Transforming New York's Public Health Insurance Programs

Expanding Access, Improving Quality, and Controlling Costs

2007-2009 Health Care Transformation Report

State of New York
David A. Paterson, Governor

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

DAVID A. PATERSON
GOVERNOR

July 10, 2009

Dear Friends,

I am pleased to share with New Yorkers the enclosed report, Transforming New York's Public Health Insurance Programs: Expanding Access, Improving Quality, and Controlling Costs. This Report documents the strides which our great State has made in transforming Medicaid into a high-quality, cost-effective health insurance program. The State health reforms we have achieved over the past two years position New York to assume a leading role in the national health reform that President Obama has called a fiscal and moral imperative.

One of my priorities as Governor and, indeed, during my more than two decades in public service, has been to reform health care in New York State and improve the public health insurance programs. Medicaid is the single largest purchaser of health care in the State, insuring more than 4 million New Yorkers at a cost approaching $50 billion. If New York Medicaid were a private insurer, it would rank among the top 10 insurers nationally based on the number of people it covers. As such, New York Medicaid has the unique potential to change New York's health care delivery system. Our goals parallel those articulated by President Obama: expand coverage, improve quality, and control costs. While the challenges are daunting, the progress we have made will serve as a strong foundation for national and state health reform.

Expanding Coverage and Access: The core mission of our public health insurance programs is to provide insurance coverage and health care access to low-income and disabled New Yorkers. This mission is made all the more imperative by our current economic downturn, which comes at a time when an estimated 2.5 million New Yorkers are uninsured. Over the past two years, New York has tackled the complex and misaligned eligibility rules embedded in the public insurance programs – eliminating some and streamlining others – so that qualified New Yorkers are able to receive and maintain health insurance coverage. With the strong belief that the health of our children starts with insurance coverage, New York determined to expand Child Health Plus to children in families with incomes between 250 percent and 400 percent of the Federal Poverty Level. Moreover, when the Bush Administration rejected our State's application for federal funding for insurance coverage for these children, New York came up with the money to cover the federal share so that, beginning on September 1, 2008, all children in New York State would have access to affordable coverage. We are grateful that the Obama Administration reversed course and will now make federal matching funds available to the State.

Lessons learned from other states show that coverage alone does not ensure access to care. With this in mind, the Doctors Across New York program, which provides financial support to practices in medically underserved rural and urban communities, will help ensure that all New Yorkers will be able to find a doctor within a reasonable distance of their home

Improving Quality and Controlling Costs: We must be certain that we are spending our health care dollars wisely – on patient-centered, high-quality, and efficient care – to make coverage affordable and accessible for all New Yorkers. Through its purchasing power, Medicaid can and must serve as a catalyst to move our health care system toward more efficient and effective delivery models. The challenge for our Medicaid program is to Buy the Right Care, in the Right Setting, at the Right Price. Meeting this challenge requires that Medicaid reimbursement be examined for every sector of the health care delivery system, including hospitals, clinics, physicians and practitioners, nursing homes and home care services. Over the past two years – and despite the vocal opposition of some entrenched interests – we have reformed how we pay for care as well as how much we pay for care. We have reduced inpatient rates and invested the savings in primary and preventative care and other ambulatory care services. In addition, we have offered incentives to providers who practice in medically underserved areas, maintain evening and weekend hours, and meet patient-centered medical home standards that advance integrated and coordinated care. These efforts are bolstered by strong programs that prevent and eliminate fraud, waste, and abuse and ensure the integrity of the Medicaid program.

The challenges faced by Medicaid have never been greater. The reforms we have achieved put New York on a path toward expanding coverage, improving quality, and controlling costs. These reforms enable New York State to partner with the President in transforming our nation's health care system so that all citizens have access to the care they need and deserve.

Sincerely,

David A. Paterson

MEDICAID: THEN AND NOW

In 1997, responsibility for New York Medicaid was shifted from the Department of Social Services to the Department of Health (DOH), now the single stage agency responsible for the administration of Medicaid and New York's other public insurance programs. This change marked the beginning of Medicaid's transition from a welfare program for the impoverished to a health insurance program for lower-income New Yorkers.

In 2007, this transition was accelerated through the establishment of the DOH Office of Health Insurance Programs (OHIP). All of the major operations of Medicaid, including enrollment, benefits, rate setting and reimbursement design, contracting, quality oversight and managed care, as well as the operations of New York's other public health insurance programs, were centralized in the newly created Office of Health Insurance Programs, under the direction and management of the State Medicaid Director. Before the formation of OHIP, Medicaid operated without a clear mission, a rational organizational structure, or the data necessary to envision or enact significant reform.

The establishment of OHIP marked the adoption of a new mission for Medicaid, namely to expand coverage and access; to buy value with New York's health care dollars; and to advance system-wide reform. The development of a strong mission for Medicaid was a critical step towards envisioning and enacting the reform agenda New York has pursued since 2007.

"Our current reimbursement system does not effectively serve the interests of patients, providers or taxpayers. It does not reflect the state's desire to purchase quality, cost-effective care in the appropriate setting, nor does it allow providers a transparent and straightforward revenue stream. We must rationalize our reimbursement system if we want to move New York's health care system into the 21st Century."

Richard F. Daines, M.D.
NYS Health Commissioner
A Report on Reform of Medicaid's Inpatient Rate Setting Methodology and Payment Levels. February 2009

RATIONALIZING REIMBURSEMENT

For decades, New York Medicaid used an outdated, opaque, and arbitrary reimbursement system. Over the past two years, New York has transitioned towards a fairer, more transparent, and straightforward system that better rewards quality and efficiency. For the purposes of reimbursement reform, the State's mantra has been "the right care, in the right setting, at the right price." New York continues to be driven by the belief that reforms inspired by this principle will result in improvements in quality and outcomes, reduced costs, and better overall health system performance.

Inpatient Reform: In 2007, New York began the critical process of reforming Medicaid's inpatient reimbursement system and transforming Medicaid into a more prudent, value-driven purchaser. In the 2007-08 Budget, the Legislature reduced inpatient rates by $225 million as the first step in bringing inpatient reimbursement in line with inpatient costs. The Legislature also established a multi-stakeholder Technical Advisory Committee, charged with examining inpatient hospital data and evaluating inpatient rate-setting methodologies.

In February 2009, the Department of Health issued a report detailing the findings and recommendations that emerged from the work of the Technical Advisory Committee. The State has begun to implement many reforms that reflect these recommendations.

The 2009-10 Budget reduces inpatient rates by an additional $225 million. Most of this money is reallocated to hospital clinics, community clinics, and doctors and practitioners. The Budget also transforms the way Medicaid sets inpatient rates from a system based on hospital costs that were over a quarter century old with a patchwork of add-ons that in most cases bore little relationship to the cost of providing care, to a system that uses current data, recognizes appropriate differences in facilities and patients, and encourages efficiency. Significantly, these reforms lay the foundation for bundled payments and other payment incentives intended to improve quality and efficiency.

Outpatient Investment: While Medicaid's payment for hospital inpatient services far exceeded the cost of providing those services, the exact opposite was true for outpatient services. Outdated payment methods and rates that had been frozen for over a decade at levels well below the cost of providing care acted as a deterrent for hospitals to treat patients in an outpatient setting (or conversely, as an incentive to admit a patient); freestanding clinics that serve a large proportion of Medicaid patients struggled financially as a result of reimbursement rates that had not kept pace with inflation or changing medical practice. Fees paid to physicians and other practitioners were also well below reasonable market rates making it difficult to ensure patient access to care.

To incentivize the provision of enhanced primary and preventive care, the FY 08-09 and 09-10 Budgets include a multi-year commitment to modernize the outpatient payment methodology and to invest over $600 million in ambulatory care reform.

Hospital and Community Based Clinics: The combined FY 08-09 and 09-10 Budgets invest $270 million in hospital ambulatory services and $50 million in community-based clinics. Recognizing that comprehensive reform means changing not only the *price* Medicaid pays for care, but also the *way* it pays for care in order to provide the right incentives, New York set out to overhaul the "one-size" fits all outpatient clinic payment methodology and to rationalize the amounts paid for ambulatory surgery and emergency department services. After careful review, the Department of Health selected an innovative new outpatient payment model, called Ambulatory Patient Groups or APGs, which captures the intensity of the services provided.

The new APG methodology along with the ambulatory care investments was implemented for outpatient hospital clinic and ambulatory surgery services in December 2008 and for emergency room services in January 2009. The second installment of the investment in hospital outpatient clinics will take place in December 2009. A comparison of the amount paid per visit before and after APG implementation and investment shows an increase of 55% for hospital outpatient clinics, 72% for ambulatory surgery, and 48% for emergency department visits. The outpatient fee increases and the APG methodology work together to more effectively incentivize the provision of the "right care, in the right setting, at the right price."

Hospital Service Setting	*Pre-APGs Payment Per Claim*	*January 2009 Amount Paid Per Claim*	*January 2010 Amount Paid Per Claim*	*Percent Increase*
Hospital Outpatient Clinic	**$127**	**$161**	**$197**	**55%**
Ambulatory Surgery	**$759**	**$1,305**	**$1,305**	**72%**
Emergency Department	**$167**	**$247**	**$247**	**48%**

The APG methodology will also be introduced in community clinics, mental health, and substance abuse clinics. These clinics play a critical role in providing care to New York's Medicaid beneficiaries. The investment of $50 million in reimbursement rates for these clinics, coupled with the APG methodology which links the amount of reimbursement to the intensity of services provided, will help ensure that they remain financially viable and available to serve Medicaid patients.

These payment reforms are complemented by New York's Health Care Efficiency and Affordability Law (HEAL NY) which provides funding to strengthen primary care, support hospital consolidations, and make New York's health care system more efficient and effective.

Physician and Practitioner Fees: Benchmarking NY Medicaid's fee schedule to fees paid by other insurers including Medicare and commercial insurers showed what providers already knew: Medicaid was significantly underpaying physicians and other practitioners. Office visits for new and existing patients were paid at a flat rate of $30 per visit, regardless of the complexity of the visit, and private physicians were reimbursed only $14 for visiting their patients in the hospital. To remedy this situation and encourage the participation of more physicians in Medicaid fee-for-service, the FY 08-09 Budget provided funding to permit a 40 percent increase in the fees paid to physicians, nurse practitioners, midwives and other practitioners effective January 1, 2009.

This funding also supported a 10 percent add-on to the fees paid to office-based physicians in Health Professional Shortage Areas (HPSAs) and an add-on for weekend and after-hours appointments in clinics and office based settings. The FY 09-10 Budget invests an additional $68 million in physician fees, bringing them more in line with the fees paid by Medicare, and also permitting physicians to bill for services provided in any hospital outpatient department or inpatient setting.

Primary Care Investments: Buying the *right* care means covering services that improve the health of enrollees and prevent more costly hospital admissions and treatments. In the past two legislative sessions, New York Medicaid has added asthma and diabetes education, social worker counseling, cardiac rehabilitation, smoking cessation and screening, brief intervention and referral to treatment (SBIRT) for substance abuse to its list of covered services. Over time, these investments are expected to more than pay for themselves in the form of reduced medical costs.

In 2010, New York will implement a program to incentivize the development of patient-centered medical homes. Hospitals and doctors that coordinate and integrate their patient's care in accordance with medical home standards will receive additional payments. Medical homes are at the forefront of a national effort to improve primary and preventive care and New York Medicaid will be on the cutting edge in implementing *and* evaluating their impact on quality and costs. In addition, Medicaid will participate in a multi-payor medical home pilot in the Adirondack region of the State.

Reimbursing Managed Care Plans: Over 2.8 million Medicaid and Family Health Plus beneficiaries receive their health care through enrollment in a managed care plan. In April 2008, New York Medicaid implemented a diagnosis-based risk adjusted capitation payment method. Under this method, regionally set capitation rates are adjusted upward or downward based on case mix of each health plan's membership. Plans with a higher than average case mix receive a higher rate, while plans with a lower than average case mix receive a lower rate. Similar to the reimbursement methods recently enacted for inpatient hospital and nursing home stays, this method encourages efficiencies while appropriately recognizing differences in costs based on enrollees medical needs.

Indigent Care Payment Reform: Along with inpatient reform and outpatient investment, the Department of Health has sought to increase the transparency, clarity and uniformity of the distribution of funding in the State's indigent care pools.

Currently, the indigent care pools distribute $847 million in Medicaid "Disproportionate Share Hospital (DSH)" payments to public and voluntary hospitals through a patchwork of multiple sub-pools and allocation formulas. Over the past decade, the formulas for pool allocation became increasingly disconnected from the cost of providing care to the uninsured. Distributions were based on hospital reported bad debt and charity care costs and could not be tied to care actually delivered to uninsured patients. In reality, the amount that a hospital received from the pools was based on accounting losses which were largely determined by the hospital's write-off policies and decisions which varied from hospital to hospital.

RATIONALIZING REIMBURSEMENT (continued)

With the assistance of the Indigent Care Technical Advisory Committee, and the Chairs of the Senate and Assembly Health Committees, an evaluation of the indigent care pools was conducted and in 2008 the Department of Health released a report detailing its findings and recommendations for reform.

Consistent with the report's recommendations, the FY 08-09 Budget segregated 10 percent of the total $847 million indigent care pool to be distributed under a revised formula which multiplies the actual number of units of inpatient and outpatient service provided to uninsured patients by the hospital's Medicaid reimbursement rates. This landmark change sets a new standard for reporting, accountability, and transparency in the distribution of these funds that will inform future allocation formulas.

With hospitals and community health centers reporting increasing numbers of uninsured patients in times of economic downturn, the FY 09-10 Budget takes additional steps to support providers servicing uninsured New Yorkers. An additional $269.5 million was made available to voluntary teaching hospitals to cover the cost of uninsured patients by converting funds in the State's former professional education pool to support indigent care. Community hospitals will receive an additional $16 million and voluntary safety net hospitals with Medicaid discharges greater than 40 percent will receive $25 million to support the cost of caring for uninsured patients. In recognition of the critical role that community health centers play in caring for uninsured patients, the Budget also makes an additional $71 million available to these providers as well as mental health facilities, subject to federal approval.

EXPANDING ACCESS TO COVERAGE

Ensuring that all New Yorkers have health insurance is a critical step towards ensuring that all New Yorkers have access to essential care, especially primary and preventive care. Because lack of coverage is such a powerful roadblock to access, reducing the ranks of the uninsured has been one of New York's most important goals.

Over the past two years, New York has sought to ensure that eligible New Yorkers are able to get and keep public health insurance by reducing arbitrary barriers and streamlining enrollment and renewal procedures. At the same time, New York has sought to expand eligibility for Child Health Plus and Family Health Plus for families with incomes just above Medicaid levels. Today's economic realities have made these efforts more critical, but also more difficult. Federal financial support remains key.

Expanding Income Eligibility:

On September 1, 2008, New York took a bold step towards ensuring universal coverage for children in the State when it increased the income eligibility threshold for Child Health Plus from 250 to 400 percent of the federal poverty level making an additional 70,000 children eligible for subsidized health insurance coverage. The benefit to New York's families is significant. To illustrate, prior to September 1, 2008, a child in a family of three whose family income exceeded $44,000 was not eligible for subsidized coverage. On September 1, 2008, that same child became eligible for subsidized coverage as long as the family's income is $70,000 or less. In addition, any family above 400 percent of the federal poverty level can buy into the program at the full monthly premium.

Effective July 1, 2009, contributions to Child Health Plus will increase modestly for some families. Child Health Plus premium contributions for children at or below 250 percent of the federal poverty level will remain at their current levels, which are among the lowest in the nation. The largest premium increase, for children at 400 percent of the federal poverty level, will be from $40 to $60 per month. Even with these increased rates, premium contributions will not exceed two percent of family income for anyone receiving subsidized coverage through Child Health Plus.

In addition, the 2009-10 Budget expands Family Health Plus for adults with children and for young adults (ages 19 and 20) to 160 percent of the federal poverty level ($29,000 for a family of three). This expansion has the largest impact on 19 and 20 year olds living on their own, a group more likely to lack coverage than other age groups. Medicaid coverage for foster care children was also extended through age 20.

Fast Fact:

Since New York's eligibility expansion was implemented in September 2008, 16,5000 additional children have enrolled in Child Health Plus and gained access to comprehensive coverage and care.

EXPANDING ACCESS TO COVERAGE (continued)

As a next step towards further expanding coverage for uninsured New Yorkers, the 2009-10 Budget provides State authority to seek federal approval and financial support to expand Family Health Plus coverage for low-income adults up to 200 percent of the federal poverty level, which would make over 400,000 additional adults eligible for coverage.

Making It Easier to Get and Keep Coverage: New York's public health insurance programs have long suffered from complex and misaligned eligibility rules, some of which exceed federal requirements. These rules made it difficult and costly to administer the program and prevented eligible people from getting and keeping health insurance coverage. Consistent with the goal of reducing the number of uninsured, New York Medicaid began to examine these rules and over the past two years New York has adopted a number of statutory and regulatory changes that dramatically simplify and streamline enrollment into Medicaid.

Critical to achieving the goal of enrolling more people, was the need to streamline the eligibility process and align income rules across programs and types of beneficiaries. Income levels for Medicaid eligibility for adults without children varied from county to county such that a person who was already determined eligible by one county could move just a few miles away into a different county and find that they lost their health insurance coverage. Family Health Plus eligibility rules treated 19 and 20 year olds more favorably if they lived with their parents than if they lived on their own. And, if that wasn't confusing enough, income eligibility levels were not aligned for parents and children. For example, parents could be enrolled in Family Health Plus, but have their young children enrolled in Medicaid and their older children in Child Health Plus. Moreover, eligibility for Medicaid was based on a net income standard while Family Health Plus and Child Health Plus used a gross income standard making them easier to administer and less burdensome on the applicant. The 08-09 and 09-10 Budgets remedy these situations by aligning income eligibility rules thereby making the eligibility process easier for families to navigate.

Also critical was the need to eliminate administrative processes that served as barriers to enrollment. New York was one of only a handful of states that required a face-to-face interview as part of the Medicaid application. Applicants' work hours, lack of transportation and wait times for appointments at the local social services districts made it difficult, if not impossible, for some people to apply. New York State law required that the applicant meet both an income and a resource test in order to be eligible for Medicaid and Family Health Plus. This meant that applicants were required to document, and eligibility staff review, records of bank accounts, retirement saving and other assets. At the end of this burdensome process, it turned out that less than five percent of those found eligible based on income alone had too many assets to qualify for Medicaid. New York also had a law on the books that required certain adults to have their finger imaged as part of the Medicaid application process, although the requirement saved the State less than $85,000 over the most recent six years.

The FY 09-10 Budget makes landmark changes by eliminating the requirements for face-to-face interviews and finger imaging as well as the resource test for non-SSI applicants. This built on the change made in the FY 08-09 Budget to eliminate several eligibility rules for single adults and childless couples that were tied to cash assistance such as the requirement for a drug and alcohol screening. Beyond making the application process easier, these historic changes open the door to the future of on-line applications for New York's public health insurance programs.

Fast Fact:

By expanding Child Health Plus eligibility to 400% of the Federal Poverty Level, New York extended access to comprehensive coverage and care to an estimated 70,000 additional uninsured children.

The past two years brought other administrative simplifications designed to promote continuity of coverage. In 2006, public programs retained about 60 percent of enrollees. By permitting Medicaid and Family Health Plus enrollees to self-attest to their income and residency at renewal, as Child Health Plus enrollees had done since 2003, retention rates increased to 70 percent. New York also requested a federal waiver that would allow 12 months of continuous enrollment for adults irrespective of income and other changes that occurred during the year. This had already been implemented for children. For enrollees entering incarceration, Medicaid coverage was suspended, rather than discontinued, making it easier for the enrollee to obtain needed health care services upon release.

While deteriorating economic conditions certainly play a role in spurring demand for public health insurance, there is no question that the State's efforts to reduce impediments to enrollment and renewal are also working to increase enrollment. In 2008, total Medicaid enrollment grew by 142,000 and the number of children enrolled in Medicaid and Child Health Plus grew by 46,000. Since the Child Health Plus eligibility expansion was implemented in September 2008, 16,500 additional children have enrolled in the program. The most recent data suggest that renewal rates for New York's public insurance programs are increasing as well.

Going forward, New York plans to further strengthen its enrollment and renewal processes through the establishment of a statewide enrollment center. In October 2008, the Department of Health released a request for proposal for a statewide enrollment center, which will include a single statewide telephone and mail-in renewal system and a toll-free call center for New Yorkers seeking information about, or assistance enrolling in, Medicaid, Family Health Plus, and Child Health Plus.

The establishment of this center will help the State and local social services districts to process a growing volume of applications and will enable further testing of simplification strategies. A new telephone renewal option will make it easier for beneficiaries to renew coverage, and should increase program retention rates. The statewide enrollment center also offers the potential to further expand enrollment through additional technological innovations in the enrollment and renewal process.

EXPANDING ACCESS TO COVERAGE (continued)

Public/Private Collaboration for Coverage: In the past two years, New York implemented two significant initiatives that hold great potential to expand coverage through innovative collaboration with private insurers and employers.

The Family Health Plus Premium Assistance Program helps income eligible families pay the premiums required for participation in their employer-sponsored health plans. With financial assistance from the Premium Assistance Program, approximately 900 additional New Yorkers have been able to take advantage of the health benefits offered by their employers. The State benefits because private health care dollars remain in the system.

The Family Health Plus Buy-In Program permits businesses to cover their employees through participation in the Family Health Plus insurance program. For employees who are otherwise eligible, Family Health Plus pays the employees' share of the premium. Enrollment in the Family Health Plus Buy-In Program began April 1, 2008 with Service Employees International Union (SEIU) 1199 home care workers in New York City. Currently over 47,500 New Yorkers have comprehensive coverage and access to care through the Family Health Plus Buy-In Program. Work continues to make the Family Health Plus Buy-In more widely available to employers later this year.

Assisting Others in Paying for Health Care Costs: New York also implemented programs to assist low income elderly and near elderly persons with paying for their health care costs even when they do not qualify for full Medicaid. New York eliminated the asset test for the Medicare Savings Program (MSP). The MSP assists seniors who do not qualify for full Medicaid coverage by paying for their Medicare Part B premiums, which in 2009 is $96.40 per month or $1,156 a year, and in some cases their Medicare deductibles and coinsurance amounts as well. The elimination of the asset test expands the Medicare Savings Program to a greater number of seniors, specifically those that have some resources but very limited income. It also entitles the senior to a higher level of prescription drug benefit under Medicare Part D because copayments are lower and the senior is not subject to the Medicare Part D "donut hole." Seniors save money on their prescription drugs and the State's Elderly Pharmaceutical Insurance Coverage Program (EPIC) saves as well when it pays secondary to Medicare Part D for these seniors.

In 2009, New York implemented a prescription drug discount card, known as the New York Prescription Saver (NYP$) Card, for income-eligible New Yorkers, aged 50-64, or with a disability, that do not qualify for Medicaid. Effective April 1, 2009, this discount card yields meaningful savings for participating New Yorkers and helps ensure that more New Yorkers can afford the medications they need.

Over 4,300 people enrolled in the NYP$ in the first month it was available and participants realized average discounts of 43 percent on brand and generic drugs. These discounts are made available through the generous participation of 3,800 chain and independent pharmacies located in New York State and through the participation of drug manufacturers who have agreed to provide rebates under the NYP$ program.

Partnership for Coverage: In July 2007, New York established the Partnership for Coverage, a joint initiative of the State Departments of Health and Insurance taskforce charged with developing a building block strategy for reaching universal coverage in New York State.

After a comprehensive request for proposal process, the Partnership awarded a contract to the Urban Institute to model various policy options for expanding coverage, including a single-payer program, a publicly-sponsored and funded plan open to all New Yorkers, a combined public-private reform strategy, and a market-based approach. The Urban Institute is scheduled to deliver its findings in mid-2009. The Partnership plans to review the report thoroughly, deliberate with stakeholders both inside and outside government, and move forward towards formulating a strategy for achieving universal coverage.

"Whether they live in one of the State's many rural areas or an inner city, all New Yorkers deserve access to high-quality health care," said Governor Paterson. "Doctors Across New York will target the areas of the State with the biggest shortages of doctors, providing residents in those communities with a much needed increase in access to health care. This program will greatly improve the overall health of New Yorkers while reducing the cost of health care in the long run."

Governor Paterson

March 23, 2009

EXPANDING ACCESS TO CARE

Increasing the number of people covered by health insurance is critical, but coverage alone will not ensure that New Yorkers get the care they need. At the same time that New York expands coverage it must also take steps to ensure that there is an adequate supply of physicians and other practitioners.

Doctors Across New York: In many areas across the State, particularly in rural counties, Medicaid beneficiaries and other patients struggle to find primary care physicians and specialists within a reasonable distance of their home or workplace. For New Yorkers living in these areas the State implemented Doctors Across New York in 2009. Doctors Across New York offers financial assistance, including up to $150,000 for loan repayments and $100,000 for practice support, to physicians who commit to practice in medically underserved communities.

Over the next five years, the Department of Health will award $11 million in loan repayment assistance to doctors that commit to working in medically underserved communities for at least five years. Over the next two years, DOH will distribute an additional $11 million to help physicians establish or expand medical practices in such communities. In addition to the incentives offered through the Doctors Across New York initiative, New York Medicaid also increased the reimbursement fees paid to physicians working in Health Professional Shortage Areas to further encourage physicians to practice in medically underserved areas.

Expanding Medicaid's Physician Network: Having a personal doctor is the first step towards being able to access primary and preventive services. New York is committed to ensuring that all Medicaid beneficiaries have the ability to find a doctor in or near their community that they feel comfortable making "their doctor" and who they visit for check-ups, screenings, consultations, etc. In keeping with this commitment, the Department of Health has initiated a physician recruitment initiative specifically targeted at physician shortage areas throughout the State. Through this initiative, New York aims to expand the number of physicians accessible to Medicaid beneficiaries and thereby make it easier for enrollees to find a regular doctor to visit for primary and preventive care.

Improving Access to Non-Emergency Care Outside Regular Business Hours: For many Medicaid beneficiaries (as well as commercially insured New Yorkers), scheduling challenges can make it difficult to access important primary and preventive care services. To make it easier for beneficiaries to visit their doctors, New York Medicaid now pays more for outpatient services provided in clinic and office-based settings on the weekends and outside regular business hours. This will enable more beneficiaries to receive primary and preventive care services and reduce the need for more costly emergency room visits – a true "win-win" for the patient and the program.

PURSUING IMPROVEMENTS IN QUALITY AND OUTCOMES

Since 2007 New York Medicaid has implemented several major initiatives to strengthen the quality of care delivered to enrollees, and thereby improve enrollee outcomes and overall health. Some of these initiatives mirror initiatives recently implemented by Medicare, as well as large private insurers.

"For women to survive breast cancer, they need access to medical services and high-quality care. The state's decision to limit breast surgery for Medicaid patients from low volume to higher volume hospitals makes sense since research shows a strong connection between procedures done at high volume facilities and the five-year breast cancer survival rate."

- Dave Momrow
Sr. Vice President
Cancer Control
American Cancer Society of NY & NJ
March 3, 2009

Selective Contracting for Breast Cancer and Bariatric Surgery: Recognizing that recent medical peer-reviewed literature has cited the association between higher breast cancer surgery volume and higher rates of five-year survival, New York Medicaid developed a selective contracting policy for lumpectomies and mastectomies. Effective March 1, 2009, Medicaid will only reimburse for breast cancer surgeries at hospitals and ambulatory surgery centers that perform at least 30 of these surgeries annually.

Bariatric surgery outcomes also vary significantly by facility. In response to these findings, New York has embarked on a selective contracting initiative to ensure that Medicaid beneficiaries only receive bariatric surgeries in facilities that produce the best outcomes for such surgeries. In February 2009, DOH issued a request for applications to all hospitals that perform bariatric surgeries in the New York City area to provide them the opportunity to become "Bariatric Specialty Centers." Beginning in late 2009, New York Medicaid will selectively contract only with such "Bariatric Specialty Centers." Strengthening the standards facilities must meet in order to provide such surgeries will improve long-term outcomes for affected beneficiaries. Over time, increased success rates and decreased complication and readmission rates will result in meaningful savings.

Non-payment for Never Events: In 2008, New York became one of the first Medicaid programs in the nation to deny reimbursement for 'never events', avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients. Adoption of this non-payment policy has heightened awareness about the prevalence of such 'never events' and encouraged the hospital community to further prioritize patient safety, which is one of the nation's most pressing health challenges.

Retrospective Utilization Management Program: Utilization management is the evaluation of the appropriateness, medical need and efficacy of health care services according to established criteria. In February 2009, New York Medicaid announced the selection of a contractor to conduct retrospective utilization review of nearly all Medicaid fee-for-service claims, including fee-for-service claims incurred by over 2.4 million Medicaid managed care enrollees for services not included in the health plan benefit package. The contractor will identify patterns of inappropriate health care utilization using evidence-based guidelines, and perform in-depth analysis of the service utilization of high cost and high risk beneficiaries. This initiative is by far the most comprehensive review of service utilization ever undertaken by New York Medicaid.

PURSUING IMPROVEMENTS IN QUALITY AND OUTCOMES (continued)

Improving Access to Durable Medical Equipment (DME): In response to longstanding complaints about the turnaround time on durable medical equipment requests, New York Medicaid sought to strengthen the DME request and receipt process. In 2007, along with the Chairs of the Assembly and Senate Health Committees and industry stakeholders, the DOH convened a workgroup to address DME coverage requirements, access criteria, and turnaround time. Since the commencement of the workgroup, the prior authorization requirements for certain types of DME have been eliminated and the process has been streamlined for other types of equipment.

New York Medicaid reduced the turnaround time for review of a DME request to two business days which far exceeds regulatory requirements. In addition to improving its own DME operations, New York Medicaid has demanded improvements in vendor performance by introducing report cards that document vendor turnaround time. These cards provide a comparative analysis of vendor performance, thereby motivating vendors to improve their performance relative to their peers.

Pharmacy Initiatives: In October 2008, New York Medicaid implemented a physician education program to provide physicians with an objective and non-commercial source of up-to-date information about pharmaceuticals. The project helps physicians to strengthen the prescribing and treatment aspects of their practice, and thereby improves the quality of care they can provide to their patients. Under a specialty pharmacy program, selected pharmacies will be the preferred providers of specialty drugs for Medicaid fee-for-service, Medicaid Managed Care, and Family Health Plus. They will be required to accept reduced reimbursement rates and provide specialized services that support patient compliance, coordination of specialty pharmacy care, and appropriate drug utilization.

One of the most significant new initiatives approved in the recent budget allocates funding to incentivize E-prescribing for pharmacies and prescribers. Over the long term, E-prescribing will reduce medication errors, encourage pharmaceutical practices that produce better patient outcomes, and yield savings. The Budget also authorizes the Drug Utilization Review Board, which is comprised of physicians and other health care professionals, to set quantity, frequency and duration limits for certain drugs in order to encourage greater adherence to clinical guidelines and authorizes a step therapy program that will require patients to try the clinically recommended, less costly, first line therapy, before coverage is authorized for a second line drug.

Finally, the Budget authorizes New York Medicaid to negotiate directly with drug manufacturers to more effectively leverage Medicaid's significant purchasing power to secure greater discounts on prescription drugs. New York currently receives supplemental rebates on certain preferred drugs through participation in the National Medicaid Pooling Initiative (NMPI). However, research and analysis conducted for the Department by an outside consultant found that the State could save more by directly negotiating with drug manufacturers. By developing a more aggressive and redesigned supplemental rebate program, New York Medicaid expects to realize significant savings in drug purchasing.

IMPROVING CARE FOR COMPLEX ENROLLEES

Providing patient-centered, coordinated, high-quality care to Medicaid beneficiaries coping with multiple infirmities, chronic conditions and on-going medical demands poses a tremendous challenge. During the past two years, New York implemented significant policies intended to improve the quality and reduce the costs of care provided to Medicaid's most complex and expensive enrollees.

Chronic Illness Demonstration Projects: In 2008, New York initiated a pilot project for Medicaid's most complicated and costly beneficiaries, those suffering from multiple co-morbidities and coping with particularly complex medical needs. These beneficiaries amount to 20 percent of the total Medicaid population, but account for 75 percent of its total expenditures. Given the extensive evidence that the pattern of care provided to such beneficiaries produces sub-optimal health outcomes at tremendous cost, New York is committed to finding a way to more effectively and efficiently care for these beneficiaries.

As a first step towards fulfilling this commitment, $10 million in State funds was authorized to finance the Chronic Illness Demonstration Project. The overarching vision for the project is to establish innovative, quality-driven, interdisciplinary models of care designed to improve health care quality and affordability, and to strengthen clinical outcomes for Medicaid beneficiaries with medically complex conditions. A predictive modeling tool will be used to identify patients most likely to benefit from participating in the demonstration; however, patient participation is voluntary. The Department of Health released a request for proposal, conducted a rigorous selection process, and awarded contracts to seven organizations in five regions across the State to conduct these projects. Through extensive data collection and performance assessment, these projects will yield significant insight and policy in caring for complicated, high-need beneficiaries. Demonstration projects that are successful in reducing costs and improving health outcomes will be eligible to share in a $6 million incentive pool.

Medicaid Managed Care Extended to SSI Population: New York took steps to assure access to services and facilitate greater care coordination for its SSI population by extending Medicaid Managed Care to these beneficiaries. Beneficiaries that receive SSI and Medicaid are now required to enroll in a managed care plan for their health benefits in most counties in the State. As of May 2009, more than 263,000 SSI and SSI–related individuals were enrolled in Medicaid Managed Care. These beneficiaries now benefit from the care coordination afforded by a managed care plan. In a consumer satisfaction survey conducted after the implementation of managed care enrollment among the SSI population, 88% of beneficiaries reported that getting a doctor's appointment was the same or easier than when they were in fee for service and 77% said that they would recommend their health plan to others.

Medicaid Managed Care for New Yorkers Eligible for Medicare and Medicaid (Dual Eligibles): New York also extended the benefits of managed care to residents that are dually eligible for Medicare and Medicaid. Dual eligibles tend to have more serious and complex medical needs and having coverage divided between two payers can be confusing to beneficiaries and result in fragmentation and misaligned incentives. Given the cost of the dual population and, as importantly, the untapped opportunity to improve and better coordinate care, New York Medicaid now allows duals to participate in managed care plans, called Medicaid Advantage plans. Medicaid Advantage plans combine the strengths of the Medicare Advantage plans and New York's Medicaid Managed Care programs, resulting in managed care plans uniquely equipped to care for the dual population. As of May 2009, over 5,200 New Yorkers benefit from enrollment in one of New York's 15 Medicaid Advantage plans. Further expansion is planned in 2009-10.

MAKING ADVANCEMENTS IN LONG TERM CARE

Medicaid is the predominant payer of long term care services in the State. Medicaid spending on long term care services comprises about 25 percent of total Medicaid spending. Over the past two years, Medicaid's focus has been on expanding the availability of community based alternatives to nursing home care and on developing rational reimbursement systems that encourage efficiency and reward quality.

Rationalizing Nursing Home Reimbursement: For many years, New York Medicaid reimbursed nursing homes based on facility specific reported costs with a series of hold harmless requirements (some more than two decades old), and arbitrary rate add-ons. The methodology was complicated and opaque. It did not incentivize efficiency or quality and it generated thousands of facility specific rate appeals and frequent litigation. Similar facilities in the same locality often received markedly different rates despite having comparable resident populations and achieving compatible quality scores. Cost data used to establish nursing home rates dated back to 1983. In 2006, legislation was enacted to require that the rates be rebased to reflect more up-to-date costs. However, the legislation did not correct the flaws in the underlying rate setting methodology. Instead, it infused hundreds of millions of dollars into a flawed system, further diminishing the efficiency and long term viability of Medicaid's nursing home reimbursement system.

The FY 09-10 Budget reforms the nursing home reimbursement methodology. Effective April 1, 2010, New York will move to a regional pricing methodology that will be adjusted for resident need and accommodate appropriate facility specific costs. Rates will be enhanced for hard to serve residents such as dementia and bariatric patients. Along with the new method, quality of care pools will be established to reward nursing homes that meet established criteria. Nursing homes that face challenges in adapting to the new methodology will be eligible to receive assistance funds from a transition pool, so long as they accept certain conditions tied to the additional assistance. To assist public nursing homes, the Budget authorizes an increase in the amount of funding that they can access under the federal upper payment limits.

Finally, struggling nursing homes will receive financial assistance through a redesigned financially distressed nursing home program, which will more effectively target funding to facilities experiencing significant financial difficulties and command accountability from homes receiving assistance.

Rationalizing Payment of Home Health Care: New York Medicaid covers a broad range of home health care services. In most cases, these services allow Medicaid beneficiaries to remain in the community and avoid more costly and restrictive nursing home placements. Medicaid pays for certified home health care services based on the

number of hours of service a patient receives. Services must be ordered by a physician, but the number of hours of care is not subject to prior authorization. During the period 2003 through 2007, the cost of home health care services increased by 50 percent while the number of patients receiving these services decreased.

Analysis showed that differences in the number of hours of home health care services provided to patients could not be explained by differences in patient need. The average number of hours varied greatly by regions of the State with patients in New York City and the downstate metropolitan areas receiving on average nearly three times as many hours as patients upstate. Utilization in New York City varied significantly by neighborhood.

The 09-10 Budget creates a workgroup of industry representatives, consumers, workers and experts to inform the development of a new home health care reimbursement methodology. Specifically, the workgroup will address prospective payment approaches, similar to those used by Medicare that match payment amounts to patient acuity, and consider the introduction of quality incentives into home health care reimbursement.

Ensuring Care in the Right Setting: In addition to making significant changes in reimbursement of long term care services, the 09-10 Budget takes several important steps that advance the goal of providing the right care in the right setting. The Budget doubles the availability of Medicaid assisted living services by replacing 6,000 unnecessary nursing home beds with 6,000 new Assisted Living Program (ALP) beds over the next five years. The Budget also provides funding to support the creation of an automated, statewide assessment instrument to evaluate patient care needs, determine program eligibility, and generate care options for consumers.

To further the State's goal of ensuring that determinations about patient need and authorization of services are made in a consistent and uniform manner, the 09-10 Budget includes demonstration authority to allow the Department of Health to establish two regional long term care assessment centers, one located in New York City and the other in a region of the State consisting of two or more neighboring counties. The long term care assessment centers will be responsible for assessing patient needs, authorizing services including certified home health care services beyond 60 days, and approving participation in the personal care services program, the consumer directed personal assistance program, the assisted living program, the long term home health care program and the managed long term care program.

Fast Fact:

In May 2009, Governor Paterson announced the availability of $175 million in grants under the Health Care Efficiency and Affordability Law (HEAL NY) to support projects that provide appropriate alternatives to nursing homes, such as assisted living programs and assisted living residences.

ASSURING PROGRAM INTEGRITY

Assuring program integrity is critical to controlling the cost of New York Medicaid and to preserving resources for taxpayers and the over four million people who rely on Medicaid for health insurance coverage. Over the past two years, New York has turned its program integrity efforts into a national model recognized by federal officials for sound practices and for increasing recoveries.

Using Audit Tools to Assure Compliance: The Office of the Medicaid Inspector General (OMIG) has expanded both the number of audits it performs, and the focus of those audits, to address the providers receiving the largest Medicaid payments, namely hospitals, skilled nursing facilities, and managed care plans. Audits are preceded by a careful review to assure that the rules upon which the audit is based are supported by the regulations and published guidance. These audits result in recoveries but also educate providers about weaknesses in their management and billing systems.

Employing State of the Art Data Mining Tools: Audits are an important tool to assure compliance, but they can also be time-consuming and costly for both health care providers and State staff. New York has developed the nation's best Medicaid database which allows staff to integrate data from multiple sources to find improper payments and outlier providers. Using advanced data analysis tools, OMIG conducts desk reviews to identify appropriate candidates for field audits. This work resulted in over $550 million in recoveries in federal FY 2008, which was the largest amount recovered by any state in 2008, and more than three times the amount New York recovered in 2007.

Providing Guidance to Providers: Most overpayments are not the result of intentional misconduct; they are the result of a lack or failure of an internal control or systems. OMIG and OHIP provide guidance on reimbursement rules and policies, and OMIG has issued a regulation on compliance program requirements under New York law. The OMIG and the Department of Health's Office of Health Insurance Programs meet regularly with provider and compliance associations to review Medicaid rules and policies; OMIG has also distributed audit protocols and results and makes available a comprehensive annual work plan to assist compliance officers in identifying risk areas.

Using Audit Tools to Change Behavior: Providers who demonstrate egregious or repeated behavior inconsistent with program integrity are identified through audits, data mining, and whistleblower complaints. OMIG develops corporate integrity programs for organizations capable of resolving these issues, and censure or exclusion for providers where appropriate.

Deterring Fraud through Surveillance and Referral: Effective deterrence of fraudulent conduct requires that the minority of providers (or their employees) who commit fraudulent acts have a reasonable risk of detection and prosecution. In the past two years, OMIG has more than doubled its professional investigative staff, and expanded and targeted its undercover and shopper programs. These staff members work closely with other major law enforcement agencies in detection, investigation, and prosecution.

STRENGTHENING INFORMATION TECHNOLOGY SYSTEMS

Information technology (IT) systems are critical to the successful operation of a health insurance program. Insurers and providers rely on them to pay claims in an accurate and timely manner. Systems provide data needed to improve quality and monitor outcomes. They must be flexible in order to meet changing business needs and, at the same time, they must have adequate controls to protect program integrity.

eMedNY is New York's Medicaid Management Information System. Each year it processes over $40 billion in payments (about one of every three health care dollars paid in the State) to a total of 70,000 providers. eMedNY is also the primary source of data used for financial reporting, program analysis, auditing, and quality measurement. In order for reform to become reality, eMedNY has to stand ready to implement program changes in a timely manner. Project management and prioritization needed to be strengthened, new and more complex system edits needed to be developed to protect program integrity, and data reliability needed to be improved in order to measure quality of care.

Medicaid's FY 08-09 and 09-10 reform agenda included far-reaching reimbursement reforms which placed unprecedented demands on IT systems. New benefit design features in the Medicaid pharmacy program demanded more flexibility in the system and requirements at the federal level, such as the National Provider Identification (NPI) number, needed to be implemented. With a new team in place and a strong commitment to improving Medicaid's IT system, the backlog of update projects was virtually eliminated by the end of calendar year 2008. In September 2008, the federally required National Provider Identification (NPI) number project was implemented along with other system projects needed to implement the 2008-09 Budget, most notably the implementation of APGs for outpatient reimbursement.

Critical to the IT improvements that have been realized over the past two years is the strong collaboration between the Department of Health's Office of Health Insurance Programs (OHIP) and the Office of the Medicaid Inspector General (OMIG), which plays a pivotal role in the elimination and prevention of fraud, waste and abuse. Working hand in hand, these two organizations have strengthened claim system controls to improve the integrity of the State's largest insurance program, Medicaid, which is so critical to New Yorkers.

eMedNY's potential for facilitating electronic exchange of health information is only now just being realized. In early 2008, the Department of Health, in collaboration with the New York City Department of Health and Mental Hygiene, embarked on a landmark clinical data exchange pilot program using data from Medicaid's information systems. With patient consent, the pilot allows authorized physicians to view their Medicaid patients' medication history through an electronic health record.

STRENGTHENING INFORMATION TECHNOLOGY SYSTEMS (continued)

In addition to making 90 days of medication history available, the pilot also provides physicians with information about Medicaid's preferred drugs so that they can make informed decisions about lower-cost therapeutically equivalent medications at the time the prescription is written. Through HEAL grants this pilot will be expanded to include more prescribers.

The pharmacy pilot opened the possibility for Medicaid's IT systems to become a critical source of information to populate electronic health records for Medicaid patients. As states begin to prepare for the funding provided in the American Recovery and Reinvestment Act to support Electronic Health Record (EHR) incentives for Medicaid providers, New York Medicaid has begun to explore how Medicaid's information systems and the wealth of information they contain can play a critical role in advancing the goal of achieving interoperable electronic health records for all Medicaid beneficiaries. In addition, HEAL NY has supported two competitive grant rounds to advance New York's interoperable health information technology infrastructure. Awards under the two rounds totaled over $158 million. A third round of grants to improve care coordination and management through a patient-centered medical home model supported by an interoperable health information infrastructure will be awarded later this year.

Finally, consistent with the goal of increasing coverage, New York Medicaid is developing electronic eligibility decision tools to be used by staff at the statewide enrollment center. The first phase of the project will result in a tool to process eligibility renewals for Medicaid and Child Health Plus members. The second phase will result in an electronic decision tool for new applications, with the future goal of making it available on the internet so that New Yorkers can apply for public health insurance coverage on-line from their homes or other community settings.

"To be successful in our mobile society, patient health records must be portable or interoperable. Providers need access to this vital information to help their patients, and interoperability will improve the availability and use of health information to improve patient care. We will see more efficient care when physicians can access the records they need at the time a patient needs care. Then we can reduce duplicative testing, make better decisions with better information, and help New Yorkers maintain and improve their health throughout their lives."

RICHARD F. DAINES, M.D. - NYS HEALTH COMMISSIONER - *April 9, 2009*

THE FUTURE: NEW CHALLENGES AND NEW OPPORTUNITIES

The Medicaid reforms enacted over the last two years go a long way toward making Medicaid a high-performing health insurer, providing coverage, and access for eligible New Yorkers, buying quality, cost-effective care for enrollees and spending taxpayers dollars in a prudent manner. As New York Medicaid moves forward, many of the current challenges will continue and new challenges and opportunities will arise. With an eye on reform at the federal level, New York will continue its effort to reduce the number of uninsured New Yorkers through a combination of streamlining eligibility rules for public health insurance programs, expanding coverage, and building private-public partnerships. We will partner with President Obama to expand coverage and enhance access to care.

Improving quality of care will remain one of New York's top priorities. Payment reforms that hold providers accountable for both quality and cost of care will continue as we seek to align and maximize the purchasing power of the federal and State governments. Reducing the number of potentially preventable complications, preventable hospital readmissions, and hospital admissions for preventable quality indicators, such as diabetes and asthma, will reduce costs and result in better patient care.

Federal stimulus funding to support health information technology (HIT) for Medicaid providers will provide new opportunities to improve quality of care through data exchange. As the largest purchaser of health care in the State, New York Medicaid will work diligently to accelerate the adoption of health information technology and the use of electronic health records. Some of the reimbursement reforms already enacted, including incentive payments for providers who attain a medical home designation, and who prescribe electronically, have already set the stage for HIT adoption.

Health care reform has again risen to the top of the federal agenda. While it is too soon to know how the debate will play out, one thing is clear: Medicaid must serve as a catalyst to move our health care system to a higher level, meeting the needs of consumers and taxpayers, and delivering higher quality care at a lower cost. New York State is committed to nothing less.