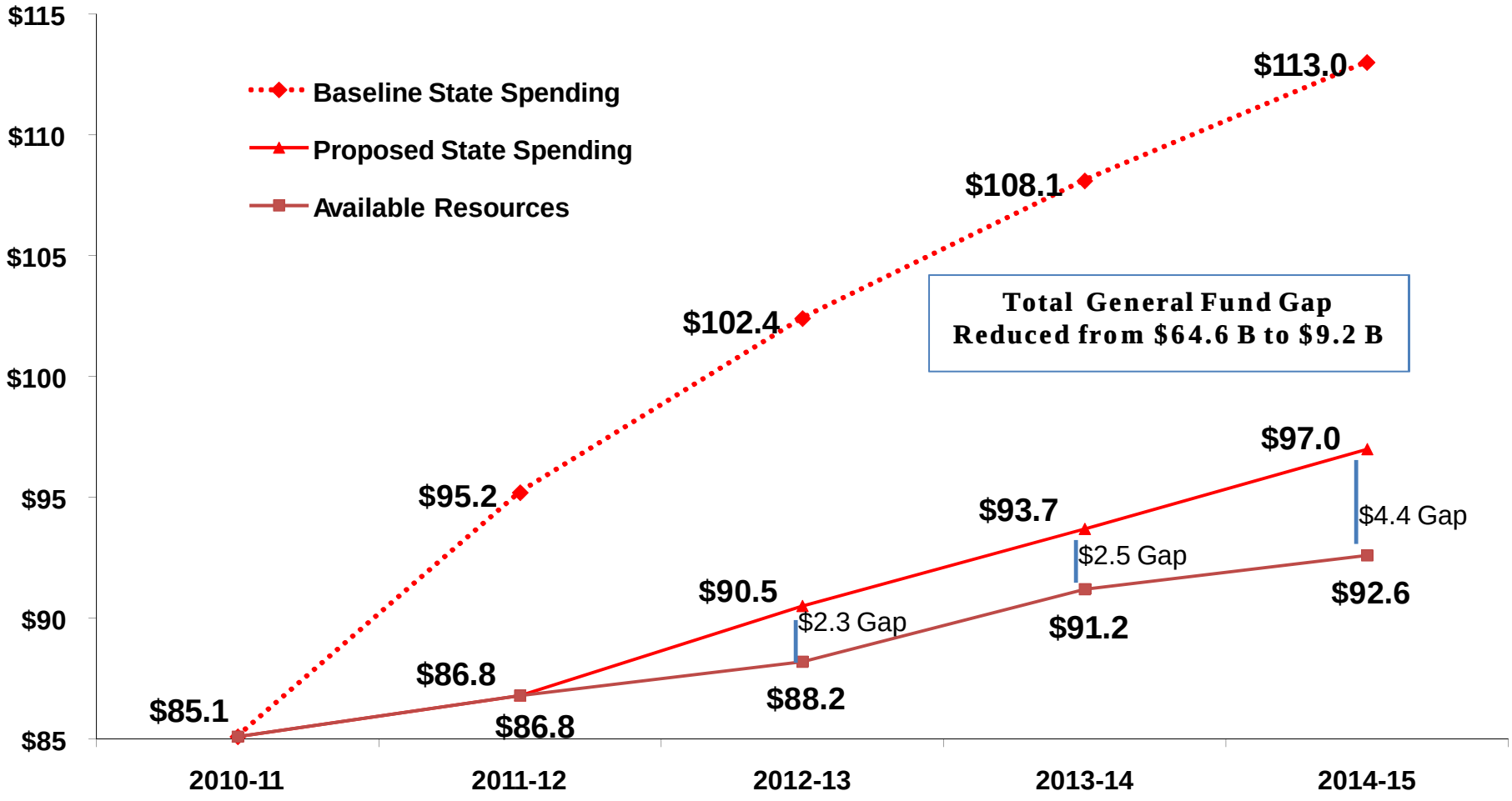


Spending adjusted to exclude the impact of enhanced FMAP and the timing of payments.

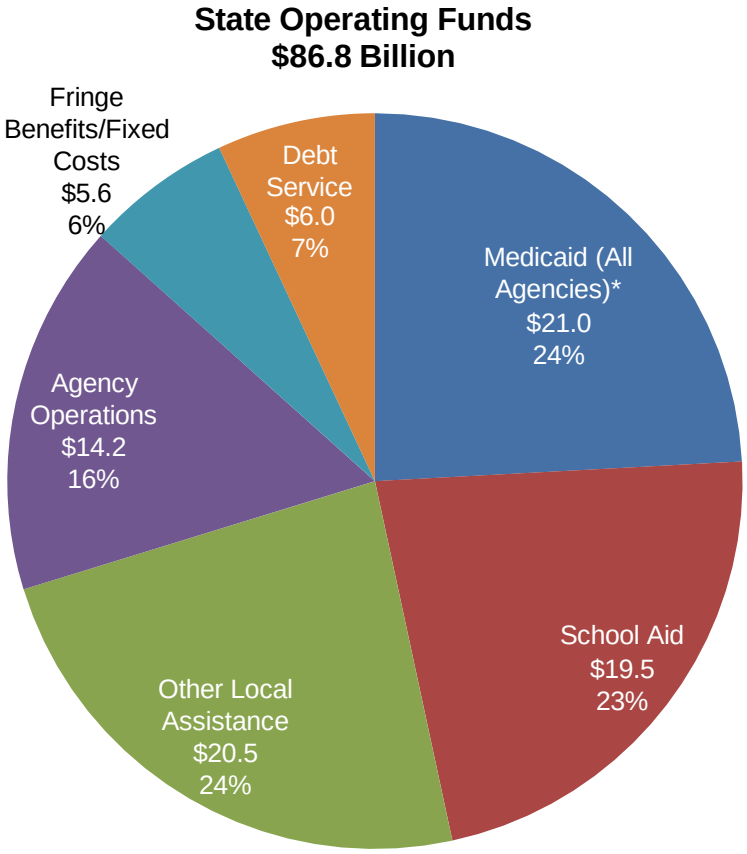
Enhanced FMAP Expires June 30, 2011
Provided $9.9B in Fiscal Relief

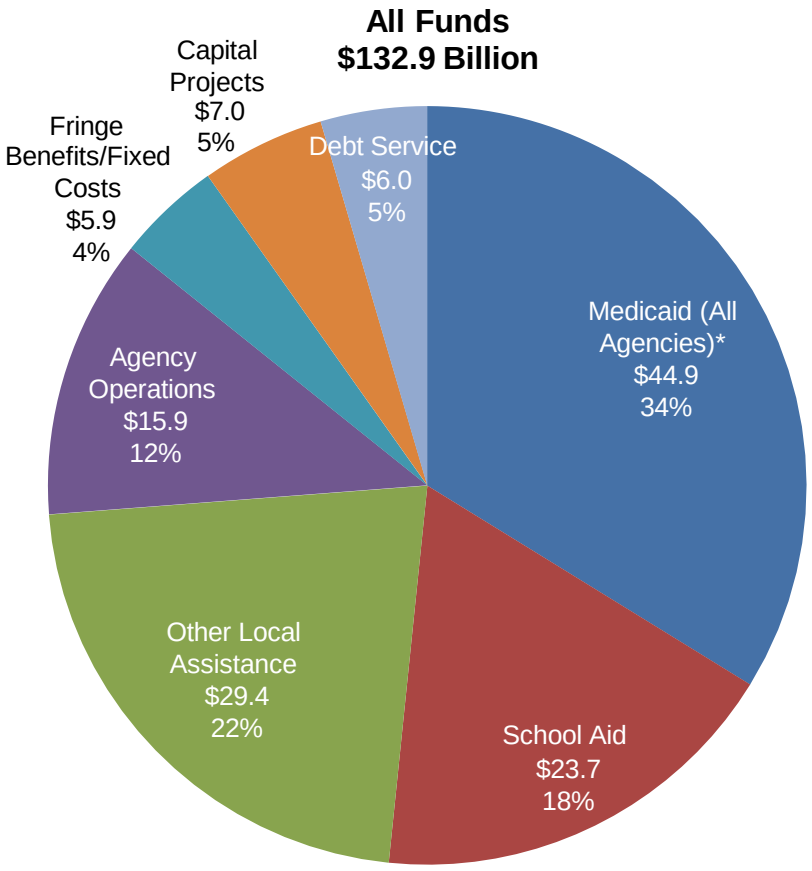


Executive Budget Would Reduce Projected Budget Gaps by $55B



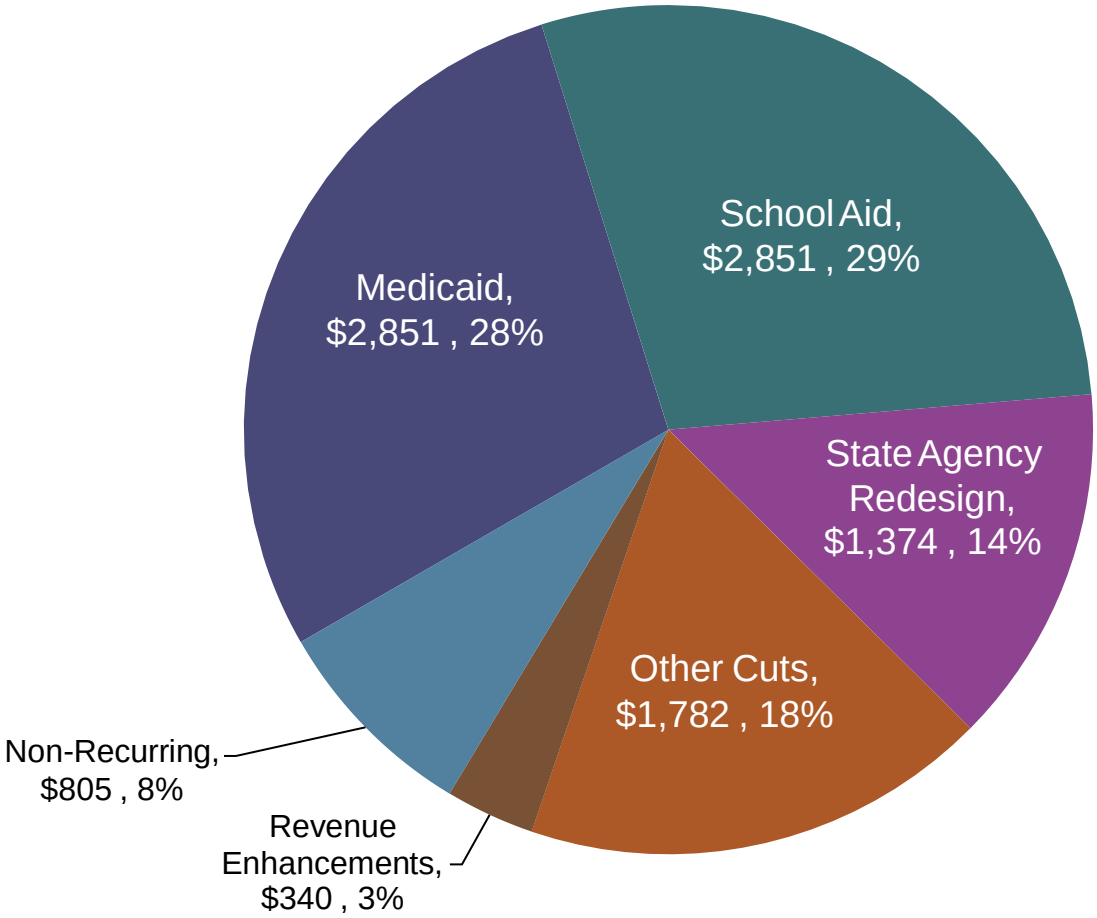
Where the Money Goes: State Operating Funds and All Funds 2011-12



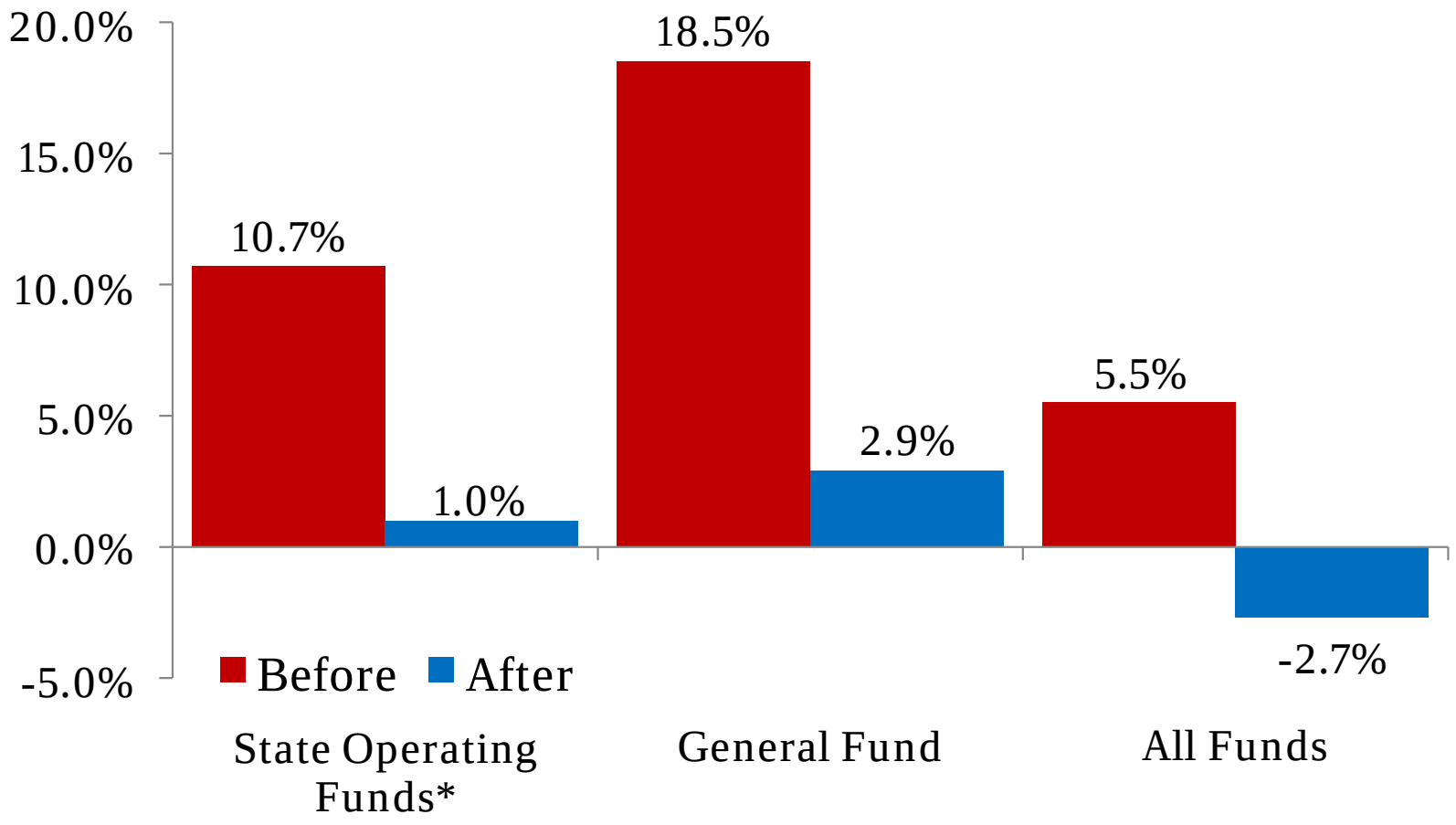


* **Includes local assistance, state operations and fringe benefit.**

$10 Billion Gap-Closing Plan

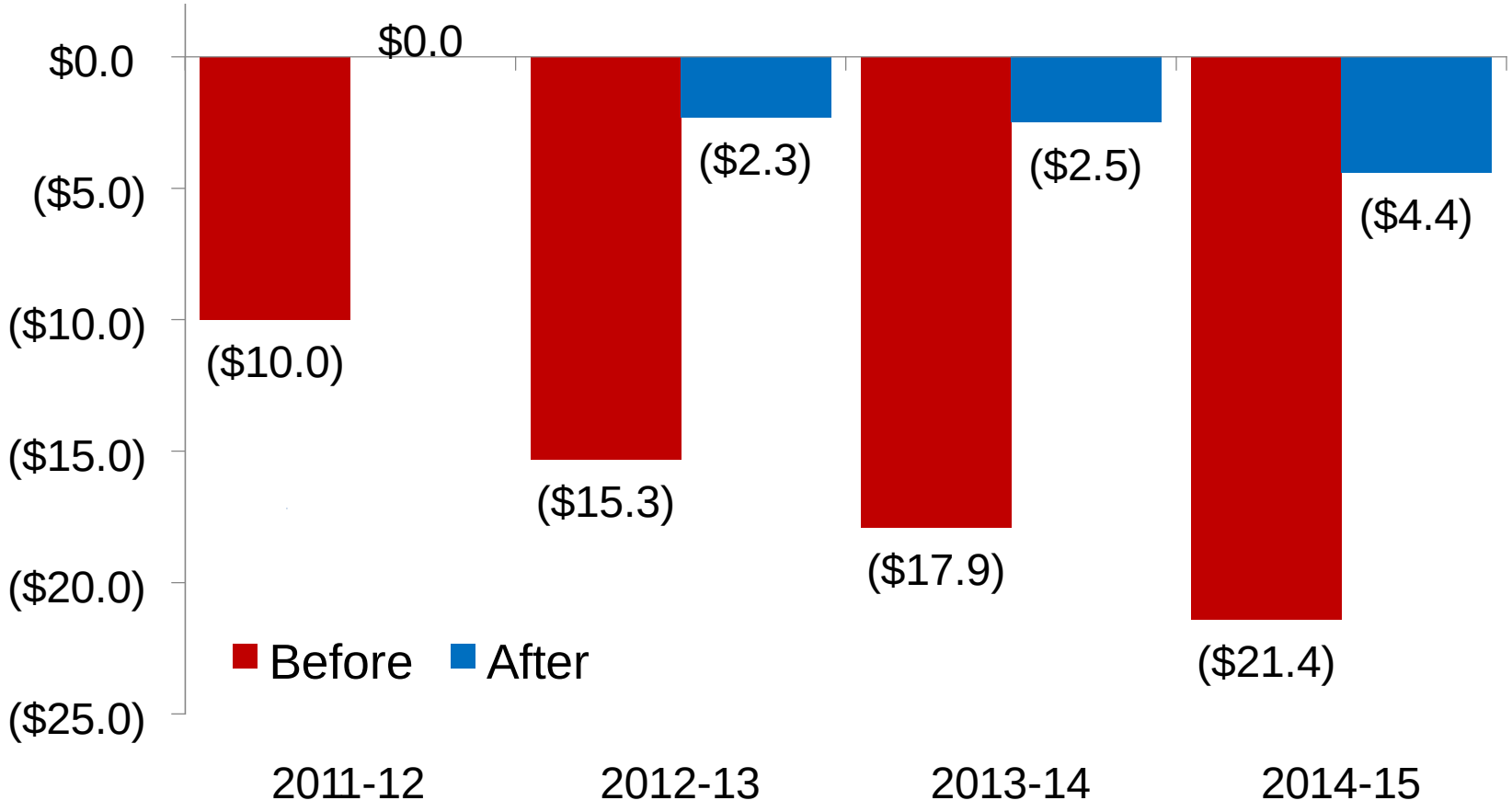


2011-12 Spending Growth Before and After Executive Proposal



* Adjusted for school aid deferral, pension amortization, retroactive labor settlements, and enhanced FMAP.

Executive Budget Impact on Budget Gaps



TIMELINE UPDATE

Jason Helgerson, Medicaid Director

Timeline Update

February 9:

- Full MRT Timeline Meeting

February 14:

- E-mail condensed list of ideas
- Provide feedback tool (with instructions)

February 17:

- Due date for Medicaid Redesign team member feedback

February 24:

- Full Medicaid Redesign Team meeting
- Brief on draft package
- Gather feedback, make modifications
- If necessary, we are reserving a room for Feb 25.

March 1:

- Full Medicaid Redesign Team meeting
- Discuss any modifications to staff suggestions
- Open discussion
- Vote up or down on package (no amendments)

PUBLIC HEARING FEEDBACK

Jason Helgerson, Medicaid Director

Public Hearings: *The Basics*

- Public Hearings held in Buffalo, Rochester, New York City, Long Island and Queensbury.
- Over 600 ideas collected at public hearings.
- 200-500 attended each of the hearings.
- Weather has been a challenge. Two hearings were canceled due to severe weather.

Public Hearing Feedback

- New York's Medicaid program is far from perfect. Public agrees that a re-design is needed.
- The program is overly complex. Too much paperwork, redundant rules and unnecessary hoops hurt members and providers.
- Providers urged the MRT to include regulatory reform proposals in its final package and lower the cost of providing care to Medicaid recipients.

Public Hearing Feedback

- Members want to control their own health care. Disabled community wants more of a say in how their needs are met by the program.
- Protect vital services. Avoid using a “sledge hammer” to cut benefits.
- Concerns about carving-in the behavioral health benefit into HMO contracts as a way to reduce program costs. There was wide agreement that current system is broken and reform is much needed.

continued …

Public Hearing Feedback

- The state needs to provide for a person's social/human service needs in conjunction with their medical needs to keep them well.
- Effective care coordination keeps cost down while keeping people well.
- Redundancies in eligibility determinations, reporting requirements, documentation, and paperwork generally will save money and time.

continued …

Public Hearing Feedback

- Access to community-based, primary and preventive care keeps people from using higher-cost institutional settings.
- Safety-net providers must be protected as they are the ones that actually serve the Medicaid and uninsured populations.
- The state must take advantage of funding opportunities and innovative initiatives provided by the ACA.

PUBLIC HEARING FEEDBACK

Jason Helgerson, Medicaid Director

http://health.ny.gov/health_care/medicaid/redesign/

Public Website Feedback

- 2,047 e-mails have been received through the Website survey tool as of February 7, 2011. The e-mails have been reviewed and suggestions for Medicaid redesign have been added to the master list of ideas.

- E-mails have been received from individuals, associations, State and local employees, Medicaid consumers and providers.

Public Website Feedback

Common themes among e-mails include:

- Continue stakeholder engagement process after the March 1 report to Governor Cuomo.
- Tighten eligibility standards through residency requirements, income/identification requirements. **(high volume)**
- Protect vulnerable recipients. **(high volume)**
- Eliminate fee-for-service and move all recipients to Managed care.

Public Website Feedback

- Streamline paperwork for enrollment/recertification for providers and recipients. **(high volume)**
- Carve-in behavioral health.
- Carve-out behavioral health. **(high volume)**
- Incentivize primary care providers and urgent care to offer services during evenings and weekends to reduce ER visits for primary care.
- Discontinue Medicaid transportation, either by ambulette or taxi.

Public Website Feedback

- More care management/care coordination. **(high volume)**
- Expand scope of practice for mid level providers. **(high volume)**
- Require co-pays.
- Focus on consumer directed programs. (**high volume)**
- Allow long-term care recipients to stay at home and reduce nursing home costs.
- Review benefit package and only offer what is required by federal government.

Public Website Feedback

- Evaluate current spousal refusal/divestment practices for long term care.
- Make benefits time limited unless there is a lifelong disability.
- Eliminate coverage of male infant circumcision. **(high volume)**
- Involve alternative providers including community health workers and peer counselors to assist in care coordination.
- Find fraud, waste and abuse in system, create strong penalties. **(high volume)**

Summary of Unduplicated Ideas

THEME	# of Proposals
Recalibrate Medicaid Benefits and Reimbursement Rates	114
Eliminate Government Barriers to Quality Improvement and Cost Containment	50
Empower Patients and Rebalance Service Delivery	37
Ensure Consumer Protection and Promote Personal Responsibility	22
Ensure that Every Medicaid Member is Enrolled in Managed Care	18
Eliminate Fraud and Abuse	16
Better Align Medicaid with Medicare and ACA	9
Pay Providers Based on Performance	8
TOTAL	**274**

- Later today the unduplicated list will be posted to the Medicaid Redesign Website.
- We are still receiving ideas for the March 1 meeting – The deadline for receiving new ideas is Friday, February 11.

MRT MEMBER FEEDBACK TOOL

Nirav R. Shah, M.D., M.P.H.
NYS Commissioner of Health

MRT Member Feedback Tool

- The MRT Feedback Tool is a tool for decision making, based on a principle that a structured group would make a more accurate decision that individuals. The tool will put a quantitative value on otherwise a qualitative process.
- Team members are asked to rate the key proposals.
- A summary of results are given back to the Team. A discussion on areas of disagreement will occur.

Each Proposal will be Scored on Four Metrics

Each Proposal will be scored on 4 metrics:

1. Cost
2. Quality
3. Efficiency
4. Overall Impact

- More instruction on these metrics will be available with the final tool.

Metric 1: Cost

- Cost will be scored on a scale of -1, 0, 1, 2, 3.
- Assessment of costs should be reflective of the SFY 11-12.
  - Proposals that will cost money in the next FY should be scored “-1”
  - Proposals that are cost neutral should be scored “0”
  - Proposals that would save up to $10M should be scored “1”
  - Proposals that would save between $10M and $50M should be scored “2”
  - Proposals that would save over $50M should be scored “3”

Metric 2: Quality

- The Institute of Medicine's definition of quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
- Quality will be scored on a scale -1, 0,1, 2, 3
  - Proposals that will decrease the quality of care for Medicaid enrollees should be scored "-1"
  - Proposals that will have no effect quality should be scored "0"
  - Proposals that will slightly improve quality should be scored "1"
  - Proposals that will create infrastructure to improve quality should be scored "2"
  - Proposals that create systems to improve quality and will significantly improve quality of care should be scored "3"

Metric 3: Efficiency

- The Institute of Medicine defines efficiency in health care as the relationship between a specific product (output) of the health care system and the resources (inputs) used to create the product.
- Efficiency will be scored on a scale -1, 0,1, 2, 3
  - Proposals that will decrease efficiency should be scored “-1”
  - Proposals that will have no effect on efficiency should be scored “0”
  - Proposals that will slightly improve efficiency should be scored “1”
  - Proposals that will moderately improve efficiency should be scored “2”
  - Proposals that will significantly improve efficiency should be scored “3”

Metric 4: Overall Impact

- Overall impact will be scored on a scale -1, 0,1, 2, 3
  - Proposals that will have a negative impact on the Medicaid program should be scored “-1”
  - Proposals that will have no impact on the Medicaid program should be scored “0”
  - Proposals that will have slight impact on the Medicaid program should be scored “1”
  - Proposals that will have moderate impact on the Medicaid program should be scored “2”
  - Proposals that will significantly impact the Medicaid program should be scored “3”

MRT Feedback Tool Process

On February 14, 2011:

- MRT Members will receive a list of proposals.
- MRT Members will be e-mailed the list of proposals to evaluate, each with 4 metrics to evaluate (cost, quality, efficiency, and overall impact).
- MRT members will have until February 17, 2011 to complete their feedback.

KEY COMPLEX ISSUES

Jason Helgerson & DOH Staff

Key/Complex Issues

- Expanding Access to Managed Care
- Regulatory and Liability Reform
- Long-Term Care
- Pharmacy Benefit Management
- Pay for Performance

GOAL

Provide more background on Key/Complex issues to Team members and initial feedback on possible solutions.

Expanding Access To Managed Care

Expand Enrollment of High Cost Population Into Managed Care Environment

- 3.5 million recipients (66%) are enrolled in a managed care model of care at the cost of $16.5B.
- 1.4 million recipients (27%) are excluded or exempt from Managed care at a cost of $28.6B.
- **Alternative:** Modify statutes and waivers to require enrollment of high-cost excluded/exempt populations in order to coordinate care, implement accountable structures, and ultimately improve health outcomes.

Benefits of Managed Care

- Instead of overseeing services provided by 104,000 Medicaid fee-for-service providers, the State can oversee and contract with fewer than 100 providers through accountable managed care providers.
- Managed Care is more effective in controlling costs through risk arrangements.
  - *From 2003-2009 MLTC spending per recipient declined by 0.3% whereas overall LTC spending per recipient increased by 26%.*
- Managed Care allows for predictability of costs – plans are paid a set capitation which levels growth potential.

Benefits of Managed Care

- Managed Care creates an “accountable entity” that is responsible for an enrollee’s care.
- Data confirms that Managed Care has produced improved outcomes for the populations served.
  - *Exceed national HEDIS benchmarks on 44 of 46 quality measures.*
  - *Performance has improved over time in virtually all quality measures .*
- Promote better care integration through increased enrollment in medical home and health home models of care.

Behavioral Health

- Many studies have recently been performed by United Hospital Fund and others showing that New York's structure for providing behavioral health services is fragmented and does not promote integration in care.
- New solutions must be developed to promote a system of organizing, financing and delivering behavioral health services which creates the right incentives to coordinate care and contain costs.
- There is wide agreement that status quo in provision of behavioral health services is no longer acceptable!

Behavioral Health Benefit

Maintaining the bifurcated managed care and fee for service system creates fragmentation and discontinuity in services.

TANF/Safety Net Enrollees

Must join a plan

Managed Care Benefits

- Physical Health
- Mental Health
- Detox
- CD Inpatient Rehab

Carved out FFS Benefits

- Outpatient CD
- Specialized mental health services

SSI Enrollees

Must join a plan

Managed Care Benefits

- Physical Health
- Detox

Carved out FFS Benefits

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

Behavioral Health Options

Carve In:

- Move BH into the managed care benefit package for all populations and include additional carve out services. (Risk model)

Carve Out

- Carve BH from the MC benefit package for all populations and contract with a Behavioral Health Organization (BHO) to conduct medical management activities for all services. (Initial non risk model with transition to risk). This may allow for some ambulatory behavioral health visits covered by the Managed care plans.

Carve In with Regional Delegation

- Move expanded BH benefit package into managed care and require plans to contract with a single regional BHO to conduct medical management and administrative activities. (Risk Model)

Regulatory & Liability Reform

Regulatory Reform

- Common theme at meetings has been that duplicative and unnecessary regulations stand between Medicaid members and access to quality, cost-effective health care.
- Unnecessary regulations drive costs, and create member/provider confusion.
- Regulatory reform should be part of Medicaid Redesign.

Regulatory Reform

Specific issues identified:

- **Innovative Delivery Models/Scope of practice**
  - Observation Units – rates, dedicated unit, flexibility for rural hospitals.
  - Free standing ED's – definition of services and rates.
  - Allow non-nursing staff to dispense medications.
- **Reporting, licensing and surveillance**
  - NYPORTS – Reduce number of reportable events and centralize report collection (current number of reportable events, approximately 12,000)
  - Temporary suspension of Nurse Quality Care Protection Act – reporting
  - Duplicative certification of services by agencies
    - *OMH/OASAS/DOH each require certain providers (hospital and clinics) to separately certify services.*

continued…

Regulatory Reform

Other issues identified:

- **Capital Access**
  - Out of State financing opportunities
  - For-profit, publically traded companies should be allowed to do business in NYS.

New York Healthcare Liability System Landscape

- Is Malpractice reform Medicaid reform?
- Medical Malpractice premiums consume scarce health care resources.
- One downstate hospital reports that it loses $8,000 per Medicaid delivery – its medical malpractice costs are $9,400 per delivery.
- Some of New York State's best clinical leaders, particularly downstate, are paying up to $140M in medical malpractice expense, annually.
- OB physician premium downstate between $146,000- $200,000 and upstate between $53,000- $132,000.Premiums continue to rise.
    - *Some premiums have grown at 15-18%.*

Liability Reform Options

Cap non-economic damages:

- At least 26 other states have some type of limit on non-economic damages; some legal challenges.
- Studies suggest that caps do slow growth of premium.
- Does not directly address itself to system improvements.
- GNYHA, NYSHFA, NYASHA, HANYS, others recommended.

Liability Reform Options

Medical Indemnity Fund for Neurologically Impaired Infants:

- Claims would be filed with and proceed through judicial system.
- Upon settlement or award, providers would be responsible for the cost of non-medical care expenses agreed upon/identified as well as for plaintiff attorney fees related to the entire settlement or award.
- Future medical costs identified through settlement or award would be paid from Fund, as incurred.
- Would also pay any Medicaid liens for past medical costs incurred.
- Medical Indemnity Fund would be funded through new assessments on insurance premium receipts.

Benefits: Medical Indemnity Fund

- Reduce the amount paid for future medical costs since payments would be made only as incurred (vs. as projected).
- Eliminate continued Medicaid coverage of future medical expenses (estimates indicate Medicaid continues to cover 50% of children post settlement).
- Ensure repayment of State's Medicaid liens for past medical expenses paid (estimates indicate Medicaid covers 70%-80% of children pre settlement).

Nursing Homes: Other Options

Series of tort recommendations with savings estimates such as:

- Allow for arbitration
- Repeal “private right of action”
- Prohibit use of certain survey documents as evidence
- Repeal extension of liability to individuals
- NYSHFA and NYASHA, recommended.

New York Medicaid Long-Term Care

Report Findings

Recent reports from New York Health Foundation, Rockefeller Institute, and Center for Health Care Strategies, Inc., demonstrate need for reform.

Current system:

- *Fragmented*
- *Lack of Coordination*
- *Program Driven vs. Consumer Centered*
- *Expensive*
- *Wide Geographic Variations*

Approaches to Long Term Care

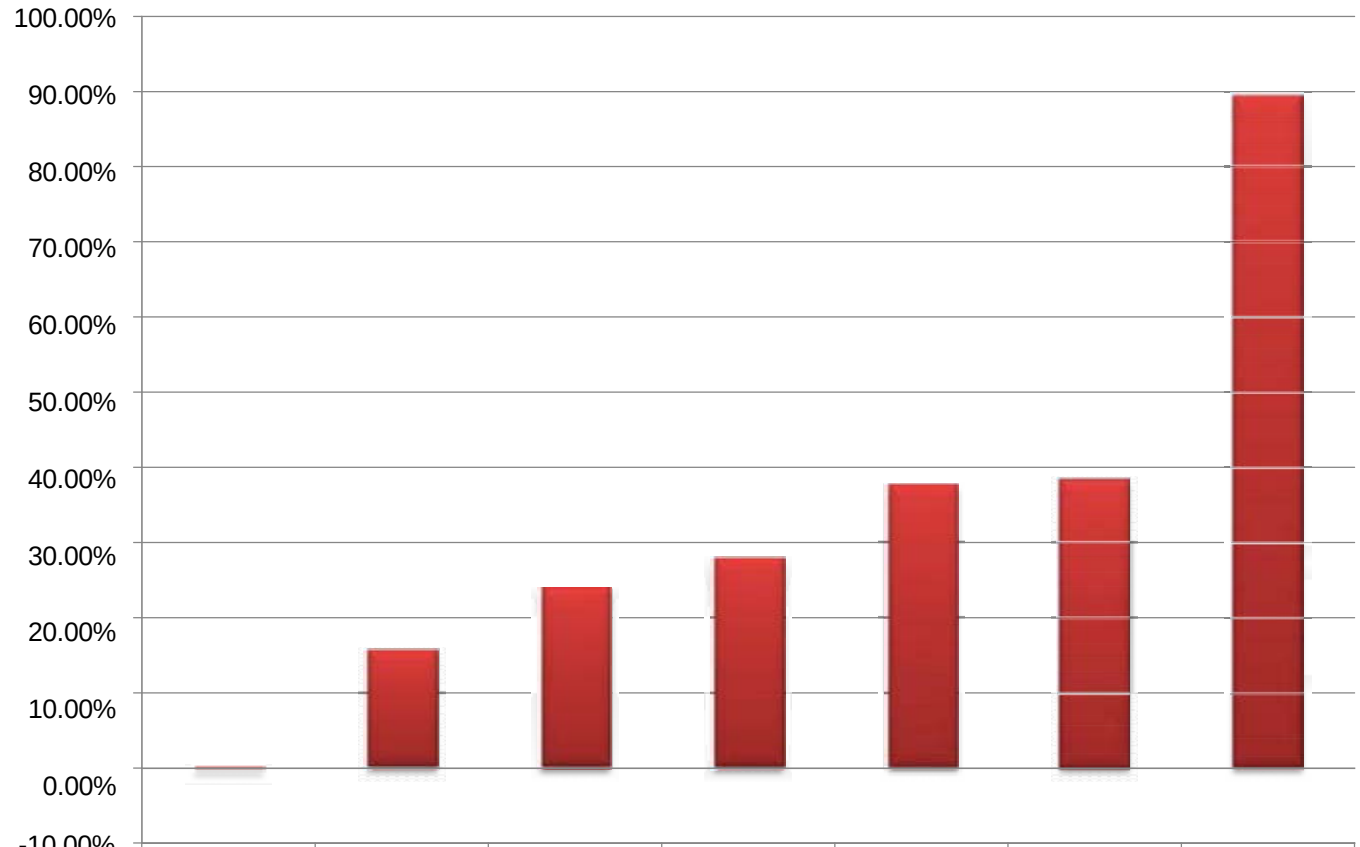
Late 70s: New York leads innovative approaches:

- **Long Term Home Health Care Program**

New York needs new thinking/solutions:

- **Managed Long Term Care**
- **Uniform assessment**
- **Integration of Medicaid and Medicare**

% Change Per Recipient Long Term Care Spending 2003-2009



	Managed Long Term Care	Nursing Homes	ADHC	ALP	Long Term Home Health Care	Personal Care	Home Care/CHHA
% Change	-0.30%	15.60%	23.60%	27.70%	37.50%	38.30%	89.50%

Potential Solutions

- Managed Long-Term Care
- Consumer Directed Models
- Single Assessment Tool
- We have heard these suggestions from a number of stakeholders.

New York State Medicaid Pharmacy Program

Issues Driving Cost

- Statutory pricing formula limits negotiation flexibility.
- Statutory limits on Prior Authorization
  - “Prescriber prevails”
  - “Protected” classes
- Lower generic dispensing rates than some states.
- Some states negotiate better manufacturer rebates.
- Drug waste in long term care facilities.
- Current payment system limits ability to implement industry standard drug utilization edits.

Potential Solutions

- Enhance drug management by carving pharmacy benefit into managed care plans.
  - *ACA allows for Managed Care Plans to collect Federal level rebates.*
- Eliminate Prior Authorization limits.
- Give Commissioner more flexibility to set pharmacy prices and negotiate better rebates.
- Carve drugs out of Medicaid rate for nursing home residents.
- Reduce drug waste by implementing short cycle dispensing consistent with Medicare rules.

NY Medicaid Program Pricing

Reimbursement			Copayments	% Dispensed*
	Ingredient Cost (Lower of)	**Dispensing Fee**		
Brand Name Drugs	AWP -16.25% or U&C	$3.50	$3.00 $1.00 (Preferred)	37%
Generic Drugs	SMAC, AWP – 25%, FUL or U&C	$4.50	$1.00	63%

**Calendar Year 2009*

NY Medicaid Pharmacy Program Drug Spend (CY 2009)

	Gross Spend	Rebates		Net Spend
		Federal	Supplemental	
Brand Name Drugs	$3.49 Billion	$1.34 Billion	$0.19 Billion	$1.96 Billion
Generic Drugs	$0.61 Billion	$0.03 Billion	$ 0	$0.58 Billion
Total	$4.1 Billion	$1.37 Billion	$0.19 Billion	$2.54 Billion

Federal Rebates: Base rebates per agreement with CMS (average 33.4%)

Supplemental Rebates: Additional rebates obtained through the Preferred Drug Program (average 4.6%)

PA Exempt Drugs are High Cost

Top 25 Drugs

DRUG NAME	2009 Spending (in Millions)
NEXIUM	$ 153
ADVAIR DISKUS	$ 88
SINGULAIR	$ 73
LIPITOR	$ 69
SYNAGIS (CDRP)	$ 57
NASONEX	$ 50
PREVACID (G)	$ 46
ACTOS	$ 45
OXYCONTIN (G)	$ 38
PLAVIX	$ 36
VALTREX (G)	$ 35
PULMICORT	$ 34
CRESTOR	$ 34
VENTOLIN HFA	$ 34

DRUG NAME	2009 Spending (in Millions)
ABILIFY	$ 126
SEROQUEL	$ 121
TRUVADA	$ 108
ZYPREXA	$ 103
ATRIPLA	$ 94
REYATAZ	$ 76
KALETRA	$ 44
NORVIR	$ 40
VIREAD	$ 36
EPZICOM	$ 35
LEXAPRO	$ 31

20 Percent of Pharmacy spend is on drugs that are exempt by State law from prior authorization. Prior authorization authority would allow the State to better control inappropriate utilization while garnering better rebates.

Pay for Performance (P4P)

Accountable Care Communities and other shared savings opportunities

Health Care Quality and Performance Proglems in NYS

- NYS ranks 50th overall in the nation in avoidable hospital admissions.
  - *49th home health patients.*
  - *34th nursing home residents.*
  - *35th hospital admissions for pediatric asthma.*
- NYS spends a total of $53B on the Medicaid program, but only $84M is dedicated to paying health plans for quality initiatives, less than 0.16%.
- There are no quality payments made in the Fee-For-Service system; more services simply drives more revenue.

Working Together

Albany cannot improve health care quality and performance …

… But communities working together can.

Health Care Delivery

- Health care delivery is also siloed - avoidable hospitalizations are due to the inability to coordinate care.
- There are ways to measure quality within hospitals and the community.
- The future of Medicaid should be based on purchasing quality health care.

Measures of Quality Performance

Potentially Preventable Admissions (PPAs)

- Facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination.
- PPAs are ambulatory sensitive conditions (i.e. asthma) for which adequate patient monitoring and follow-up (i.e. medication management) can often avoid the need for admission.

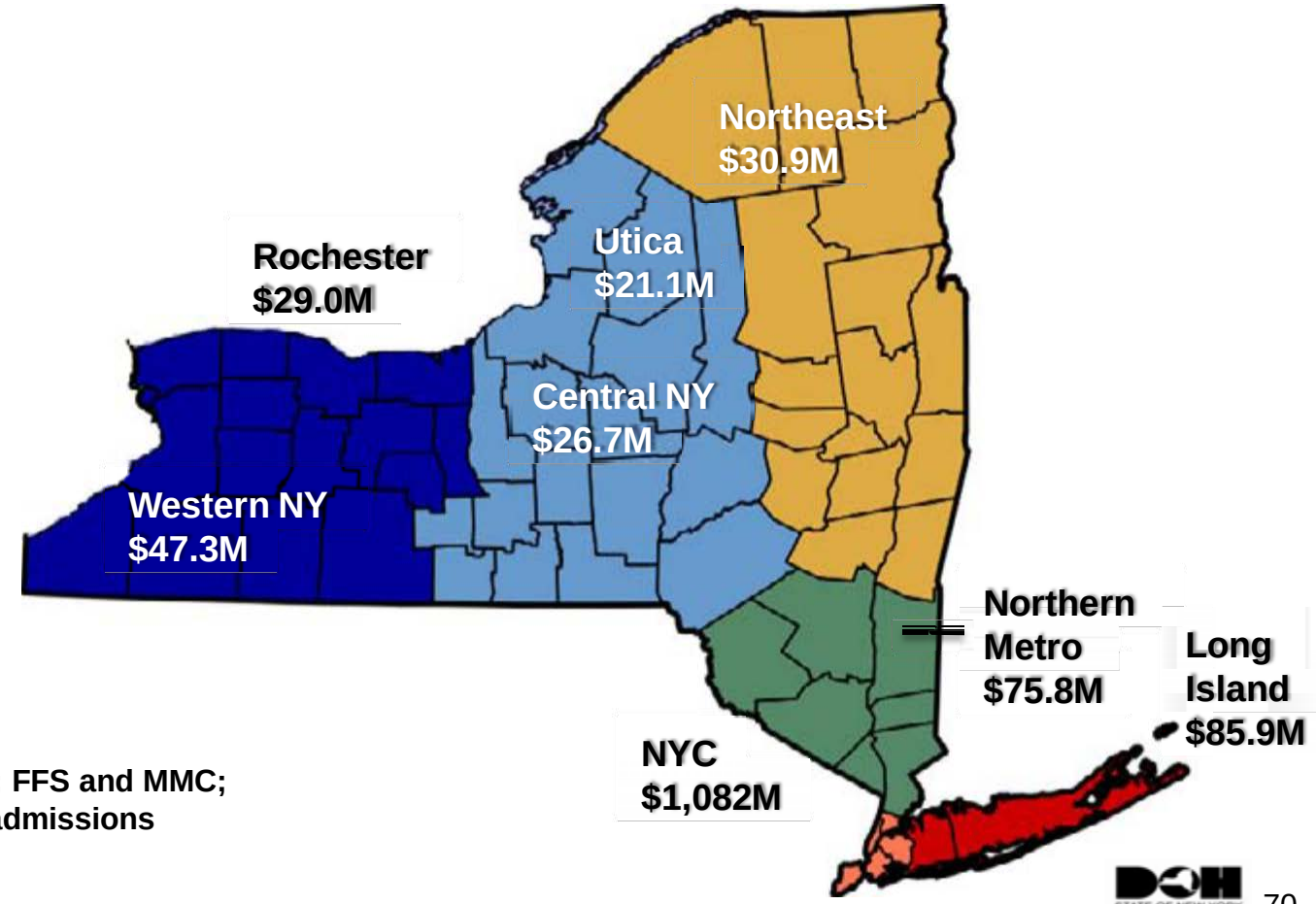
Potentially Preventable Readmissions (PPRs)

- Return hospitalizations that may result from deficiencies in the process of care and treatment (readmission for a surgical wound infection) or lack of post discharge follow-up (prescription not filled) rather than unrelated events that occur post discharge (broken leg due to trauma).

Total Inpatient Medicaid Spending Related to PPAs and PPRs

(spending by NYPHRM region)

	PPAs	PPRs	
NYPHRM-R:	**(per 100 admissions)**		
Long Island	15.7	6.7	
New York City	18.5	7.7	
Northern Metro	13.1	6.9	
Northeast	13.8	7.0	
Utica	14.2	6.7	
Central	12.7	5.8	
Rochester	12.3	6.0	
Western	13.2	6.4	
STATEWIDE	**16.8**	**7.3**	



***Data Source: 2008 SPARCS; FFS and MMC; Includes Behavioral Health admissions**

Approaches for Performance-Based Care

- **Hospital Only:** Apply performance targets and incentives to hospitals only.
  - *Measure individual hospital performance against a statewide benchmark.*

-OR-

- **Hybrid:** Performance targets and incentives are shared among both hospital and community providers (home care, health plans, nursing homes, and clinics).
  - *Benchmarks are community specific not statewide.*

Method: Creating Incentives for Performance-Based Care

- Establish community-specific (or statewide) performance levels for reducing avoidable admissions and readmissions.
- In Year 1, hospitals (and/or community providers) will have a specified uniform % reduced from their Medicaid rates (withhold).
- In the following year the withholding will be reconciled by measuring actual performance levels to benchmarks from the previous year.
- DOH will report progress against performance levels on a quarterly basis.

Hospital/Community P4P Example

Community XYZ	**Current Avoidable Hospital Admissions (per 100)**	**Target Avoidable Hospital Admissions (per 100)**	**Withhold**
Hospital ABC & other Community Providers	10	5	$5,000,000

Reconciliation / Incentive Payment:

	Year 1	**Year 2**	**Year 3**
Observed PPA (per 100)	7	5	3
Incentive Payment	$3,000,000	$5,000,000	$7,000,000
Net Community Impact			
Hospital	($1,000,000)	$0	$1,000,000
Other Providers	($1,000,000)	$0	$1,000,000

Rationale: Implementation of Quality Performance Measures

- Generates immediate financial plan savings based on quality of care and performance standards rather than across the board reductions.
- Provides incentives for communities to work together to reorganize the delivery system (i.e. ACO, Medical Home, Managed Care).
- Provides opportunities to improve quality of care.
- More transparency through performance evaluations and quality standards.

Key Decisions

- How do we define community? Geographically and provider type?
- The calculation of the withhold %.
- Do we establish separate targets for behavioral health non-behavioral health admissions and readmissions?
- Should the Department provide strategic investments in community services (i.e. post-discharge follow-up; SBIRT; community planning grants)?
- Should fee-for-service and Managed care admissions and readmissions be separated?

Conclusion

- Lots of work still needs to be completed.
- Ideas gathered thus far have put us off to a strong start.
- State will now begin process of drafting the “staff recommendation”
- Stop accepting new ideas for consideration in the March 1 package at COB Friday, February 11.

Discussion