Redesigning
THE MEDICAID PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Redesign Team (MRT)

Workforce Flexibility and Scope of Practice Work Group

FINAL RECOMMENDATIONS

Redesigning THE MEDICAID PROGRAM

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[1]
- 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[2]
- Valerie Grey, Executive Deputy Commissioner, New York State Education Department[3]
- 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

[1] Not a voting member of the MRT Workforce Flexibility Workgroup.

[2] Tina Gerardi, MS, RN, CAE, Chief Executive Officer, New York State Nurses Association had been the originally appointed representative to this Workgroup.

[3] 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.[4]

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), 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.

[4] 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

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
Not ranked	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

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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

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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[i]	x		
Native Hawaiian or Other Pacific Islander[ii]	x		
People with a disability[iii]	x		
People who identify as transgender[iv]	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.

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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[i]	X		
Native Hawaiian or Other Pacific Islander[ii]	X		
People with a disability[iii]	X		
People who identify as transgender[iv]	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.

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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/prevailing 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.

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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: ☑ **Administrative Action** ☑ **Statutory Change**

☐ **State Plan Amendment** ☐ **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.[5] 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.[6] 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 **r**emove the requirements for written collaboration agreements and written practice protocols between nurse practitioners and physicians.

[5] N.Y. Education Law § 6902
[6] *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.[7] 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.

[7] *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).

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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**[8] ☑ **Statutory Change**[9]

☐ **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 21st 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.[10] 38.4% of Medicaid children in New York State accessed NO dental services in 2009.[11] 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.[12] 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.

[8] Amend Title VIII, Article 133, Section § 6606. Definition of practice of dental hygiene (both for collaborative practice and redefining the practice).

[9] 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.

[10] *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

[11] Source: Centers for Medicare and Medicaid Services. CMS-416

[12] 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***.[13] 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 (27and 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.[14]

New York State's experience may be different, however. Under the current NYS Medicaid fee schedule, the DOH Bureau of Dental Heath does not anticipate cost savings because there is no separate Medicaid fee schedule for dental hygiene services.[15] Therefore, a dental hygienists performing dental sealant placement would receive the same Medicaid rate as a dentist doing similar work.

[13] 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
[14] 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.
[15] 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.**[16]

* 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.

[16] 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**[17] ☐ **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)

[17] 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.

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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.

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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.[18]

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 scholarship 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:

[18] 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.[19]
- 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.

[19] 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.[20]

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

Program	Description	Number of obligated clinicians
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.

[20] New York State Department of Health, Office of Health Insurance Programs.

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.[21] 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.

[21] 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.[22]
- 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.

[22] 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[i]			X
Native Hawaiian or Other Pacific Islander[ii]			X
People with a disability[iii]	X		
People who identify as transgender[iv]			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 Chapter132 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
• Nursing assessment • Psychiatry services, including: medication-treatment, medication management • Psychological testing • Case management	• Assessment • Skill building • Supported education • Supported employment services • Recreational & socialization services • Discharge planning, advocacy, linkage to social and support services Respite(short term child supervision)

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	**$22,641,813.00**
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/

  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

Number of Programs Licensed, Regulated, or Funded by OMH; by Auspice.						
Programs	**Not-for-profit**	**State**	**For-profit**	**County**	**Total**	
Licensed	1384	633	27	69	2113	
Non-licensed	3697	242	4	703	4646	
Total	5081	875	31	772	**6759**	

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	Psycho-therapy	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	
Total Licensed	**6663**	**4529**	**4757**	**5613**	
Unlicensed Practitioners*					
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	
OTHEROPE***	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	
Total Unlicensed	**1760**	**392**	**1795**	**414**	
Contract titles or					
Volunteers	40	19	93	26	
Total ALL Staff	**8463**	**4940**	**6645**	**6053**	

*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*

Title	Number at risk	Comment
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
Total	**4254**	

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	**DIRECT CARE**		
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	

***** 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.

CODE NUMBER	POSITION TITLE! JOB TITLE(S)	DEFINITION
205	Senior (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Mode.
206	Supervisor (OMH CR Only)	All individuals who perform this role as defined in the OMH Community Residence Program Model.
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: Case Aide, Worker, Intern-Social Services, Family
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 Teacher of Deaf and Hearing Impaired.
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

		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 t development of instructional materials and assisting i 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 10 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 l.
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.
	CLINICAL STAFF	
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,

		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:

[i] Includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and Other Asian
[ii] Includes Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander
[iii] 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,
[iv] NYS Disparities Workgroup recommendation not included in the ACA.