PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 1

Proposal (Short Title):
Increase the Health Facility Cash Assessment Rates

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 04/01/2011

Implementation Complexity: N/A
Implementation Timeline: N/A

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

Proposal Description:
Increase health facility cash assessment percentages (additional revenue to fiscal plan) for hospital inpatient, nursing home, & home care services. These increases are not Medicaid reimbursable. This proposal cannot be enacted in conjunction with HCRA Streamlining for hospitals.

New York State designated providers are required to pay an assessment on cash operating receipts on a monthly basis under the Health Facility Cash Receipts Assessment Program (HFCAP). Increasing the HFCAP rates would result in a significant additional revenue stream for the State. Under federal regulations states may increase tax collections from 5.5% (of total patient revenues) to 6% effective October 1, 2011. The impact of this assessment increase is outlined in the chart below:

	Current Rate	Proposed Rate as of 4/1/11	Proposed Rate as of 10/1/11	SFY 11/12 Net Increase -	SFY 12/13 Net Increase -
Nursing Homes	**6.00%**	**7.00%**	**7.50%**	**$92M**	**$122M**
Hospitals	**0.35%**	**0.75%**	**1.25%**	**$186M**	**$292M**
Home Care Agencies	**0.35%**	**0.75%**	**1.25%**	**$27M**	**$42M**
Grand Total				**$305M**	**$456M**

None of these increases would be reimbursable by Medicaid.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-305.00	$-456.00	$-456.00	$-456.00
Total Savings	$-305.00	$-456.00	$-456.00	$-456.00

Benefits of Proposal:
Providers and trade associations have preferred the approach of an assessment increase in lieu of additional rate cuts, since the gross impact of a rate cut would have to be at least two times greater than the value of an assessment increase in order to generate the same financial plan benefit.

Concerns with Proposal:
Many will view this as an increase in State imposed taxes. If increases are considered, they must be broad-based, uniform and within federally acceptable provider tax class designations to avoid potential federal financial penalties. In addition, the aggregate tax collections for each provider class can not exceed 5.75% of the total patient revenues for the class for this SFY, and 6% for SFY 11-12. This limitation will not allow for the enactment of both this proposal and the HCRA Streamlining proposal for hospitals since each one of these proposals uses all of the available tax cap room for this provider class.

Impacted Stakeholders:
All assessed providers and potentially self-pay patients receiving services that may be billed for the portion of the provider assessment due on their payments.

Additional Technical Detail: (if needed, to evaluate proposal)
Due to Federal provider tax rules, the assessment on Personal Care providers within the Home Care group is considered an impermissible provider tax and is subject to a 50% penalty on associated collected receipts. The State will be required to pay this penalty to the Federal government. This penalty is valued at $6.6M in SFY 11/12 and $10.3M in SFY 12/13, 13/14 and 14/15. These amounts have been reflected in the Financial Impact. In addition, a retroactive contingent assessment is authorized to be imposed on Licensed Home Care Service Agencies if a federal waiver to exclude them from the assessment is not obtained.

System Implications:
Not significant. Routine changes will be required to both the HFCAP database and the Department of Health website.

Metrics to Track Savings:
Monthly reporting of collections.

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Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 2

Proposal (Short Title):
Reduce and Control Utilization of Personal Care Services

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
This proposal will eliminate Level I personal care services and implement provider-specific aggregate annual per patient spending limits that is at approximately the 2006 per recipient spending level.

Total Personal Care Medicaid expenditures in 2009 were $2.2 billion. Approximately 80% or $ 1.76 billion is attributable to New York City. Despite a decline in the number of personal care recipients served from 2003 to 2009, spending per recipient over this same period increased dramatically, or by almost 40 percent.

	Personal Care Spending Trends						
	2003			2009			
	# Recipients	Total Spending	Spending Per Recipient	# Recipients	Total Spending	Spending Per Recipient	% Change Per Recipient Spending
Statewide	84,823	$1.825B	$21,512	75,023	$2.233B	$29,761	+38.3%
New York City	63,332	$1.550B	$24,471	51,744	$1.757B	$33,961	+38.8%

Although personal care services are authorized by a physician, the level of service provided is determined by the local district (i.e., New York City HRA or local county Department of Social Services). The current Medicaid rate setting methodology for providers outside New York City establishes provider-specific, fee-for-service rates. The rates are based upon a rolling cost base which is updated annually (i.e., 2010 rates are based upon 2008 reported costs).

Since 1996, the New York City personal care program has operated under a regulatory exemption to the cost based methodology. Under the exemption, NYC HRA sets personal care rates, which are subject to a city-wide weighted average maximum price. The rates are monitored and approved by the Department and the Division of the Budget.

Personal care rates are not adjusted for patient acuity and there is no incentive to control the amount or level

of services authorized or provided.

This proposal would contain escalating per patient costs for Personal Care services by:
● Eliminating Level I Personal Care Services (i.e., housekeeping, shopping, meal preparation).
● Implementing provider specific, aggregate annual per patient spending limits on each PC agency based on provider-specific average paid Medicaid claims per patient during a designated base period.
● These savings would be achieved by reducing payments to PC providers. Payments would be reconciled using actual paid claims. Providers that reduced their aggregate per patient spending levels below the limit would receive a payment and providers that did not adjust their spending levels would have their rates or payments further reduced. Please see "Attachment" for an example of how the provider limits would be calculated.
● Transitioning approximately 7,000 recipients to Managed Long Term Care (MLTC) by 3/31/12. (See MRT paper #90 for additional information).

The 2011-12 fiscal impact for FFS PCA provided below reflects $310 million of savings from eliminating Level I PC services ($56 million) and establishing aggregate provider per patient spending limits of $32,345 ($254 million).

The annual decline in savings beginning in 2012-13 assumes that effective April 1, 2012 the mandatory enrollment of personal care recipients to MLTC will continue to shift personal care recipients (an additional 35,000 by April 2014) from fee-for-service to MLTC.

The fiscal impact does NOT include savings on the MLTC side from shifting patients from fee-for-service to MLTC. (See MRT paper #90 for additional information)

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-155.00	$-121.00	$-81.00	$-63.00
Total Savings	$-310.00	$-243.00	$-162.00	$-126.00

Benefits of Proposal:
● Provide fiscal incentives for providers to take immediate action to control utilization. The provider limits would reduce average annual statewide spending per recipient to 2006 levels or to approximately $28,756.
● Better alternative to achieve targeted savings than across-the-board savings that would impact efficient providers.
● The Department and providers can monitor and track performance against the cap.
● The proposal is relatively easy to implement.
● The proposal begins to better manage the care of high cost, high need patients by transitioning these patients to Managed Long Term Care.

Concerns with Proposal:
● May provide agencies an incentive to "cherry pick" patients by serving only those with lower acuity and less intense needs. However, the migration of patients to MLTC should mitigate this concern.
● Providers will claim the proposal is unfair because it's the local services district (HRA in the City), and not the provider that controls or determine the level of services to be provided to the patient. However, this proposal will provide an opportunity for the provider and local service district to collaborate on the appropriate level of services to be provided.

Impacted Stakeholders:

Regional Impact of Eliminating Level I Services and Establishing Aggregate Provider Spending Limits			
Region	**Total Number of Providers**	**Number of Providers Impacted By Proposal**	**Impact of Proposal (millions $)**
NYC	97	83	-$265.6
Downstate Suburban	81	37	-$24.6
Upstate	358	97	-$20.1
TOTAL	536	217	-$310.3

Additional Technical Detail: (if needed, to evaluate proposal)
The overall average annual statewide spending after the implementation of the caps (and the savings of $310 million) would reduce average annual statewide spending per recipient to 2006 levels or to approximately $28,756.

System Implications:
The proposal will not require any changes to eMedNY system or modifications in billing procedures.

Metrics to Track Savings:
Paid Medicaid claims data for each 12-month period will be used to determine whether each provider was under or over its calculated spending limit. Combined totals for all providers will allow calculation of statewide savings.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

Attachment: Example of payment calculation

Example of Personal Care Provider Cap and Reconciliation				
	Base Period (2009) **Provider A**	**4/1/11-3/31/12 Spending Per Recipient Equal to the Cap** **Scenario 1**	**4/1/11-3/31/12 Spending Per Recipient Less than the Cap** **Scenario 2**	**4/1/11-3/31/12 Spending Per Recipient Exceeds the Cap** **Scenario 3**

PC Recipients	**100**	**100**	**100**	**100**
Total Hours Service	**228,000**	**227,942**	**190,826**	**250,000**
Hours Per Recipient	**2,280**	**2,279**	**1,908**	**2,500**
Current FFS Rate	**$16.95**	**$14.19**	**$14.19**	**$14.19**
Total Cost	**$3,864,500**	**$3,234,500**	**$2,707,800**	**$3,547,500**
Cost per recipient	**$38,645**	**$32,345**	**$27,078**	**$35,475**
Provider Cap	**$32,345**	**$32,345**	**$32,345**	**$32,345**
Percent Decrease in FFS	**-16.30%**			
New FFS Rate	**$14.19**			
RECONCILIATION:				
Reconciliation Payments		**$0**	**$526,700**	**($313,000)**
Total Final Costs		**$3,234,500**	**$3,234,500**	**$3,234,500**
Total Savings		**$630,000**	**$630,000**	**$630,000**
Final Adjusted Rate		**$14.19**	**$16.95**	**$12.94**

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 3

Proposal (Short Title):
HCRA Streamlining

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Other: Health Care Payers and Providers

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Imposes a uniform surcharge for both Medicaid and private payers; eliminates hospital based physician surcharge; provides additional State revenue and clarifies other administrative complexities.

The Health Care Reform Act (HCRA) imposes a surcharge at varying percentage rates on revenue received for inpatient and outpatient services of NYS general hospitals, and services of Diagnostic and Treatment Centers (DTCs) that provide comprehensive care or ambulatory surgical services. Additionally, certain payers are required to remit to the State "covered lives assessments" (CLAs) for each insured individual or family. These surcharges and CLAs, in combination with other HCRA receipts, generate over $5.0 billion annually. The monies generated are used to fund various state health care initiatives, including Medicaid expenses.

Federal law and regulations require provider taxes to be "broad based", meaning they must apply to all non-federal patient services revenue of all providers within a provider tax class (e.g. Inpatient hospital services). NYS does not comply with this requirement because we do not apply HCRA surcharges to all the inpatient and outpatient revenue of all hospitals. For example, HCRA surcharges do not apply to State Operated Psychiatric Hospitals. Federal law and regulations also require provider taxes to be "uniform", meaning the rate of taxation cannot vary among providers in a provider tax class (e.g. outpatient services). NYS does not comply with this requirement because HCRA surcharges are imposed at differential rates. The Medicaid surcharge is 7.04% while the private payor surcharge is 9.63%. Had the State not secured a NYS-only federal law that makes HCRA permissible (Pub. L 105-33 Section 4722(c)), often referred to as the "D'Amato Provision", it would have suffered a Medicaid disallowance equal to 50 percent of total HCRA receipts.

Under the "D'Amato Provision" HCRA is effectively grandfathered as long as the State does not change its structure. At this time, however, the State does wish to make changes to HCRA to deal with certain issues that have vexed payors, providers and the Department for some time. The way to do this without putting the system at risk is to make HCRA broad based and uniform, thus negating the need for the "D'Amato Provision. It is proposed that HCRA surcharge rates be flattened to a uniform 8.3% and applied to all inpatient and outpatient services revenue, including that of state operate psychiatric hospitals. Doing so will generate $25 million of additional HCRA revenue (an additional $223m of HCRA revenue as a result of increasing the Medicaid surcharge rate and applying it to previously untaxed revenue, offset by a decrease of $198m attributable to lowering the private payor surcharge rate**). Importantly, the $198m private payor windfall**

could be recovered by the State through an increase to private payor covered lives assessments, with $100 million benefiting the State Financial Plan and the rest potentially funding the NIF.

Other HCRA issues the Department seeks to address include the need to clarify: (1) whether it is providers or payors that should remit surcharges associated with copayments and deductibles and (2) what information payors should provide on their beneficiary cards.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-125.00	$-125.00	$-125.00	$-125.00
Total Savings	$-125.00	$-125.00	$-125.00	$-125.00

Benefits of Proposal:
HCRA revenue and federal funding would increase.

If HCRA is made broad based and uniform, the surcharge would be automatically permissible under federal law without having to pass a federal waiver test. The State would then be free to make rational policy decisions, and at the same time impose federally reimbursable surcharges on public and private psychiatric hospitals and clinics, thus increasing HCRA revenue.

The State would have flexibility to clarify current policies.

Concerns with Proposal:
Implementing a disincentive for payers that do not pay the surcharge directly to the State. This can be accomplished through attaching a "handling fee" or penalty to payment from payers who choose not to pay directly. This may be subject to federal scrutiny.

This proposal would be opposed by those providers not previously part of the HCRA.

Payers may have to make substantial system modifications.

In addition, the aggregate tax collections for each provider class cannot exceed 5.5% of the total patient revenues for the class (the percentage increases to 6% effective October 1, 2011). This limitation will not allow for the enactment of both this proposal and the proposal to increase the Health Facility Cash Assessment Rates.

Impacted Stakeholders:
Payers and Providers of health care services

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

System Implications:
Substantial system modifications may be required by the State to implement this proposal.

Metrics to Track Savings:
The Department's HCRA database maintains a payment history that easily allows for tracking revenues.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

MRT Proposal Number: 4

Proposal (Short Title): Eliminate 2011 Trend Factor (1.7%)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 04/01/2011
Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Eliminate the 1.7% 2011 trend (inflation) factor for Hospital Inpatient & Outpatient, Nursing Home, Home Care, & Personal Care Services as of 4/1/2011. Providers will receive a trend factor for 1/1/2011 – 3/31/2011.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-102.00	$-118.00	$-118.00	$-118.00
Total Savings	$-204.00	$-236.00	$-236.00	$-236.00

The savings by category of provider are as follows:

Gross ($'s in millions)		
	2011-12	**2012-13**
Hospital Acute & Ambulatory Care	($56.0)	($65.0)
Nursing Home	($95.0)	($109.0)
Home Care	($27.0)	($32.0)
Personal Care	($26.0)	($30.0)
Total Gross Savings	**($204.0)**	**($236.0)**
Total State Share Savings	**($102.0)**	**($118.0)**

Benefits of Proposal:

Eliminating the 2011 trend factor would produce significant General Fund savings and slow the growth of Medicaid.

Concerns with Proposal:
If this savings action is implemented, it will be the fourth consecutive year that these health care sectors have not received a trend increase.

Impacted Stakeholders:
This proposal will directly impact hospitals, nursing homes, home care and personal care services. Providers will be forced to implement efficiencies to reduce costs.

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

System Implications:
None.

Metrics to Track Savings:
Calculation of payment rates with and without inflation factor and across utilization of services.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

MRT Proposal Number: 4 Attachment 1

Proposal (Short Title): Eliminate 2011 Trend Factor (1.7%)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: All

Effective Date: 04/01/2011

Final Financial Impact (Dollars in Millions):

SFY Total	**2011-12**	**2012-13**
State Savings	$-102.00	$-118.00
Total Savings	$-204.00	$-236.00

Gross ($'s in millions)		
	2011-12	**2012-13**
Hospital Acute & Ambulatory Care	($56.0)	($65.0)
Nursing Home	($95.0)	($109.0)
Home Care	($27.0)	($32.0)
Personal Care	($26.0)	($30.0)
Total Gross Savings	**($204.0)**	**($236.0)**
Total State Share Savings	**($102.0)**	**($118.0)**

Hospital Acute and Ambulatory Care

State Savings	$ -27.70	$ -32.30
Total Savings	$ -55.40	$ -64.60

Nursing Homes

State Savings	$ -47.50	$ -54.70
Total Savings	$ -95.00	$-109.40

Personal Care

State Savings	$ -12.90	$ -15.00
Total Savings	$ -25.80	$ -30.00

Home Care

State Savings	$ -13.70	$ -16.00
Total Savings	$ -27.40	$ -32.00

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 5

Proposal (Short Title):
Reduce and Control Utilization of Certified Home Health Agency Services

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
This proposal will implement provider-specific aggregate annual per patient spending limits on CHHA (Certified Home Health Agencies) services that are at approximately the 2006 per recipient spending level.

Total CHHA Medicaid expenditures in 2009 were $1.3 billion. Approximately 90 percent or $1.2 billion of this spending is attributable to New York City. Utilization of CHHA services has increased dramatically since 2003, and this trend is particularly pronounced in New York City:

CHHA Spending Trends

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

Although CHHA services are authorized by a physician, the level of services provided is open-ended and is determined by the CHHA provider. The current Medicaid rate setting methodology established provider-specific, fee-for-service rates. The rates are based upon a rolling cost base which is updated annually (e.g., 2010 rates are based upon 2008 reported costs), and includes no incentive to control costs or achieve efficiencies. The rate methodology is not rationalized by patient acuity and there is no incentive to control the amount or level of services provided.

This proposal would contain escalating per recipient costs for CHHA patients by implementing provider-specific, aggregate annual per-patient spending limits for all agencies. This proposal uses elements of the work

done by the Department and outside consultants (ABT Associates) on the CHHA Episodic Pricing Model for the Home Care Work Group (see proposal #79).

The provider-specific spending limits would be informed by provider case mix and regional wage index factors to capture regional differences in labor costs. The limits would be calculated using a weighted combination of the provider-specific average total paid Medicaid claims per patient during a designated base period (e.g., 2009) and the statewide average for all CHHAs during the same period.

Savings would be achieved by reducing the payments made to providers. Payments would later be reconciled using actual paid claims and updated case mix. Providers that reduced their aggregate per patient spending levels below the limit would receive a payment and providers that did not adjust their spending levels would have their payments further reduced. Please see "Additional Technical Detail" for an example of how the provider limits would be calculated.

This proposal can be coupled with a longer term proposal to transition CHHA patients to Managed Long Term Care or to an alternative fee-for-service methodology (e.g., Episodic Pricing). The estimated savings shown below would also apply to the episodic system and are reflected here, rather than in the episodic proposal (#79).

A stakeholder group has suggested that an adjustment could be made to reward the most efficient providers and to areas of the State (i.e., upstate) where there are reported barriers to access services. However, to provide such adjustments while preserving savings would require a further adjustment to the provider limits.

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:

- Provides fiscal incentives for providers to take immediate action to control utilization.
- Costs per patient would be reduced to their 2006/2007 levels.
- Better alternative to achieve targeted savings than across-the-board savings that would impact efficient providers.
- The Department and providers can monitor and track performance against the cap.
- Limits are fair and equitable because they adjust for case mix and regional wage differences.
- The proposal is relatively easy to implement.

Concerns with Proposal:

- May provide agencies an incentive to "cherry pick" patients by serving only those with lower acuity and less intense needs. However, the case mix adjustment component of the limit should mitigate this incentive.
- This proposal does not currently include a pool of funds to reward providers that provide high quality service. The Department worked with the Home Care Episodic Pricing Work Group to develop quality measures.

Impacted Stakeholders:

Based on the most recent available Medicaid paid claims data for 2009 and a savings assumption of $200 million annually, this proposal would impact only 23 of 139 CHHAs. These 23 agencies billed a combined average of $33,421 per patient during calendar year 2009 or $17,851 more than the statewide average. The proposed spending limits would provide CHHAs with an incentive to control per-unit costs and to reduce excess utilization.

Fiscal Impact by Region	New York City	Other Downstate	Upstate	Total ($ millions)
Negative Impact ($ millions)	-$192.0	-$2.2	-$5.8	-$200.0
Negative Impact: # of providers	16	4	3	23
No Impact: # of providers	13	27	76	116
Total # of providers	29	31	79	139

Additional Technical Detail:
The level of savings can be targeted by adjusting the weights. The fiscal impact provided below assumes gross annual savings of approximately $200 million, which would require provider specific weights of 60% and a statewide weight of 40% (adjusted for case mix and regional labor cost index). Under these assumptions, the statewide average spending per recipient would be reduced to the 2006/07 level of $13,285.

The case mix adjustment will be based on a Medicaid grouper developed by the Department and presented to the Home Care Reform Work Group in February 2010. The grouper uses OASIS data (currently collected by all CHHAs for nearly all Medicaid patients) to evaluate clinical and functional characteristics of patients. Impacts are based on 2009 claims and the 2009 Case Mix Index for each provider.

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

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

System Implications:

The proposal will not require any changes to eMedNY system or modifications in billing procedures.

Metrics to Track Savings:
Paid Medicaid claims data for each 12-month period will be used to determine whether each provider was under or over its calculated spending limit. Combined totals for all providers will allow calculation of statewide savings.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 6

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Reduce the profit component included in the plan rates from 3% to 1.0% for the Medicaid and Family Health Plus managed care programs.

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

Final Financial Impact (Dollars in Millions):

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

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

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

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

MCOs and corresponding associations will oppose the proposal.

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

System Implications:
None

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

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 7

Proposal (Short Title):
Elimination of the Personal Care Benefit for Persons who are not NH Certifiable

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 07/01/2011
Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
This proposal eliminates the PC benefit for persons who are not NH eligible.

The Personal Care Services Program (PCSP) expends over $2 billion annually and provides services to approximately 74,000 individuals statewide. The PCS program, unlike HCBS Medicaid waivers, does not have a requirement that individuals must be NH eligible to access services through the program.
Analysis of a sample of individuals enrolled in the program in NYC indicates 23% of those individuals sampled would not meet the NH eligibility standard used by managed long term care (MLTC) plans for admission into that program. These individuals accounted for 11.8% of the PC costs for the cohort. Extrapolation of these findings indicate that approximately 18,000 individuals participating in the PCS program in NYC are not NH eligible.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	-$90.00	-$90.00	-$90.00	-$90.00
Total Savings	-$180.00	-$180.00	-$180.00	-$180.00

Benefits of Proposal:
A nursing home eligibility criterion that establishes a threshold for participation in the PCSP would align the program with other home and community based services and would provide consistency across programs.

Concerns with Proposal:

The PCSP provides services to aging and infirm individuals in the community and assists in maintaining a safe environment. It also slows the decline of an individual's health status thereby preventing or delaying admission to nursing homes or other institutional settings that are more expensive.

Impacted Stakeholders:
Current recipients of services who are not determined to be nursing home eligible; Personal Care Workers; home care providers; senior advocacy groups; disabled advocacy groups.

Additional Technical Detail: (if needed, to evaluate proposal)
Various assessment tools currently exist that are used to determine nursing home eligibility. A uniform tool to determine eligibility is planned for development. It is in the first stages of system development (Universal Assessment Tool). The MLTC programs will be converting to this tool as well as other community based programs.

System Implications:
Local districts or the State would need to develop systems to appropriately assess individuals for entry into the program.

Metrics to Track Savings:
Number of person receiving personal care statewide. Number of nursing home admissions.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 8

Proposal (Short Title):
Reduce Medicaid Managed Care, Family Health Plus and Child Health Plus trend factor (1.7%)

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Reduce the projected increase to Managed Care rates by 1.7% as of 4/1/2011, by reducing the trend factor by 1.7%.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-83.60	$ -85.5	$ -85.5	$ -85.5
Total Savings	$-167.20	$ -171.0	$ -171.0	$ -171.0

Benefits of Proposal:

Reducing the projected increase in Managed care rates will produce significant General Fund savings and slow the growth of Medicaid.

The 1.7% reduction is consistent with other areas of healthcare spending that are receiving the same trend reduction.

Concerns with Proposal:
It will be argued that premium rates are not increasing consistently with program expenditures.

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

MCOs and corresponding associations will oppose the proposal.

Additional Technical Detail: (if needed, to evaluate proposal)
Estimated savings includes Medicaid Managed Care, Family Health Plus, and Child Health Plus.

System Implications:
None.

Metrics to Track Savings:
No metric needed as the rates established by the Department will reflect the proposed 1.7% trend reduction.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 9

Proposal (Short Title):
Eliminate All Targeted Case Management for Managed Care Enrollees

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 01/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
This proposal will eliminate Medicaid coverage for Targeted Case Management Services for recipients that are in Medicaid Managed Care Plans.

Comprehensive Medicaid Case Management (CMCM), also known as Targeted Case Management (TCM) was authorized by Congress under the COBRA act of 1985. According to the Centers for Medicare and Medicaid Services definition, "Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services. 'Targeted' case management services are those aimed specifically at special groups of enrollees such as those with developmental disabilities or chronic mental illness." New York State currently has 12 separate TCM programs. Federal and State Medicaid policy and regulations do not permit recipients to receive TCM services in more than one TCM program for the same time period. Therefore, Medicaid restricts recipients receiving TCM services to one TCM provider at any given time. Managed care recipients who qualify for TCM are presently permitted to receive both TCM services as well as have their care managed and coordinated by their managed care plan. This may result in duplicative case management services. If this proposal is adopted, managed care enrollees would be prohibited from receiving TCM services since coordination and referral to medically necessary services will be provided by the managed care plan.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-40.50	$-40.50	$-40.50	$-40.50
Total Savings	$-81.00	$-81.00	$-81.00	$-81.00

Benefits of Proposal:

Duplication of case management services will be avoided, resulting in better patient care.

Concerns with Proposal:
Managed care plans generally focus on assisting enrollees with managing their medical services and needs. Targeted case management has a broader scope, encompassing additional enrollee needs including social, educational, and housing issues. Managed care plans will need to take on the additional role of providing case management support for these non-medical services.

Impacted Stakeholders:
Managed care plans and enrollees who are presently in Targeted Case Management and are also receiving care through a Medicaid managed care plan.

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

System Implications:
Minimal eMedNY systems work will be required.

Metrics to Track Savings:

Contact Information:

Organization: DFPP
Staff Person: Greg Allen
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Viability: Short term

Modified Delphi Scoreable: Yes
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 10

Proposal (Short Title):
Eliminate Direct Marketing of Medicaid Recipients and Facilitated Enrollment activities by Medicaid Managed Care Plans.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

Proposal Description:
Eliminate funding included in Medicaid and FHPlus premiums for direct marketing of Medicaid recipients and facilitated enrollment activities for Managed Care in all counties.

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

The facilitated enrollment program provides application assistance for government-sponsored health insurance programs to adults and families throughout New York State. Facilitators are located in community based sites frequented by the target population and are available at days and times convenient for families including evening and weekend hours. Facilitators are culturally and linguistically representative of the population being served. The total number of complete applications submitted by Health Plan Facilitated Enrollers in the past year was 325,283. However, it is unknown how many resulted in eligibility. Many local districts currently heavily rely on the services of facilitated enrollers (FE) for applications. In some counties approximately 90% of applications are submitted by FEs.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-56.80	$-61.50	$-61.50	$-61.50
Total Savings	$-113.60	$-123.00	$-123.00	$-123.00

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

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

Concerns with Proposal:
It will be argued that marketing activities are needed to maintain the enrollment base due to churning and recertification. Also, advocates may want marketing to continue in order to educate consumers on their options for enrollment. The elimination of facilitated enrollment will affect the ability to impact the uninsured since they submit half of all applications to the local district. Local districts rely heavily on FEs to identify and educate the potential eligible population. With the elimination of FE activities in all counties, the delays in eligibility determinations may be worse, which could possibly generate more lawsuits.

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

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

System Implications:
None

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

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 11

Proposal (Short Title):
Bundle Pharmacy into MMC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

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

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

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

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
With passage of the Affordable Care Act, Federal rebates for prescription claims paid for by Managed Care Plans are equal to the Federal rebates available to the Medicaid fee-for-service (FFS) program. Additionally, Managed Care Plans use Pharmacy Benefit Managers (PBMS) that employ utilization management tools that steer volume to the lowest cost clinically effective product. Management of the prescription drug benefit by the

managed care plans will also enable access to pharmacy data which can improve their ability to manage patient care.

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

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

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

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

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

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

Contact Information:

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

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 12

Proposal (Short Title):
Reduce/Redirect Indirect Medical Education (IME) Payments

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Reduce IME teaching factor from 4.2% to 3.0%, bringing it closer to empirical value of 1.2%, & providing fiscal plan relief while redirecting funds to health home (18M 11/12, 80M 12/13, 108M 13/14).

Hospitals that have residents in an approved Graduate Medical Education (GME) program receive additional payments for both Fee-For-Service (FFS) and Medicaid Managed Care (MMC) to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals. There are two components to Graduate Medical Education costs: Direct Medical Education (DME) and Indirect Medical Education (IME). Each component has been updated as part of the Hospital Inpatient Reimbursement Rate Reform as of 12/1/09:

1. Direct Medical Education covers the salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians.

2. Indirect Medical Education is less tangible and intended to measure the unique costs of teaching hospitals, specifically longer treatment times, increased testing associated with training residents, more severely ill patients within a particular DRG, additional costs associated with maintaining trauma, emergency and specialized services and research associated with clinical care and treatment.

IME costs are predicted using an IME teaching adjustment factor which is determined by conducting a New York State specific regression analysis that measures the relationship between resident training (residents per bed) and operating costs. Currently, the IME teaching adjustment factor is stated at 4.2 percent. This represents an increase in operating costs of 4.2 percent for every 10 percent increase in the resident-to-bed ratio. Current IME payments total over $750 million between FFS and MMC discharges.

As part of the Hospital Inpatient Reimbursement Rate Reform effective 12/1/09 the State re-examined the regression analysis using more up-to-date operating costs, resident & bed statistics, and the newly implemented severity DRGs (APR-DRGs). The result of the regression analysis proved that the 4.2 percent was overstated, but it was agreed with the Legislature and the hospital industry to leave the 4.2 percent intact during the 2009/10 Final Budget in order to protect teaching hospitals. The "true" value of the teaching

adjustment factor was determined to be 1.2 percent.

As part of this proposal the IME teaching adjustment factor will be phased down from 4.2 percent to generate Financial Plan savings and establish funds to invest in Health Home services for Medicaid enrollees with chronic conditions. A reduction in the teaching adjustment factor does not reduce hospital costs for IME; it reduces the current payments that have been assigned to those IME costs. The following chart provides the multi-year phase-down and reinvestment of IME funds:

	Gross Dollars (in Millions)		
	2011-12	**2012-13**	**2013-14**
Current Hospital IME Funding *(4.2% Teaching Factor)*	$750.0	$750.0	$750.0
Financial Plan Savings	($100.0)	($100.0)	($100.0)
Health Home Investment from IME	($18.9)	($79.6)	($108.0)
Remaining IME Funding	$631.1	$570.4	$542.0
Resulting IME Funding Reduction	*($118.9)*	*($179.6)*	*($208.0)*
Revised Teaching Adjustment Factor	**3.5%**	**3.2%**	**3.0%**

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
This proposal seeks more direct and accountable subsidization of hospital care services. It is intended to better align Medicaid spending to patient care cost.

In addition, this proposal generates immediate financial plan savings and creates a pool of funds to fund the State's health home initiative that is expected to generate overall system savings.

Concerns with Proposal:
Teaching hospitals will argue that these monies are indeed being used for GME related expenses which, if diverted, would impede their ability to continue such teaching programs.

Impacted Stakeholders:

Teaching hospitals and their affiliated academic programs. Since a majority of the teaching hospitals reside in New York City, this proposal will disproportionately imapct that region.

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

System Implications:
None.

Metrics to Track Savings:
Not applicable.

Contact Information:

Organization:	Division of Health Care Financing
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Viability: S

True

Modified Delphi Scoreable:

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 14

Proposal (Short Title):
Restructure Reimbursement for Proprietary Nursing Homes

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011
Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

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

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

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

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

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

Final Financial Impact (Dollars in Millions):

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

Total Savings	$-87.00	$-87.00	$-87.00	$-87.00

Benefits of Proposal:

● Eliminating the return on equity eliminates a State payment for which there is no reported costs.

● Provides for an approach to reimbursing capital costs that is consistent across sponsorship by eliminating a benefit in the methodology that is now available to only proprietary facilities.

Concerns with Proposal:

● Not all proprietary facilities are reimbursed for mortgage amortization and interest (i.e., the terms of the mortgage were not approved by the Department and costs are not reimbursed). Eliminating return of and return on equity for these homes would limit reimbursement to capital costs related to only moveable equipment.

● Removes the incentive for proprietary facilities (many of whom are low cost providers) to make investments in the facility. This could be a concern going forward as many facilities are in need of repair or replacement and will discourage proprietary facilities from making such investments.

● This proposal conflicts with legislation enacted in 2009 to authorize the recalculation of the capital rate for proprietary facilities that are at the end of their useful life (i.e., they are and being paid residual reimbursement) and that make capital investments that protect and maintain the health and safety of patients or make capital improvements or renovations to an existing facility for the purpose of converting beds to alternative care uses. The State Plan Amendment to implement this law has recently been approved by CMS.

Impacted Stakeholders:

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

NYPHRM Region	# of Proprietary Facilities Impacted	Impact of Eliminating Return of and On Equity and Residual Reimbursement (Savings in Millions $)
Central	17	(3.2)
Long Island	44	(23.2)
New York City	62	(25.5)
Northeastern	18	(4.0)
Northern Metropolitan	42	(17.6)
Rochester	23	(2.9)
Utica	15	(2.3)
Western	28	(7.6)
Total	**249**	**($86.7)**

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

N/A

System Implications:

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

Metrics to Track Savings:

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

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 15

Proposal (Short Title):
Rebuild NY Preferred Drug List

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

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

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

This proposal would change the PDL process as follows:

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

- Designated State staff will chair the P&TC.

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

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

- The "Prescriber Prevails" provision will be eliminated.

The savings for this proposal are "standalone" and independent of the savings projected for Proposal #11 - "Bundle Pharmacy into Managed Care." Preliminary savings are based on an increase in generic dispensing rate from 65% to 70%. Final savings will be calculated based on a class by class review, comparing New York's PDL to Wisconsin's PDL.

Preliminary Financial Impact (Dollars in Millions):

2011-12	Minimum	Average	Maximum
State Savings	$-25.00	$-37.50	$-50.00
Total Savings	$-50.00	$-75.00	$-100.00

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

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

Impacted Stakeholders:
Prescribers, Pharmacies, Recipients, Manufacturers

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

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

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

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 16

Proposal (Short Title):
Implement Pricing Reimbursement Methodology for NHs

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 07/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Implement a Statewide pricing methodology for nursing homes that is adjusted for differences in labor costs and case mix and includes a multi-year transition pools to smooth impacts.

Effective July 1, 2011, current law provides broad authorization to implement a regional pricing methodology for nursing homes. Effective July 1, 2011, this proposal would implement a similar pricing methodology, that uses 2007 costs as a base year and establishes a Statewide price (rather than a regional price as now required under the current law) for the operating component (non-capital) of the nursing home rate. The pricing methodology would include the following elements:

● Statewide price adjusted for facility specific case mix and labor costs
- ✓ Medicaid only case mix adjustments (required under current law) would continue to be made using the 53 RUG-III patient classification system
- ✓ A Wage Equalization Factor (WEF) would adjust for facility specific differences in salaries and benefits and would be similar to the WEF used in the hospital pricing methodology

● Facility-specific price for non-comparable costs (i.e., include costs related to medical director's office, laboratory services, radiology, dental services, hearing therapy, and utilities).

● Specialty facilities (pediatric, ventilator, traumatic brain injury, AIDS, neurobehavioral) will remain on their January 1, 2009 rate.

● Set a price that achieves annual Financial Plan savings of $100 million gross annually.

● A four-year transition pool would be used to smooth the impacts to providers as the system moves to a statewide price. The transition pool will gradually increase rates for homes whose current rate (i.e., January 1, 2009 rate in effect today and not rebasing rates) is below the price and will gradually decrease rates for homes whose current rate is above the price.
See attachment below for a table that shows how the transition pool would be implemented.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-37.50	$-50.00	$-50.00	$-50.00
Total Savings	$-75.00	$-100.00	$-100.00	$-100.00

Benefits of Proposal:

● Provides rate stability and predictability for nursing home industry.
● Transition pool provides mechanism to mitigate significant swings on facility rates on a year-to-year basis.
● Replaces the current overly complex and administratively burdensome methodology with a transparent pricing methodology that will eliminate burdensome appeals and reduce litigation risk.
● Generates immediate Financial Plan savings - the $100 million price reduction is about 1.5 percent of total Medicaid spending.
● Pricing methodology establishes a fair price that creates incentives to achieve efficiencies and mitigate unexplained variations in rates.

Concerns with Proposal:

● There are 326 facilities whose rates now exceed the Statewide price that would be negatively impacted by the proposal. However, a transition pool will phase in these rate reductions over four years to give these facilities time to adjust business practices to achieve efficiencies.
● The current proposal does not include funds for a quality pool. However, the Department does have measures that were developed in conjunction with input from the Nursing Home Work Group. These measures include staffing, MDS quality measures, and survey scores.

Impacted Stakeholders:

See attached table below

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

N/A

System Implications:

The proposal, already enacted in law, would require minimal computer programming to implement.

Metrics to Track Savings:

Current spending levels (calculated using current rates) will be reduced by $100 million and that level of spending will be used to calculate Statewide price and transition pool.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

Attachments:

Four Year Transition to Statewide Price (Impacts Compared to Current January 1, 2009 Rate Paid Today)				
$ Millions	**Year 1***	**Year 2**	**Year 3**	**Year 4**
# Facilities Above Statewide Price -$314M Impact				
Transition Pool	$214	$144	$70	$0
Rate Impact	-$100	-$170	-$244	-$314
# Facilities Below Statewide Price +$214M Impact				
Transition Pool	$0	$70	$74	$70
Rate Impact	$0	$70	$144	$214
Financial Plan Savings (Sum of Rate Impacts)	-$100M*	-$100	-$100	-$100
*Year 1 assumes full year impact - Impacts would be reduced by 25% to reflect July 1, 2011 effective date				

Stakeholder Impacts:

Impact on Nursing Homes Year 1 of Four Year Transition to Statewide Price (Compared to Current Rate Paid Today)			
Region	**# Facilities Below Statewide Price (No Impact Year 1)**	**# Facilities Above Statewide Price**	**Impact on Facilities Above Statewide Price ($ Millions)**
Central	30	19	-$3.6
Long Island	26	51	-$14.7
New York City	49	120	-$56.2
Northeastern	41	14	-$2.4
Northern Metropolitan	43	47	-$9.7
Rochester	25	26	-$4.9
Utica	34	22	-$2.9
Western	51	27	-$5.6
Total	**299**	**326**	**-$100.0**

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 17

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-30.19	$-30.19	$-30.19	$-30.19
Total Savings	$-60.38	$-60.38	$-60.38	$-60.38

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

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

Impacted Stakeholders:

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

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

System Implications:
Minor

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

Contact Information:

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

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 18

Proposal (Short Title):
Eliminate spousal refusal.

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Eligibility

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

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

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

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

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

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

Final Financial Impact (Dollars in Millions):

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

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

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

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

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

System Implications:
None

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

Contact Information:

Organization: Division of Coverage and Enrollment
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Viability: S

Comments:

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 19

Proposal (Short Title):
Eliminate D&TC Bad Debt and Charity Care

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Eliminating the Diagnostic and Treatment Center (D&TC) indigent care pool and the Health Care Reform Act (HCRA) funds will produce additional HCRA revenue which can be redirected to other purposes.

Section 2807-p and 2807-l of the Public Health Law provides $54.4 million to be distributed to eligible voluntary, non-profit and publicly sponsored diagnostic and treatment centers (D&TCs).

To be eligible, the facility must provide a comprehensive range of primary health care services; must have provided services to uninsured individuals to account for at least 5% of the total base year threshold visits; must be able to demonstrate that it has made reasonable efforts to maintain financial support from community and public funding sources; must be able to collect payments from third party insurance payers, governmental payers and self-paying patients; and must receive an all-inclusive cost based Medicaid rate in accordance with the Commissioner of Health's Administrative Rules and Regulations Part 86-4.11.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-54.40	$-54.40	$-54.40	$-54.40
Total Savings	$-54.40	$-54.40	$-54.40	$-54.40

Benefits of Proposal:
Eliminating D&TC Indigent Care funds will produce additional HCRA revenue which can be redirected to other purposes as well as reduce administrative work by eliminating the need to calculate and process an annual Indigent Care distribution.

Concerns with Proposal:

Elimination of Indigent Care may cause eligible D&TCs to reduce services to the uninsured or to be closed thereby forcing patients to higher cost venues such as hospital emergency rooms for their care.

Currently a Budget Proposal is contained in the extension of the 1115 Managed care waiver to request federal participation in funding this pool. This along with the state dollars would have increased funds available to approximately $110 million annually. The additional funding would go to support uncompensated care for free-standing article 31 clinics to replace funds currently provided as deficit financing Comprehensive Outpatient Program Services (COPS) as well as provide additional coverage to Article 28 D&TCs for uncompensated care. This COPS funding has been questioned if appropriate and justifiable, so is being eliminated and this funding will take its place for these clinics.

Impacted Stakeholders:
Voluntary not-for-profit Comprehensive Primary Care D&TCs.

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

System Implications:
None.

Metrics to Track Savings:

Contact Information:

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Viability: L

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 22

Proposal (Short Title):
Establish New Ambulette Dialysis Transportation Fee

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Transportation

Effective Date: 01/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

Proposal Description:
Reduce the reimbursement for ambulette transportation for dialysis treatment to the fee level currently paid for ambulette transportation for Adult Day Health Care programs (ADHC).

The Medicaid Program currently reimburses for dialysis ambulette trips at the same level as individual ambulette medical trips. However, because dialysis trips are predictable, regularly recurring, and can accommodate a group of riders, Medicaid is paying a higher fee than necessary.

An ambulette transportation provider can route dialysis trips efficiently because the trips are for the same individuals at the same time, on the same three days a week, over many months. These factors make the trips similar to the ambulette trips currently provided to ADHC programs, which are reimbursed statewide at a lower fee than that paid for individual ambulette medical transportation including dialysis.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-18.00	$-18.00	$-18.00	$-18.00
Total Savings	$-36.00	$-36.00	$-36.00	$-36.00

Benefits of Proposal:
Ambulette transportation services for dialysis will be reimbursed at a more appropriate and reduced cost, resulting in ongoing savings to the Medicaid Program. Also, this initiative can be implemented quickly through administrative action.

Concerns with Proposal:
Ambulette transportation providers will claim that if their profit is reduced it will adversely impact the quality of transportation, and eliminate longer distance dialysis trips from the group of trips the ambulette provider is willing to deliver (the proposed reduction represents a 14.1% decrease in all ambulette transportation fee-for-service Medicaid reimbursement). However, the Department of

Health believes that there is an adequate number of ambulette providers that will continue to provide dialysis transportation at the reduced fee level, as there is for ADHC transportation services.

Impacted Stakeholders:
Medicaid ambulette transportation providers.

Additional Technical Detail: (if needed, to evaluate proposal)
The Department of Health can provide analysis of the impact of this proposal for the ambulette industry revenue in each county.

System Implications:
Upon approval, the procedure code file will be updated with new fees. This will require only one day to implement.

Metrics to Track Savings:
Data Warehouse query.

Contact Information:

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Viability: S

Modified Delphi Scoreable:
True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 23

Proposal (Short Title):
Coverage for Dental Prosthetic Appliances

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Eliminate or limit coverage of dentures for adults.

All dental services for adults are an optional benefit currently provided by New York State Medicaid. Preventative care must be the cornerstone of an optional Dental benefits program. The most recent Kaiser Commission Medicaid Benefits comparative data published in 2008 shows that at that time only 29 states covered dentures for the full adult population. Since that time, some of those states have eliminated all dental optional benefits including dentures for adults. This proposal would eliminate coverage for all adult dentures resulting in an annual state share savings of $19.3M. An alternative would limit coverage of replacement dentures resulting in $7.5 M annual state share.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-16.10	$-19.30	$-19.30	$-19.30
Total Savings	$-32.20	$-38.60	$-38.60	$-38.60

Benefits of Proposal:
The proposal preserves and encourages restorative and preventative adult dental services. It also more closely aligns NY with the standard adult dental benefit package of other State Medicaid programs. With elimination of the prosthetic appliance benefit, no dentures would be covered by Medicaid except in rare cases when the denture is a component of an implanted facial prosthesis (e.g. as a result of a severe injury, trauma or cancer surgery). The alternative limited benefit would cover full dentures every 10 years and partial dentures every 8 years, allowing repairs. This would encourage responsible maintenance and appropriate, quality fitting dentures.

Concerns with Proposal:
Poor oral hygiene persists in the Medicaid population, over time resulting in the need for dentures to replace teeth which are no longer viable. Without dentures, patients may face challenges in obtaining adequate nutrition and employment. In addition, the limited coverage proposal does not address lost or unrepairable dentures.

Impacted Stakeholders:
Dentist and clinics providing dentures would be negatively impacted economically. Beneficiaries may not have the funds to obtain dentures on a private pay basis in cases when their teeth are no longer viable or to replace lost or broken dentures.

Additional Technical Detail: (if needed, to evaluate proposal)
First year savings are impacted by the need to make minor system changes, notify providers and beneficiaries of benefit change and provide time for completion of denture services that are in process on 4/1/2011, resulting in 2 months lost savings.
The fiscal impact describes elimination of the benefit. Limiting the replacement as described would result in a lower fiscal impact: $6.25 million State and $12.5 million federal for FY 2011-12 and $7.5 million State and $15 million federal thereafter.

System Implications:
Changes can be made to the payment and prior approval processes to prevent payment under new coverage criteria, but would take several months to completely implement.

Metrics to Track Savings:
The Data Warehouse will be used to track utilization trends by procedure code and service category.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 25

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

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

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

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

Final Financial Impact (Dollars in Millions):

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

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

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

Impacted Stakeholders:
Hospital outpatient providers of service.

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

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

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

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 26

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

Theme: Eliminate Fraud and Abuse

Program Area: Behavioral Health

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Under this proposal, each mental hygiene agency would establish two threshold levels based on the number of clinic visits a given patient receives during a 12 months period.

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-13.30	$-13.30	$-13.30	$-13.30
Total Savings	$-26.60	$-26.60	$-26.60	$-26.60

Benefits of Proposal:
It will help to control overutilization.

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

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

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

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

Metrics to Track Savings:
eMedNY data queries

Contact Information:

Organization: Division of Financial Planning and Policy
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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 32

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

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

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

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

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-6.40	$-17.10	$-17.10	$-17.10
Total Savings	$-12.80	$-34.20	$-34.20	$-34.20

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

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

Impacted Stakeholders:
Prescribers, Recipients and Pharmacies

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

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

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

Contact Information:

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Staff Person: Greg Allen
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Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 35

Proposal (Short Title):
Prescription Limitation to 5/month

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 12/01/2011

Implementation Complexity: High
Implementation Timeline: Long Term

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

Proposal Description:
Limit the number of brand name prescriptions that a beneficiary could receive to five (5) per month.

Currently, the Medicaid Pharmacy Program covers medically necessary FDA approved drugs. Prescription drugs require a prescription order. Covered over-the-counter (OTC) drugs require a fiscal order (which contains the same information required a prescription order). While certain drugs require prescribers to obtain prior authorization and some drugs have frequency, quantity and duration limits, all Medicaid covered drugs are available without limitations on the number of prescriptions filled per month.

A number of states including California, Kansas, Maine, Mississippi, Texas, and Wisconsin limit the number of prescriptions allowed on a monthly basis. This proposal would limit the number of brand medications that a beneficiary could receive to five (5) per month. Certain populations would be exempt from this limit (i.e. nursing home residents), and an exception process would be required which would allow for an override (in certain circumstances) of this limit.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-4.70	$-14.30	$-14.30	$-14.30
Total Savings	$-9.40	$-28.60	$-28.60	$-28.60

Benefits of Proposal:
Generic drugs are substantially less expensive than brand name drugs and this proposal is designed to encourage physicians and patients to use cost effective generic drugs when they are clinically appropriate. The majority of beneficiaries uses four brand name drugs or less in a month and would not be affected by this proposal. Less than 4% of beneficiaries utilize five or more brand name prescriptions in a month.

Concerns with Proposal:
Advocacy groups for patients with chronic illness, such as diabetes, HIV/AIDS, and organ transplant recipients would oppose prescription limits, asserting that prescription limits may result in beneficiaries not obtaining necessary treatment, or deciding not to fill prescriptions to stay within the prescription limit.
Prescribers may oppose because it creates a burden to review all Medicaid beneficiary drug regimens and find alternative generic medications. Physicians that treat beneficiaries with multiple disease states may also oppose additional administrative tasks required to obtain overrides or authorizations for beneficiaries who appropriately exceed the five brand prescription limit.

Impacted Stakeholders:
Prescribers and beneficiaries with chronic or multiple disease states

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

System Implications:
Point of sale pharmacy claim editing would need to be developed to deny brand prescription drug claims that exceed the five prescriptions per thirty day limit. A system authorization and override process would also need to be developed for extenuating circumstances where it has been determined that additional brand drugs (over the five prescription limit) are medically necessary.

Metrics to Track Savings:
Savings would be evaluated by comparing generic dispensing rate and brand drug spend pre and post implementation of a system edit that would deny brand drug claims that exceed five prescriptions in a thirty day period.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 43

Date Submitted:01/28/2011

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 10/01/2011

Implementation Complexity: Low
Implementation Timeline: Short Term

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

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

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

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-2.80	$-7.50	$-7.50	$-7.50
Total Savings	$-2.80	$-7.50	$-7.50	$-7.50

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

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

Impacted Stakeholders:

Beneficiaries, Part D plans, Pharmacies

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

System Implications:

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

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Viability: S

Comments:

Modified Delphi Scoreable: True

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 57

Date Submitted:02/03/2011

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Pharmacy

Effective Date: 12/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

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

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.20	$-0.60	$-0.60	$-0.60
Total Savings	$-0.40	$-1.20	$-1.20	$-1.20

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

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

Impacted Stakeholders:
Prescribers, pharmacies and beneficiaries

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

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

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

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 61

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

Proposal Description:
This proposal will require as a condition of provider enrollment in the Medicaid program that all CHHAs, LTHHCPs, and MLTC comply with any local living wage law within a geographic area in which they serve Medicaid recipients.

Final Financial Impact (Dollars in Millions):

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

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

Concerns with Proposal:
This proposal will increase costs for home care providers and due to the current cost based reimbursement system this will increase the cost of Medicaid. This proposal may have a ripple effect to other providers as CHHAs, LTHHCPs and MLTCs may be sponsored by hospitals, nursing homes or other entities.

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

Additional Technical Detail: (if needed, to evaluate proposal)
Determine the number of local governments that have living wage requirements

System Implications:

Metrics to Track Savings:

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 66

Proposal (Short Title):
Revise Indigent Care Pool Distributions to align with Federal Reform

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
Revise Indigent Care methodology for voluntary hospitals to be based on 100% Medicaid and uninsured losses (consistent with federal reform) and reduce pool by $140M (gross). Options for a rural and high-Medicaid safety net hospital allocation, and a phase-in\transition allocation, are under consideration.

Presently, New York State provides $3.2B in disproportionate share hospital (DSH) funding, of which $2.4B is paid to public hospitals ($1.4B to HHC). Of the $3.2B in funding, approximately$900M does not comport with the recently enacted federal DSH payment legislation. Almost all of this amount results from the numerous allocations (10 in total) contained within the Indigent Care Pool, most of which use bad debt and charity care as a basis for the allocation. The objective of this proposal is to conform to federal legislation and to simplify the allocation methodology.

Federal health reform legislation includes provisions which will progressively reduce federal DSH funding to states by $1.5 billion nationally, beginning in federal fiscal year (FFY) 13-14. States which continue to allocate DSH payments using methodologies that are not based on uninsured and/or Medicaid losses will experience the greatest reductions in federal DSH spending. Since a substantial portion of New York's Indigent Care Pool is currently allocated using methodologies which are inconsistent with the federal requirements (i.e. bad debts), alternate DSH allocation methodologies are being considered in order to minimize or avoid these pending federal DSH spending reductions.

One option under consideration which would bring New York into full compliance with federal DSH funding principles is to allocate Indigent Care Pool resources for voluntary hospitals based entirely on Medicaid and uninsured losses. These losses would be determined based on information reported by hospitals to the Department pursuant to Section 2 of Part B of the SFY 11-12 Article VII Executive Budget. Under this Medicaid and uninsured losses methodology, voluntary hospitals will receive an allocation from the Indigent Care Pool based on their relative share of Medicaid and uninsured losses for all voluntary hospitals. Major public hospitals will be exempt from the proposed methodology change.

This shift to a full 100% Medicaid and uninsured losses allocation methodology will be combined with an additional $140 million indigent care pool reduction. This reduction will be comprised of aggregate allocation

reductions of $25M to major public hospitals and $115M to voluntary hospitals. The reduction to the Indigent Care Pool will result in increased available DSH payment room that will be used to make additional DSH IGT payments, which are based on a methodology consistent with federal reform, to public hospitals.

The Department is discussing with other stakeholders an approach to set aside a certain amount to provide an allocation to rural and high-Medicaid hospitals, as these hospitals serve as the "safety net" providers for the medically indigent in their respective communities.

The Department recognizes that the proposed change in allocation methodology may lead to redistributions in DSH funding on a regional and facility-specific basis, which could potentially impact service delivery. Accordingly, a transition or phase-in approach is being considered that will mitigate swings in levels of reimbursement.

An alternative allocation approach would involve using uninsured units of services, priced at the Medicaid rate, as a means for distributing Indigent Care Pool dollars. This approach also has merit since it is consistent with federal DSH reform and is based on a price and not cost, however it does not provide for funding for those hospitals serving high levels of Medicaid patients.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-70.00	$-70.00	$-70.00	$-70.00
Total Savings	$-140.00	$-140.00	$-140.00	$-140.00

Benefits of Proposal:

- Creates financial incentive to serve uninsured.
- Generates financial plan savings by reducing annual state-share DSH spending.
- Switching to a full 100% Medicaid and uninsured losses allocation methodology brings NYS into full compliance with federal reform principles.
- Maximizes the State's federal DSH allotment.
- The State is required to use this methodology to determine the hospital-specific DSH caps; therefore there will be no reductions to voluntary hospitals as a result of the DSH caps.
- Provides greater transparency.

Concerns with Proposal:

- There will be major redistributive funding impacts among hospitals which could affect service delivery at individual hospitals. However, a phase in/transition payment could be considered to deal with this aspect.
- May adversely impact safety net (rural and high-Medicaid) hospitals, however a special allocation is under consideration.
- Underinsured (i.e. insured, but with minimal coverage or high co-pays and deductibles) will no longer be recognized in the allocation methodology.
- The $140M reduction in Indigent Care Pool DSH funding will accrue primarily as a benefit to HHC under current statute, mitigating any impact the reduction will have on its hospitals. However, these payments (which are DSH IGT payments) will require a federal\local match, which will impact New York City’s budget.
- Eliminates the $126K annual rural subsidy.

Impacted Stakeholders: All hospitals

Additional Technical Detail: (if needed, to evaluate proposal)
The data which is needed to properly determine the allocations for 2011 will not be available until April 2011, and will be subsequently revised based on new data submitted in October 2011.

System Implications: No implications for eMedNY.

Metrics to Track Savings: Reduced monthly pool distributions

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 67

Date Submitted:01/28/2011

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

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

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

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

(2) Use HEAL capital funds.

(3) Explore use of other capital/debt assistance

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

(5) Allow for DOH to appoint temporary operators of facilities. This will allow arrangements whereby a

management team is assigned to a provider in an effort to develop an evolution plan, which may involve downsizing the existing facility, merger with another provider, or outright conversion from one provider type (hospital) to another (D&TC; free standing ED/urgicenter; primary care center).

(6) Direct workforce retraining funds to assist restructuring.

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

Preliminary Financial Impact (Dollars in Millions):

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

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
This proposal would provide support to providers while creating incentives for cost efficiencies and improved quality. It will also provide an orderly redesign of healthcare services in communities with struggling essential providers. This will allow them to make needed changes and in some cases close in an orderly fashion versus due to bankruptcy.

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

Impacted Stakeholders:
Hospitals and communities served.

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

System Implications:

There should be no system implications for this proposal.

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

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 69

Proposal (Short Title):
Uniform Assessment Tool (UAT) for LTC

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2011
Implementation Complexity: High
Implementation Timeline: Short Term

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

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

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

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

The design of the current project allows alignments with future connections between acute care and long term care referrals such as nursing home and home care placements, the Health Information Exchange (HIE) infrastructure and other State Agency programs. Additional funding and time are needed to expand the current project to implement those efforts such as service planning and program determination.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.00	$0.00	$-5.00	$ -10.00

Total Savings	$0.00	$0.00	$-10.00	$ -20.00

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

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

Impacted Stakeholders:
HCBS providers, consumers, MLTC plans.

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

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

This is an investment in infrastructure in the short term.

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

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

Modified Delphi Scoreable: True
Modified Delphi Score:

Proposal Number: 70

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

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Ambulatory Care

Effective Date: 01/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

Proposal Description:
Expand the current Statewide Patient Centered Medical Home Program (PCMH) to more payers and broader patient participation.

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

Medical home is a model of care where each patient has an ongoing relationship with a personal physician, nurse practitioner, or clinic. Medical homes organize care around patients, working in teams and coordinating and tracking care over time to assure that patients receive appropriate care when and where it is needed. Medical homes use open scheduling, expanded hours and communication between patients, providers, and

staff to improve care. Care is also managed through use of registries, information technology, health information exchange, and other means to assure patients obtain proper care.

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

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

The fiscal does not the Child Health Plus impact; that is still under review.

Final Financial Impact (Dollars in Millions):

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

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

Concerns with Proposal:
There are challenges with expanding medical homes. The number of primary care practitioners is decreasing and financial incentives may be needed to encourage health care practitioners to become primary care practitioners. The use of health care technology and information exchange can be expensive and difficult to implement, especially within smaller practices. Improvements in patient outcomes and cost savings can be

difficult to measure and often happen gradually over time while the cost of providing care is immediate which presents challenges in developing financing models.

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

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

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

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

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 79

Proposal (Short Title):
Implement Episodic Pricing for Certified Home Health Agencies

Theme: Recalibrate Medicaid Benefits and Reimbursement Rates

Program Area: Long Term Care

Effective Date: 04/01/2012

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
Implement a CHHA Episodic Pricing methodology (which is similar to the Medicare Pricing model) and is based upon 60-day episodes of care and adjusts for case mix and labor costs. Independent physician assessments for initial and subsequent episodes of care would be required.

Total CHHA Medicaid expenditures in 2009 were $1.3 billion. Approximately 90 percent or $1.2 billion of this spending is attributable to New York City. Utilization of CHHA services has increased dramatically since 2003, and this trend is particularly pronounced in New York City, where spending per recipient increased from $11,867 in 2003 to $23,253 in 2009 - a 96% increase per patient.

Although CHHA services are authorized by a physician, the level of services provided is open-ended and is determined by the CHHA provider. The current Medicaid rate-setting methodology establishes provider-specific, fee-for-service rates. The rates are based upon a rolling cost base which is updated annually (e.g., 2010 rates are based upon 2008 reported costs), and includes no incentive to control costs or achieve efficiencies. The rate methodology is not rationalized by patient acuity and there is no incentive to control the amount or level of services provided.

Effective April 1, 2012, this proposal would replace the current reimbursement system of paying by the hour or by the visit with payments for each 60-day episode of care. A statewide base price would be established, based on paid Medicaid claims data during a specified base period, and this price would be adjusted for case mix and differences in regional labor costs (see attachment below). CHHA patients under the age of 18 and low utilization claims (under $500/less than 25 hours of care in 60-day period) would continue to be paid fee-for-service.

The tool used to assess the case mix/needs of a patient would be a New York State Medicaid grouper that was developed by the Department and outside consultants (ABT Associates) and presented to the Home Care Reform Work Group in February 2010 (see "Additional Technical Detail"). This would assure that payment levels reflect the patient's medical diagnoses, functional needs, and age level.

Financial Plan savings can be achieved by reducing the base price and/or by applying outlier thresholds. The

outlier payment is a risk-sharing adjustment which provides a CHHA with partial reimbursement for exceptionally high-cost cases within each case mix group.

The estimated fiscal savings from this proposal are reflected in Proposal #5 ("Reduce and Control Utilization of Certified Home Health Agency Services"), which would serve as a transition to the episodic payment system.

Total reimbursement to New York City providers would decrease by $221.8M, which represents less than half of the $575M increase in CHHA spending in New York City from 2003 to 2009. Medicaid spending would increase by $1.8M in the NYC Suburban area and by $20M upstate.

Final Financial Impact (Dollars in Millions):

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

Estimated Regional Impacts:

Fiscal Impact by Region (Gross)	New York City	Other Downstate	Upstate	Total
Negative Impact: # of providers	22	10	6	38
Negative Impact ($ millions)	-$253.1	-$4.1	-$4.6	-$261.8
Positive Impact: # of providers	8	21	72	101
Positive Impact ($ millions)	$31.3	$5.9	$24.6	$61.8
Total # of providers	30	31	78	139
Total Net Impact ($ millions)	**-$221.8**	**$1.8**	**$20.0**	**-$200.00**

Benefits of Proposal:

● Provides payment-based incentives to discourage over-utilization of home health services.
● Creates stronger correlation between reimbursement levels and patient needs.
● Utilizes grouper methodology created specifically for NYS Medicaid patients.
● Includes provision for high-cost cases in the form of additional outlier reimbursement. Outlier thresholds were modified based on the recommendations of the Home Care Reform Work Group to provide greater reimbursement for high-acuity cases.
● Enhanced care management and service capability.
● Fosters provider fiscal stability and planning.
● Redirects Medicaid spending from New York City, where over-utilization of CHHA services has driven rapid increases in per-patient cost, to other areas of the state where additional resources can be used to meet staffing needs.
● Opportunity to enhance patient access and quality of care.

Concerns with Proposal:
● Providers have expressed concern that the grouper employed to determine Case Mix may not adequately reflect all aspects of patient need, including chronic illness, psycho-social factors, and special needs populations. To address these issues, the Department designed a new grouper specifically for New York State Medicaid patients, and made significant changes to the clinical and functional scoring mechanisms to better reflect the needs of this population.
● The proposal does not include funding for rewarding provider quality and performance. However, alternatives for providing financial incentives to meet clearly defined quality standards were presented to the Home Care Reform Work Group and can be implemented in the future.
● HCA and others are concerned about a reduction in total CHHA Medicaid spending as a result of implementing the episodic system. The current proposal, which calls for a gross annual reduction of $200M, would leave per-patient spending at or above 2006 levels.
● Provider groups have requested sufficient time for the episodic system to be tested and for CHHAs to make necessary changes to their billing and information systems. To address this concern, the Department has pushed back the proposed effective date to April 1, 2012.

Impacted Stakeholders:
● Consumers
● Health personnel
● Providers

Additional Technical Detail: (if needed, to evaluate proposal)
The proposed Medicaid grouper uses OASIS data (currently collected by all CHHAs for nearly all Medicaid patients) to evaluate clinical and functional characteristics of patients. The grouper also considers the age of the patient and whether the episode is "start of care" or recertification. The Department is in the process of updating the model to reflect 2009 claims and 2009 case mix/OASIS data.

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

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

Metrics to Track Savings:
Paid Medicaid claims data will be used to compare the amounts paid to providers under the episodic system with amounts previously paid through the traditional fee-for-service model.

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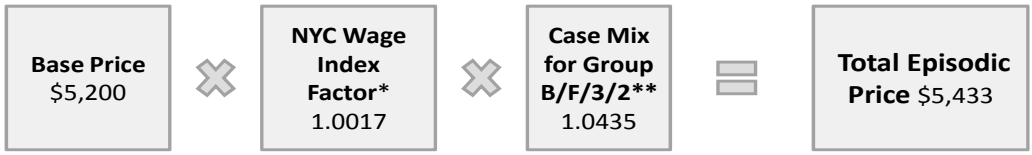
Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

Attachment: Example of payment calculation

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



Calculation of Total Reimbursement to CHHA under 2 cost scenarios

Total cost of visits/hours	Outlier Threshold	Episodic Payment	Outlier Payment	Total Payment
$4,000	$9,556	$5,433	$0	$5,433
$11,000	$9,556	$5,433	$722	$6,155

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

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 87

Proposal (Short Title):
Reduce Unnecessary Hospitalizations - Community Based Pay for Performance

Theme: Pay Providers Based On Performance

Program Area: Hospitals & Other Providers

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:

The Federal Health Care Reform bill (the Affordable Care Act, ACA) provides States the financial incentive tools to encourage providers in a community to set up networks and work together to provide coordinated care to the most vulnerable populations in the health care system. Many of the proposals under consideration by the Medicaid Redesign Team (i.e., Accountable Care Organizations, medical health homes, bundled payments) are aimed at reconfiguring the service system in this manner.

Specifically, this proposal of pay for performance (P4P) or accountable community care is intended to create financial incentives to move the provider community in this direction and to provide opportunities for gain sharing when targeted efficiencies are achieved. This will ultimately reduce unnecessary hospital admits and readmits that will lower cost and improve quality. This approach seeks to link payment to quality, thereby increasing the value of our health care expenditures. The Department of Health is willing to work with industry stakeholders and/or a workgroup comprised of MRT members to further develop and assist in this proposal.

The new APR-DRG system, implemented in State Fiscal Year 2009-10, has the ability to measure quality and performance. This allows the State to review such measures and implement performance based financial incentives. Two such quality measures are:

- Potentially Preventable Admissions (PPAs), which are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. PPAs are admissions for ambulatory sensitive conditions (e.g., asthma) for which adequate patient monitoring and follow-up (e.g., medication management) can often avoid the need for admission. The occurrence of high rates of PPAs represents a failure of the ambulatory care provided to the patient.

- Potentially Preventable Readmissions (PPRs), which are return hospitalizations that may result in deficiencies in the process of care and treatment (readmission for a surgical wound/infection) or lack of post discharge follow-up (prescription not filled) rather than unrelated events that occur post discharge (broken leg due to trauma). The State has already implemented a form of PPRs in the 2010-

11 Budget that made risk adjusted adjustments to hospital inpatient rates and which generated $47M in total savings. This P4P proposal could replace the PPR penalty approach currently in place.

Based on 2008 Medicaid data (will be updated to 2009), nearly $1.40B in New York has been identified as potentially preventable admissions and readmissions. On a statewide basis, on average the State experiences a PPA rate of 16.8 and a PPR rate of 7.3 per 100 admissions. The spending on PPAs and PPRs by region can be found on Attachment One.

There are two identified approaches to incentivizing performance based care. The first approach focuses solely on the hospital. It sets performance based targets on the hospital and pays incentive payments back to the hospital for improved care. Since the intent is to promote open communication among and between all provider types in a given community, the preferred approach of the Department of Health is more of a hybrid approach.

In a hybrid approach, performance targets and incentive payments will be shared among the hospital and other community providers. Those "community" providers would be determined by the Department of Health but could include nursing homes, home care providers, clinics and/or physicians. The performance targets would be based on and ultimately measured on the performance of each defined community. In the first year, a with-hold would be implemented with the community's ability to earn back such funds by meeting set performance targets. Ultimately the desire will be to bend the overall cost curve by reducing unnecessary hospitalizations, thereby providing the opportunity to providers to gain share on the achieved savings.

Furthermore, the Department will be collaborating with the Leapfrog Group, industry trade associations, other academic entities, Hospital Quality Alliance and the Federal CMS to develop clinical quality measures that could be incorporated into the defined targets and benchmarks. This collaboration and the development of the additional quality measures will occur subsequent to March 1, 2011.

An example of how this proposal could be implemented can be found in Attachment Two.

Final Financial Impact (Dollars in Millions):

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

While the targeted savings is not yet established, this proposal will save greater than $50 million and will score the highest in the MRT survey ranking process.

Benefits of Proposal:

This proposal provides an opportunity to generate immediate financial plan savings as the with-hold in year one can occur immediately. It also encourages communities to have open communication and work together to move towards a more coordinated care environment. Finally, the P4P proposal financially incentivizes communities to provide higher quality care and ultimately will reduce costs in a transparent manner with performance evaluations and quality standards available to all those in a community. There are a number of States and private insurers that are currently using this or similar approaches as a tool for measuring performance in a P4P environment and to determine the readiness of their provider communities to adapt to Accountable Care or other Care Coordination initiatives.

Concerns with Proposal:

While the hospital industry has opposed the State's previous policy on PPRs, the hybrid P4P approach has the benefit of providing appropriate financial incentives based on performance standards that are transparent, based upon all providers in the community (not just the hospital), has opportunities for provider gain sharing and uses more real-time data for measuring performance.

In addition, concerns have been raised that potentially preventable admissions are measurable due to the lack of community care. The hybrid P4P approach is a preferred option because it allows targeted investments to occur in those communities to address this very issue. Another concern raised by hospital provider groups is the potential level of the with-hold and whether the with-hold should apply to communities whose provider base is already performing at an acceptable standard. This could be counterintuitive and interpreted to be a true budget cut. Finally, a hospital trade association has stated that the Federal CMS is developing quality measures specific to the Medicaid population and expressed concerns that the State should wait and not prematurely implement their quality based P4P program. However, the State is committed to working with CMS in this process and incorporate any quality measures they develop where appropriate.

Impacted Stakeholders:
Defined Community Providers

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

System Implications:
None.

Metrics to Track Savings:
A comparison of historical potentially preventable admissions and readmissions to potentially preventable admissions and readmissions after the implementation of such financial incentives.

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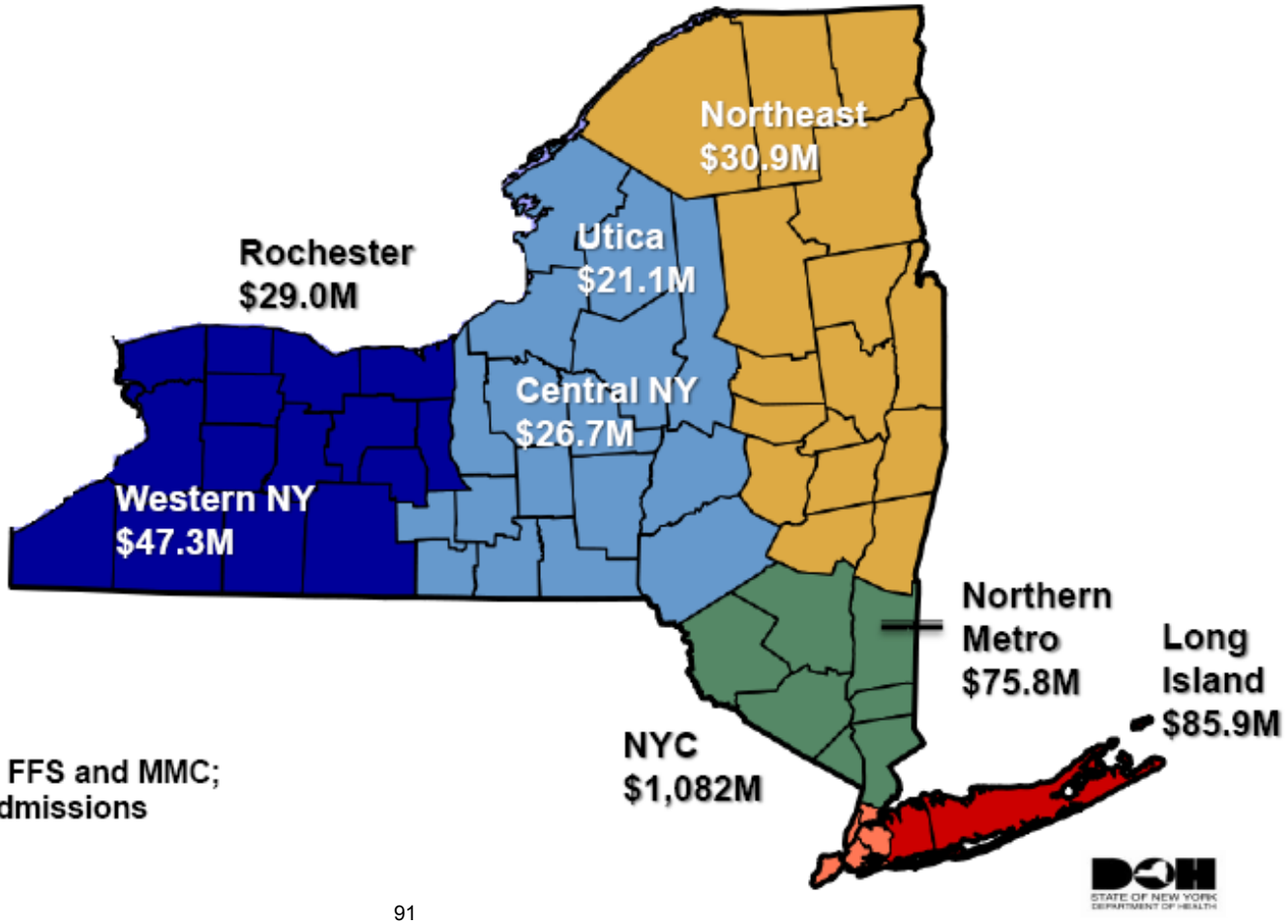
Viability: S

Modified Delphi Scoreable: True

Modified Delphi Score:

Medicaid Redesign Team
Proposal #87: Pay-For-Performance
ATTACHMENT 1

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



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

Medicaid Redesign Team
Proposal #87: Pay-For-Performance
ATTACHMENT 2

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

Reconciliation / Incentive Payment:

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

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 89

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

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

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

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

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

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

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

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

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

Health homes require strong community ties to social service providers to address the numerous social barriers to health care that Medicaid enrollees may encounter, particularly for those with co-occurring mental illness and chemical dependency. It is only after these barriers are addressed that enrollees become able to participate in their health care.

Data will play a key role in measuring the success of health homes. Participating providers must have access to electronic health records that include all Medicaid-covered services for participating beneficiaries. To determine whether the plan is working, each patient's health home team and providers must be able to observe whether the patient is adhering to the care plan and, if not, to determine the cause of barriers and how to overcome them, which might require amending the plan. Access to Medicaid data is necessary to perform these tasks.

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

Ideas on patient engagement include offering primary care clinician stipends, waiving copayments of evidence-based treatments, and giving patients monetary incentives to achieving certain medical milestones such as blood pressure control. The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) tool for access to psychiatric medication information could be very helpful in health home patient management. Costs associated with bringing this tool to additional providers could reach $1.5M.

Final Financial Impact (Dollars in Millions):

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

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

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

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

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

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

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

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 90

Date Submitted: 01/28/2011

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

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

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Long Term

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

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

Three models of MLTC are available in New York - partially capitated plans, Medicaid Advantage Plus and the Program of All Inclusive Care for the Elderly.
Medicaid spending for long term care services continues to grow at a significant rate while the total number of Medicaid recipients receiving long term care services has remained flat. Between 2003 and 2009, Medicaid long term care expenditures increased by 26.4% from $9.8 billion to $12.4 billion annually.

A federal waiver will be needed to require mandatory enrollment of individuals into MLTC. Beginning in April, 2012 in New York City, where MLTC capacity is adequate, individuals who need community based long term care services for more than 120 days would be required to enroll in MLTC plans. This would include those currently served in personal care, Long Term Home Health Care, and other community-based long term care programs as well as people who are new to long term care. Mandatory enrollment would expand throughout the rest of the State as MLTC plans become available.

A consumer advisory group will be established to provide input to the State in the development of this program.

Partially capitated plans will expand their target population beyond those who are nursing home eligible to include all Medicaid recipients in need of long-term, community based services.

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

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

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

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-15.60	$-75.60	$-115.05	$-111.30
Total Savings	$-30.40	$-150.40	$-229.30	$-221.80

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

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

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

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

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

Additional Technical Detail: (if needed, to evaluate proposal)
Year 1 savings assumptions based on 6% off the fee-for-service costs in year 1 for high-end personal care and home health care recipients that voluntarily shift to MLTC due to other fee-for-service proposals that limit personal care and home care expenditures. (Assumed 6,500 new enrollees shifting in Year 1). For Year 2 and beyond, savings assumptions based on 5% off the fee-for-service costs for all remaining personal care and home health care recipients in FFS (assumed 3150 new enrollees per month for 24 months). Savings estimates are preliminary pending further review by State actuaries.

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

Assumes a decrease in administrative costs from $231 per member per month (pmpm) to $220 pmpm in Year 1, $200 pmpm in Year 2, and $175 pmpm in Year 3 and beyond, due to economies of scale resulting from increased enrollment.

The following table summarizes the savings impact by component: (Dollars in Millions).

Component	SFY 2011-12	SFY 2012-13	SFY 2013-14	SFY 2014-15
New Enrollees	6,500	44,300	82,000	82,000
Enrollment into MLTC	-$10.0	-$76.6	-$163.3	-$203.1
90% Share F-MAP Health Home	-$19.7	-$64.1	-$47.3	-$0.0
Reduced Admin Costs	-$2.3	-$11.3	-$20.3	-$20.3
Staff Resource costs	+$1.6	+$1.6	+$1.6	+$1.6
TOTAL SAVINGS	-$30.4	-$150.4	-$229.3	-$221.8

These savings have not been reduced by the impact of the claim payment lag as enrollment is phased in.

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

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

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

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Viability: S

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 91

Proposal (Short Title):
Carve In for Behavioral Health Services into Managed Care

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

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Change the Medicaid managed care benefit package to expand the scope of behavioral health services provided by plans to their members.

Currently MCOs provide no BH services to SSI members while providing basic inpatient and outpatient mental health service and inpatient substance abuse services for TANF/SN members. This proposal would be implemented in two phases. In phase 1 (effective 10/1/11) all basic BH services would be added the benefit package of SSI members while phase 2 (effective 4/1/12) would expand the scope of BH services provided to all members. The expanded BH services to be added to the managed care benefit package in phase 2 would include but are not limited to Prepaid MH Plans, OPWDD Clinic, Intensive Psychiatric Rehab Treatment Programs, Intensive Chemical Dependence Residential Rehab Services Programs, MH Day Treatment, Case Management, Partial Hospitalization, SED Children Services, Assertive Community Treatment, OASAS Methadone Clinic MMTP, and Rehabilitation services to residents and families of OMH certified Community Residences.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$34.25	$1.45	$-29.60	$-29.60
Total Savings	$68.50	$2.90	$-59.20	$-59.20

Benefits of Proposal:
MCOs have the ability to coordinate care for behavioral (mental health and substance abuse) and physical health services that is lacking in the FFS environment. Ending the BH carve-outs for Medicaid members will give MCOs the opportunity to employ focused case management services directed at those individuals with chronic mental health and substance abuse problems who also tend to develop physical health problems that are routinely treated in costly acute care settings. Integrating physical and BH case management programs will produce better outcomes, lower costs and improved long-term prognoses for affected individuals.

Concerns with Proposal:

Advocates will argue that MCOs would provide inadequate access to BH services, would deny needed services to reduce costs, do not have the ability or interest to engage transient populations with psychiatric problems and have not historically proven to be successful treating people with complex BH problems.

MCO's and BH Organizations may need lead time to develop an integrated BH case management infrastructure; MCOs will also need time to contract with new BH providers. Changes in outpatient utilization patterns could affect funding streams to current OMH and OASAS providers. For optimum results, coverage of pharmaceuticals should also be added to the MCO benefic package

Impacted Stakeholders:
MCOs, BH providers, OMH, OASAS, DOH, Advocacy Groups.

Additional Technical Detail: (if needed, to evaluate proposal)
The savings assumes a 6% discount off fee for service expenditures with the expanded benefits phased in over a two year period beginning October 1, 2011. Managed care savings is offset by fee for service claim lag payments in SFY11-12 and SFY12-13 estimated to be 15% of full annual disbursements (approximately 2 months). Estimates are preliminary pending further review by the State's actuary.

This proposal would not change the benefit package for Family Health Plus enrollees.

System Implications:
No major changes would be needed.

Metrics to Track Savings:
No metric needed as the rates established by the Department will build in the savings associated with the carve-in of BH services.

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Viability: s

Modified Delphi Scoreable: True
Modified Delphi Score:

Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 92

Date Submitted:01/28/2011

Proposal (Short Title):
Allow Restricted Recipient Program in Managed Care

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

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

Proposal Description:
Authorize the Department of Health (DOH) to allow recipients in the Recipient Restriction Program (RRP) to enroll in Medicaid Managed Care.

This would allow restrictions to be placed on managed care enrollees for non-plan covered services such as pharmacy in instances where the Office of the Medicaid Inspector General (OMIG) has documented evidence of abuse while maintaining enrollment.

In addition, if the person is enrolled in the RRP for covered services such as physician, hospital, or emergency room, they would be required to enroll in MMC and the plan would be given authority to place individuals in a similar restriction program to better monitor and manage the care provided.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-7.90	$-39.80	$-39.80	$-39.80
Total Savings	$-15.80	$-79.50	$-79.50	$-79.50

Benefits of Proposal:
Social Services Law Section 364-j and the state's 1115 (b) Demonstration waiver prohibit enrollment of persons who are in the Recipient Restriction program into Medicaid Managed Care (MMC). At the time the MMC program was developed, the managed care benefit package included all medical benefits including those included in the Recipient Restriction program. Since that time, pharmacy has been carved out of the MC benefit package.

A person can be restricted in four main areas pharmacy, physician, inpatient and emergency room. Of the approximately 5,600 recipients in a RRP, the main reason for the restriction is pharmacy. Currently, the OMIG identifies recipients who would be appropriate for the RRP due to pharmacy utilization; however, the client must be disenrolled from Medicaid Managed care in order to be placed in the program. Many times, this causes a break in continuity and coordination of the client's care and removes them from the most cost effective system of care. Also, these individuals are usually high users and very costly. This is the population we believe could benefit from having their care managed and monitored by managed care organizations.

Concerns with Proposal:
Medicaid managed care plans will be concerned about enrolling this population due to high consumption of services and will believe the population is difficult to manage.

Impacted Stakeholders:
Managed Care plans.

Additional Technical Detail: (if needed, to evaluate proposal)
The majority of people enrolled in RRP are downstate.

The individuals enrolled in the RRP are 5 times sicker than those currently enrolled in the plan with a demonstrated pattern of abusive utilization of services. Approximately $159 million is being spent Medicaid Fee-For-Service (FFS) for comparable services in the managed care benefit package. Resulting from enrolling these persons in Medicaid Managed Care, the State could save approximately 20% of cost in SFY 11-12 based on enrollment ramp-up and initial review of utilization patterns. SFY 12-13 savings estimated at 50% as Medicaid Managed Care plans are able to establish administrative mechanisms to control utilization of services for these recipients.

System Implications:
System change will be needed to open enrollment to the RRP individuals. In addition, change to the eMedNY system will be needed to enforce restrictions on FFS billing for other than covered services in Medicaid managed care.

Metrics to Track Savings:
No metric needed as the rates established by the Department will build in the savings associated with enrolling this population into Medicaid managed care.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 93

Proposal (Short Title):
Implement Regional Behavioral Health Organizations

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

Program Area: Managed Care

Effective Date: 01/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

Proposal Description:
OMH and OASAS support the goals of service integration and recommend the creation of a Behavioral Health Organization (BHO) as the entity to manage the enhanced service coordination.

To achieve these goals, the State should:
--Carve all behavioral health services out of mainstream plans (with the possible exception of some basic level of clinic, psychiatrist, and psychologist visits).

--Rapidly establish regional behavioral health organizations (BHO), accountable to State government, to initially provide a managed fee-for-service (FFS) model to infuse accountability, engagement, comprehensive care coordination and utilization management (UM) for the existing FFS system. This will provide savings and improve access using appropriate UM approaches and care management expectations. One BHO will cover a region of the State to avoid cost shifting and further fragmentation of the mental health system. Budget authority will be required to allow rapid procurement of BHOs.

--Through the authority vested in the BHO, require intensive accountability and care coordination for the most expensive Medicaid users (health and behavioral health costs).

OASAS recommends including all crisis and inpatient substance use disorder (SUD) care in the BHO carve-out to ensure better clinical management and potentially greater savings.

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

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

establishing and operating the BHO before the savings are appreciated.

Final Financial Impact (Dollars in Millions):

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

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

Concerns with Proposal:
--System monitoring requires the development and implementation of outcome measures and reporting systems.
--Concerns that mental health and physical health will not be integrated.

Impacted Stakeholders:
--Recipients of mental health services would need to be automatically enrolled in a BHO.
--Utilization management and responsibility for care planning would be placed in the BHO, "medical homes" and "health/behavioral health homes" and removed from providers.
--Provider revenues per person could decline due to BHO utilization management and care coordination. The reduction of revenues would probably be offset by an increase in the number of people engaged in care by the BHOs.
--Mental health providers and consumers have come out strongly in favor of implementing a BHO rather than "carving in" behavioral health services into MCOs.

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

System Implications:

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

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Viability: Short term

Modified Delphi Scoreable: Yes
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 95

Proposal (Short Title):
Include Personal Care Benefit in Managed Care

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

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Require Medicaid managed care plans to cover personal care services in the benefit package.

This would require an amendment to the Social Services Law (365-a(2)(k)) which requires an entity to be approved as a managed long term care plan to cover certain long term care services on a capitated basis.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-1.50	$-1.40	$-1.40	$-1.40
Total Savings	$-3.00	$-2.80	$-2.80	$-2.80

Benefits of Proposal:
Medicaid managed care plans cover comprehensive primary and acute care benefits including home health services in their benefit packages but they do not cover personal care services. Personal care services are needed by disabled and chronically ill members when they have an ongoing need for assistance with activities of daily living or with household tasks. Managed care members who have personal care needs must contact the local department of social services (LDSS) and be approved to receive those services on a fee-for-service basis through the traditional Medicaid program. Often this service is needed at the end of a home health episode and the member must be transitioned from services managed through the plan to another agency arranged through the LDSS resulting in disruption, discontinuity and delays.

The savings were based on "new" users of personal care and those newly enrolling in Managed Care. New users were identified as having no personal care services for 3 months prior to personal care use.

It is assumed that savings will only come from new users since established users can request a continuation of their current level of service.

Inclusion of personal care in the Medicaid managed care benefit package will result in better care coordination and continuity for the member. Savings will result for the State by:
1. achieving faster transitions from care by a certified home health agency to less costly licensed home care services agencies.
2. allowing managed care plans to develop more effective assessment tools and providing enhanced care management.
3. relieving the LDSS of the administrative burden of processing these personal care referrals and putting services in place as well as addressing requests for changes in care authorized.

This proposal aligns with the propoal related to mandatory Managed Long Term Care enrollment so that persons enrolled in Medicaid managed care plans who need extended personal care services are also in a managed environment.

Concerns with Proposal:
Medicaid managed care plans are unfamiliar with the personal care and lack the tools necessary to develop and monitor the personal care benefit for members. To refute this argument, many of the health plans that participate also have a long-term care line of business.

Impacted Stakeholders:
Medicaid managed care plans
Managed long term care plans
Home care agencies (CHHAs, LTHHCPs and LHCSAs)
Local Departments of Social Services
Consumers/Consumer Advocates
Unions (Dist 1199)

These groups will be opposed to the proposal.

Additional Technical Detail: (if needed, to evaluate proposal)
Personal care services are much more prevalent among managed care enrollees in New York City than Upstate. During calendar year 2008, 83% of the managed care enrollees receiving personal care lived in New York City. Those same New York City residents accounted for 91% of the $124.5 million spent on personal care for managed care members.

System Implications:
Change will needed to the Scope of Benefits file to add this benefit. This will not be an onerous change.

Metrics to Track Savings:

No metric needed as the rates established by the Department will have the proposed benefit change.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 96

Proposal (Short Title):
Expand Managed Care Enrollment

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

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Long Term

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

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

Proposal Description:
This proposal would authorize the Department of Health (DOH) to enroll additional non-dually eligible Medicaid recipients into mainstream Medicaid managed care programs.
Under current New York State Law and included in the state's federally approved 1115 demonstration waivers, there are categories of Medicaid eligibles who are either excluded from enrolling into mainstream Medicaid managed care, or exempt from mandatory enrollment. Approximately 229,000 of non-dually eligibles fall into one of these excluded or exempt categories.

This change would allow for the enrollment of additional categories of persons into a managed care environment where complex medical needs may be better managed.

Patient cash incentives or vouchers for healthful products could be considered to induce patients into plans with higher HEDIS and customer service scores.

The phase in schedule would be as follows:

Year 1

Exclusion categories to be enrolled:
Blind or disabled children living separate and apart from their parents for 30 days or more

Exemption categories to be enrolled:
Primary Care provider not participating in any managed care plans
Persons living with HIV (upstate)
Persons without a choice of primary care provider within 30 miles-30 minutes
Non-institutionalized foster care children
Non-SSI SPMI adults and non-SSI SED children
Individuals temporarily living out of district
Prenatal Care - provider not participating in any managed care plans

Chronic Medical with specialist provider not participating in any managed care plans (exemption would be limited to 6 month duration)

Year 2

Exclusion categories to be enrolled:
Infants born weighing under 1200 grams or disabled under 6 months of age
Individuals enrolled in the Long Term Home Health Care Program
Institutional foster care children
Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY)
Residents of residential health care facilities

Exemption categories to be enrolled:
Individuals with characteristics and needs similar to those in the LTHHCP
Individuals with characteristics and needs similar to those receiving services through a Medicaid Home and Community-based Services Waiver
Individuals receiving services through a Medicaid Home and Community-based Services Waiver
Individuals with characteristics and needs similar to those receiving services through a Medicaid Model Waiver (Care at Home) Programs
Individuals receiving services through a Medicaid Model Waiver (Care at Home) Programs
Renal Disease
Individuals receiving services through the Chronic Illness Demonstration Program
Individuals receiving services through the Nursing Home Diversion and transition waiver

Year 3

Exclusion categories to be enrolled:
Medicaid Buy-In for the working Disabled
Residents of State-operated psychiatric centers

Exemption categories to be enrolled:
Residents of an ICF/MR
Individuals with characteristics and needs similar to residents of an ICF/MR
Homeless
Residents of Long Term Chemical Dependence programs
Children enrolled in the Bridges to health (B2H) foster care waiver program

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.83	$ -10.03	$ -17.30	$ -17.86
Total Savings	$-1.66	$ -20.06	$-34.60	$ -35.73

Benefits of Proposal:
This proposal would allow the Department to enroll additional persons into Medicaid managed care, many in categories that are high utilizers of medical services. Enrollment of additional persons in

Medicaid managed care will result in higher quality of care through management of medical services as well as cost savings both on the medical services side (better management of medical services for high cost recipients) and administrative side for printing, mailing and processing exemption/exclusion forms.

Concerns with Proposal:
Advocates and consumers will be impacted by this proposal as these are recipients currently not enrolled in managed care and may feel this will have a negative impact on their Medicaid.

The managed care plans will be impacted by this proposal as many of the additional recipients to be enrolled may have chronic illnesses that some plans have little experience in managing, including persons presently living in a residential or institutional setting.

Impacted Stakeholders:
Managed care plans
Advocates

Additional Technical Detail: (if needed, to evaluate proposal)
Year 1 savings is small as the enrollment in these categories is small and enrollment is projected to be phased in beginning October 2011. See attachment A for population summary.

For all years, savings is calculated from current Managed Care benefit FFS expenditures only. For some categories, a large portion of their costs is not part of the current managed care benefit and therefore is not build into these estimates. Additional savings will be realized through "carving in" additional benefits to Managed Care including Pharmacy and Mental Health/Substance Abuse services. Carving in these benefits is part of a separate redesign proposal. See attachment B for expenditure summary.

Estimated savings are subject to review by the State's actuary.

Estimated savings have not been adjusted for FFS claim lag.

Additional staff are needed in order to implement

System Implications:
WMS systems changes will be necessary to include additional categories in the enrollment process, changed edits, etc. There will also be programming changes necessary with enrollment broker transactions

Metrics to Track Savings:
No metric needed, as the rates established by the Department will build in the savings.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

MRT #96 Expand Managed Care Enrollment
Summary of Recipients - Attachment A
Calendar Year 2009
Data Source: DOH/OMM Datamart (based on date of service) and Maximus Enrollment Broker

Eligible Category	Recipients
Total Medicaid Eligibles Identified	**5,420,382**
Managed Care Enrolled	3,755,237
Dual Eligible	716,556
Restricted Recipients	6,196
Targeted Categories for Enrollment	
Year 1	23,795
Year 2	23,317
Year 3	19,601
Total	**66,713**
[1.] Categories not identified for enrollment	155,636
[2.] Remaining Eligibles	720,584

* Each recipient assigned to a mutually exclusive category

[1.] Categories not identified for enrollment include:
- Spend Down
- Cancer Treatment Program
- Family Planning Services Only
- LTC Demo
- Emergency Services Only
- Mental Health Family
- OPWDD

[2.] Remaining eligibles include those recipients pending auto assignment or in a voluntary county

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 97

Date Submitted:01/28/2011

Proposal (Short Title):
Assign Medicaid Enrollees to Primary Care Providers

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

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
Assign Primary Care Providers to Medicaid Enrollees.

Approximately 75% of the Medicaid population is in Medicaid Managed Care. The remaining 25% receive their care on a fee-for-service basis, with little or no management or coordination of their medical care.

Under this proposal, the Medicaid population that is presently not enrolled in a Managed Care plan will be required to do so, or will be required to choose a primary care provider, who will manage their overall care, and have a full clinical picture of the patient. The primary care provider may be a physician, nurse practitioner, or Article 28 clinic (hospital outpatient department or free-standing diagnostic and treatment center, including Federally Qualified Health Centers). If an enrollee fails to choose a primary care provider, the Health Department will designate either a practitioner or clinic for the enrollee. In addition to the requirement that a patient pick a PCP or enroll in managed care, the Department will also explore other incentives to utilizing a PCP including restricting the patient to the PCP, higher copays and certain claims denials. In addition, the Department will explore a requirement that members see their PCP at least once per year.

Linking Medicaid enrollees to a primary care provider will help to ensure that patients receive coordinated care, which may result in reduce overutilization of services as well as reduce use of the emergency room.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-1.20	$-1.20	$-1.20	$-1.20
Total Savings	$-2.40	$-2.40	$-2.40	$-2.40

Benefits of Proposal:
It is important for individuals to have an ongoing, continuous relationship with a primary care physician who will assist them in managing their medical needs. When such a relationship exists, it is more likely that the individual will receive coordinated care and appropriate health planning in a manner consistent with their medical needs. Such linkages help to reduce overutilization of services, as well as reduce unnecessary use of the emergency room.

Concerns with Proposal:
To encourage physicians/clinics to act as care coordinators, Medicaid will need to consider providing enhanced reimbursement to practitioners/clinics who agree to participate in the program (e.g., monthly fee), especially if recipients are "restricted" to the care coordinator. This will reduce overall cost savings.

Impacted Stakeholders:
-Physicians and clinics that will be designated as primary care providers.
-Enrollees that are not already participating in Medicaid managed care who will either choose or be assigned to a primary care provider.

Additional Technical Detail: (if needed, to evaluate proposal)
There are a number of administrative issues that will need to be considered as we move this proposal forward:
1- will enrollees be "restricted" to their primary care practitioner/clinic.
a- restricting enrollees to a primary care practitioner/clinic will require a federal waiver of recipient free choice.
2- will enrollees need a referral from their primary care physician/clinic before seeking services from a physician specialist.
3- must ancillary services (laboratory, radiology, prescription drugs, etc.) be ordered by the designated primary care physician/clinic.
4- to encourage physicians/clinics to act as care coordinators, Medicaid will need to consider providing enhanced reimbursement to practitioners/clinics who agree to participate in the program (e.g., monthly fee), especially if recipients are "restricted" to the care coordinator.
5- for those enrollees who fail to designate a primary care provider, the Medicaid program will designate a primary care provider on behalf of the enrollee. The Medicaid program will need to solicit providers to agree to act in this capacity (the Medicaid program does not have the legal authority to require a practitioner/clinic to accept any or all Medicaid enrollees).
6-if enrollees are not "restricted" to a designated primary care practitioner/clinic, a federal waiver will not be required. However, failing to restrict enrollees to a primary care practitioner/clinic will decrease the effectiveness of the program.

Medicare/Medicaid dually eligible individuals (disabled individuals as well as those over 65 years of age) will be exempt from the requirement. While Medicaid can designate a primary care provider for such enrollees, dually eligible individuals may seek care from any provider that participates in the Medicare program.

System Implications:
Restricting recipients to a primary care provider will require extensive eMedNY and WMS systems changes. The eMedNY and WMS file will need to identify and link providers with specific recipients. If the enrollee is "restricted" to the primary care provider, further system changes will need to be made so that only those medical services ordered or referred to by the primary care provider are reimbursed.

Metrics to Track Savings:

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Viability: Short term

Comments:
Assign all Medicaid recipients a primary care provider - could be expanded to needed specialty assignments (e.g. psychiatrists)

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 98

Proposal (Short Title):
Streamline Managed care enrollment eligibility process

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

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

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

Proposal Description:
Mandate selection of a Medicaid Managed Care plan as a condition of eligibility for Medicaid recipients in counties with mandatory enrollment.

Similar to enrollment rules for the Family Health Plus program, Medicaid recipients who are newly eligible will be required to select a managed care plan at the time of application for Medicaid. Recipients who currently have eligibility, or are ending their period of exemption/exclusion, would be informed at renewal that they would have 30 days to select a managed care plan before the State would auto assign them into a health care plan. In addition, pregnant women will be required to pick a managed care plan at the point of application for presumptive eligibility. This would allow for immediate enrollment into a managed care plan once eligibility is determined. In 2009 a letter was sent to all presumptive eligibility providers requesting that they comply with this directive.

The state's 1115 demonstration waivers and SSL 364-J need to be amended to implement this proposal.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-0.47	$-0.94	$-0.94	$-0.94
Total Savings	$-0.94	$-1.87	$-1.87	$-1.87

Benefits of Proposal:
Streamlining the Medicaid eligibility process and managed care enrollment process will accomplish goals in two priority areas.
1. Employing an earlier plan selection would reduce the administrative resources that currently exist in the enrollment process, including confusion on the applicant with differing program rules as well as

multiple mailings to remind potential enrollees to chose a plan or be assigned. As additional categories of recipients are enrolled into managed care, the pool of potential enrollees would increase, necessitating a streamlined enrollment process that would reduce local district efforts to monitor enrollment cycle and cut back the need for costly enrollment reminder mailings.
2. Deliver recipients into the managed healthcare system more expediently. As has been seen, managed care enrollees tend to utilize services more appropriately with a primary care doctor managing their health care.
3. Pregnant women would be enrolled in a managed care plan sooner to promote early entry into prenatal care. This would improve outcomes for high risk women.

Concerns with Proposal:
Education of local district staff directing the program would need to be done in a timely fashion so that enrollment procedures can be modified. Training (via teleconference) would be made a priority.
Client advocacy groups may voice concerns that persons with more complex medical needs will need time to choose a health plan.

Impacted Stakeholders:
The 1115 Waiver and SSL 364-J need to be amended to allow this proposal. Advocates and other interested parties would need to be informed.
Health plans will likely support this proposal.

Additional Technical Detail: (if needed, to evaluate proposal)
Potential savings were calculated for this proposal based on information from the state's contracted enrollment broker and administrative costs for the mailing of mandatory enrollment materials to persons newly eligible for Medicaid that will be required to chose their health plan at the time of application, thus, avoiding the mailing costs.
Currently, the enrollment broker (contracted to assist with managed care education and enrollment in NYC and upstate counties representing approximately 83% of the eligible population enrolled into Medicaid managed care) is paid an amount per mailing that considers both the cost of the postage as well as the printing and processing of the mailing.
Approximately 34,500 initial mandatory mailings are mailed each month from the broker at a cost of $22.79 each. This accounts for approximately $783,000 per month in mandatory mailings to newly eligible as well as persons being renewed or have a change in their Medicaid coverage. If roughly 20% of the mailings are for persons newly applying for assistance who will have picked a plan at application and avoided the mailing, the savings could be calculated at a monthly savings of approximately $156,000 monthly.
In addition, the shortening of the choice period for current eligibles who will have 30 days to now choose a plan will negate the need for reminder mailings, which will generate an additional administrative savings.

Additional staff is needed in order to implement.

System Implications:
The enrollment broker enrollment systems, which currently functions in counties that make up approximately 75% of all recipients, would have to be reprogrammed with new selection rules.
The State's Welfare Management System for auto assignment would have to be updated to reflect the rule changes. The enrollment broker call center and renewal center would need training and both the State and broker would need time to program system changes.

Metrics to Track Savings:
Reduction in administrative costs.

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 101

MRT Number: 446

Date Submitted:02/04/2011

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

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

Program Area: Managed Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Long Term

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

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

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

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

Preliminary Financial Impact (Dollars in Millions):

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

Final Financial Impact (Dollars in Millions):

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

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

Concerns with Proposal:
Will likely require federal waivers.

Impacted Stakeholders:
Dual eligible consumers and advocates
Health care providers

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

System Implications:

Metrics to Track Savings:

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Viability: S

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 111

MRT Number: 134

Date Submitted:01/28/2011

Proposal (Short Title):
Limit divestment and encourage private LTC insurance

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
This proposal will create additional plan options for the Partnership for LTC insurance program (PLTC).

Program data show that plan participants utilize less than two years of insurance benefit. Current plan options have minimum benefits of 3-6 or 4-4 (years of nursing home coverage and years of home care coverage). Adding a 2-4-100 plan that would cover two years of nursing home care; four years of home care; and protect 100% of family assets. A lower premium will result in increased sales and result in fewer people accessing Medicaid for LTC.

The Partnership for LTC provides that with the purchase of LTC insurance with appropriate minimum standards and protections, individuals receive Medicaid extended coverage when their insurance benefits lapse. With 92,819 policies purchased to date and 3674 policies accessed to date, only 255 people have accessed Medicaid. The alternative for most of these people would be to transfer assets for quicker access to Medicaid. The Partnership has resulted in Medicaid savings to date of over $68 million.

Additional options/proposals related to increasing LTC partnership purchases include proposed 291 to suppoprt costs of marketing.

Preliminary Financial Impact (Dollars in Millions):

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

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
This proposal affords individuals the opportunity to take personal responsibility for their LTC costs while protecting family assets for surviving family members. The result is significant Medicaid savings by avoiding spenddown eligibility to the Medicaid program.

Expansion in purchase of PLTC policies will translate into Medicaid savings.

The average time between initial purchase and access of LTC services is just over 8 years, so the full benefit of additional policy sales will have greater impact in future years.

Concerns with Proposal:
While this will be a more attractive plan for purchase because of lower premium costs, it is essential that some outreach/marketing happen to facilitate public awareness of the opportunity. This also requires a change to State Insurance Regulations to add this option.

Impacted Stakeholders:
Individuals approaching the need for LTC services; AARP; other senior advocates; Insurers

Additional Technical Detail: (if needed, to evaluate proposal)
The pricing of the premium levels needs to be developed with approved PLTC insurers to determine the market impact of this change.

System Implications:
Systems to follow policy holders and access to the medicaid extended coverage needs to be upgraded.

Metrics to Track Savings:
Upgrade partnership for LTC Program data systems can identify purchases and benefit use.

Contact Information:

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Viability: L

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 131

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

Theme: Eliminate Government Barriers to Quality Improvement and Cost Containment

Program Area: Hospital

Effective Date: 04/01/2011

Implementation Complexity: High
Implementation Timeline: Long Term

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

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

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

In 2009, NYS hospitals spent $1.6 billion to cover medical malpractice expenses. This represents an estimated 3% of their revenue. In addition, it has been estimated that 30-50% of the premium dollar is directed toward obstetrical cases ($500m-$800m). Of these obstetrical cases, Medicaid is the insurer for an estimated 50% of the deliveries and covers the medical costs of a significant number of children affected by neurological impairment both before and after settlement or award. The variation in both malpractice payouts and premiums differs significantly between upstate and downstate. There are some downstate providers that cite that they pay up to $9,400 a delivery in Medical malpractice expense . This can significantly undermine patient access to critical services in many communities and provider financial health.

This proposal would:

* Cap non-economic damages for medical malpractice awards. In 2004, Milliman estimated that a $250,000 cap would reduce hospital and physician premiums Statewide by 24%, which translates to a $384m savings for hospitals.

* Establish a Neurologically Impaired Infant Medical Indemnity Fund that will provide payment for medical expenses of eligible children as well as repayment of the State's Medicaid lien where applicable. Participation would be mandatory. The Fund could be capitalized by an assessment on all insurers' gross premiums (except annuities) or other sources including HCRA funds or some combination of sources.GNYHA estimates that a Fund of this nature would reduce costs to hospitals by 20% or $320m. It also estimates that the Fund would result in additional savings to the State Medicaid program in terms of Medicaid lien repayment from the Fund (estimated to be $75m per year) and from reduced expenditures for future medical expenses of children covered by the Fund (ranging from $5m in year one to $37.5m by year 8).

OB providers would be required to demonstrate participation in meaningful obstetrical safety and quality initiatives.

* Monitor the impact of the $3 million/ 3year AHRQ demonstration project that DOH is conducting along with the Unified Court System and Maimonides, Montefiore, Beth Israel, Mount Sinai and NY Presbyterian hospitals. The project will assess and measure patient safety culture and outcomes of malpractice adjudication as the hospitals implement increased emphasis on patient safety culture, specific patient safety interventions in the surgical departments, a disclosure and early settlement program and judge-directed negotiations for cases that do end up in Court.

These projects do not require statute but do require significant investment in provider resources to try these relatively new approaches in disclosure and settlement, along with new Court based procedures for judges.

* To support the foregoing proposals, a few modest tort reforms are also contained on the proposal:

o Allow peer review privileges to be extended to defendants;
o Early pre-trial showing of each defendants' involvement in case;
o Some protection of statements of remorse and acceptance of responsibility;
o Require a 182 Day Pre-Suit Notice Period;
o Savings would be generated by reducing hospital rates by expected savings generated by the program.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-234.30	$-234.30	$-234.30	$-234.30
Total Savings	$-468.60	$-468.60	$-468.60	$-468.60

Benefits of Proposal:
The proposal has the potential of reducing medical malpractice premiums for both physicians and hospitals.

Concerns with Proposal:
There will concerns from plaintiffs that medical care maybe limited.

Impacted Stakeholders:
Trial lawyers, medical malpractice insurers, consumer groups, hospitals, physicians.

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

System Implications:

Metrics to Track Savings:
Longitudinal studies on the number and amount of medical malpractice claims and settlements. Also, on the level of medical malpractice premiums adjusted for medical inflation and number of providers participating.

Contact Information:

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Viability: S

Comments:

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 155

Proposal (Short Title):
Mandate Participation in the OMIG Cardswipe Program for all Pharmacies.

Theme: Eliminate Fraud and Abuse

Program Area: Fraud and Abuse

Effective Date: 07/01/2011

Implementation Complexity: Medium
Implementation Timeline: Long Term

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

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

Proposal Description:
Requires all pharmacies billing Medicaid to participate in the OMIG Cardswipe Program (landline).

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-13.00	$-56.00	$	$
Total Savings	$-26.00	$-112.00	$	$

Benefits of Proposal:
Would generate signicant State savings by eliminating unnecessary pharmacy orders.

Concerns with Proposal:
Providers may object additional administrative burden and costs associated with the purchase of Cardswipe devices.

Impacted Stakeholders:
Pharmacies would be responsible for the purchase of devices (approximately $800 per device) and respective telephone charges.

Additional Technical Detail: (if needed, to evaluate proposal)
Savings are measured using a pre and post implementation methodology.

System Implications:

Metrics to Track Savings:
Provider billing activity.

Contact Information:

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Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 162

Proposal (Short Title):
Eliminate Medicaid Payments for Medicare Part B Co-insurance

Theme: Better Align Medicaid with Medicare and ACA

Program Area: Ambulatory Care

Effective Date: 04/01/2011

Implementation Complexity: Medium
Implementation Timeline: Short Term

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

State Plan Amend: Yes **Federal Waiver:**

Proposal Description:
Medicaid will no longer reimburse physicians the Medicare Part B coinsurance amount for patients that have both Medicare and Medicaid coverage.

The Centers for Medicare and Medicaid Services permits State Medicaid programs to limit the amount of cost sharing they contribute to patients who are dually covered by both Medicare and Medicaid. Under Medicare Part B, providers are reimbursed 80% of the amount approved by Medicare. The remaining 20% Part B co-insurance is the patient responsibility. State Medicaid programs may pay providers the full Part B co-insurance amount, a portion or a percentage of the Part B co-insurance amount, or may opt to pay no cost sharing. NYS Medicaid does not pay practitioners the full Medicare Part B co-insurance amount, but rather pays 20% of the Medicare Part B co-insurance amount. For example, if Medicare Part B approves $100 for a medical service, they will pay 80% of the approved amount ($80.00). The remaining 20% ($20.00) is the Medicare Part B co-insurance amount or the patient responsibility. Medicaid will reimburse the provider 20% of the Medicare Part B co-insurance amount or, in this case, $4.00 (20% of $20.00 = $4.00). The practitioner must accept the Medicare and Medicaid payment as full payment for the service. In most situations, the combined Medicare/Medicaid payment that the provider receives is greater than the amount the provider would have received if the patient had Medicaid-only coverage. If this proposal is adopted, Medicaid will no longer pay any portion of the Medicare Part B co-insurance amount, when the total Medicare payment received by the provider is more than what the practitioner would have received if the patient had Medicaid-only coverage.

Final Financial Impact (Dollars in Millions):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$-42.00	$-42.00	$-42.00	$-42.00
Total Savings	$-84.00	$-84.00	$-84.00	$-84.00

Benefits of Proposal:

This proposal will provide considerable cost savings to the Medicaid Program. Since Medicare's payment is almost always greater than the Medicaid fee, physicians will continue to receive payments that equal or exceed the dollar amount that the practitioner would have received if the patient had Medicaid-only coverage.

Concerns with Proposal:
Medicaid payments to physicians for Medicare/Medicaid dually eligible recipients will be reduced. This may discourage physicians from participating in the Medicaid program, reducing patient access.

Impacted Stakeholders:
Physicians

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

System Implications:
Considerable eMedNY system changes will be required.

Metrics to Track Savings:

Contact Information:

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Viability: Short term

Modified Delphi Scoreable: Yes
Modified Delphi Score:

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 196

Proposal (Short Title):
Supportive Housing Initiative

Theme: Ensure Consumer Protection and Promote Personal Responsibility

Program Area: Long Term Care

Effective Date: 01/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
Lower costs by keeping patients out of institutional care (Nursing homes, etc) and establishing a supportive housing initiative

There are many activities underway as alternatives to nursing homes such as assisted living, assisted living residences, special needs assisted living residences,and the OMH supportive housing initiative. The need to expand these alternatives is critical to reducing reliance on nursing homes and other institutional settings. A NY/NY 4 agreement with New York City would be pursued based on the findings of earlier agreements.

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
Provides housing resource to aged and disabled that avoids institutional placements

By providing hoousing stability, research has shown that health care costs inclusing Medicaid can be reduced.

Concerns with Proposal:
In order to expand this type of resource additional funding is required for development.

Impacted Stakeholders:

Consumers, developers, housing providers

Additional Technical Detail: (if needed, to evaluate proposal)
There is a lack of detail on the nature of what "supportive housing" means and the role of the state Medicaid system.

System Implications:

Metrics to Track Savings:
Institutional placements pre and post agreement

Contact Information:

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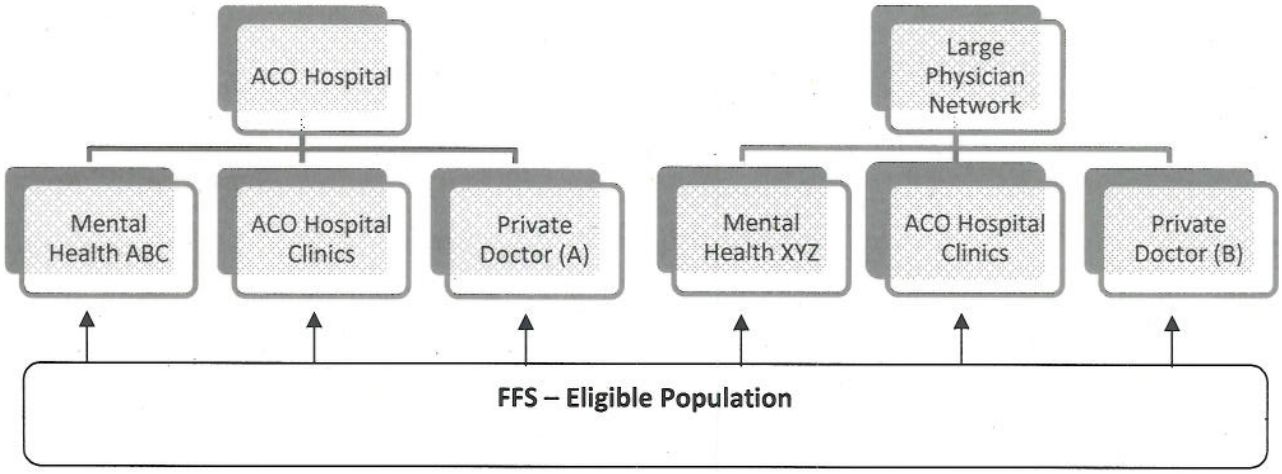
Viability: S

Modified Delphi Scoreable: True
Modified Delphi Score:

POTENTIAL ACCOUNTABLE CARE ORGANIZATIONAL STRUCTURES



Potential Bonus and Penalty Criteria for ACOs

Quality Over Three Years

Resource Use over three years	Meets Target In All Three Years	Mixed Performance On Target	Fails Target In All Three Years
Meets Target In All Three Years	Return Withhold And Share Of Savings (Bonus)	Return Withhold	Withhold Not Returned (Penalty)
Mixed Performance On Target	Return Withhold	Return Withhold	Withhold Not Returned (Penalty)
Fails Target In All Three Years	Return Withhold	Return Half Withhold	Withhold Not Returned (Penalty)

Source: MedPac, June 2009

Illustrative Example of ACO Withhold and Bonuses

Quality of Care	ACO Base Spending in 2011	Target Spending in 2012	Actual 2012 FFS Billing	Withhold (10%)	Bonus of 80% Share of Savings	Net Medicare payment
Good	$7,000	$7,500	$7,000	$700	$400	$7,400
Poor	$7,000	$7,500	$8,000	$800	$0	$7,200

Source: MedPac, 2009

PROPOSAL TO REDESIGN MEDICAID

Proposal Number: 243

Proposal (Short Title): Accountable Care Organizations (ACOs)

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

Program Area: Managed Care

Effective Date: 10/01/2011

Implementation Complexity: High
Implementation Timeline: Short Term

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

Proposal Description:
Explore reimbursement models to implement Accountable Care Organizations (ACOs) for Medicaid beneficiaries. Need guidance from CMS.

Explore models through which to implement Accountable Care Organizations (ACOs) for Medicaid beneficiaries, including individuals eligible for both Medicare and Medicaid. ACOs are provider-led entities that monitor patient care across multiple care settings (e.g., Medicare, Medicaid and private insurers) for the overall cost and quality of care for a defined population. ACOs create incentives for providers to emphasize primary care, prevention and adherence to evidence-based guidelines. These practices reduce patient care costs, the surplus of which is shared among participating providers.

ACOs will need to satisfy the following Federal requirements: (1) become accountable for the quality, cost and overall care of the fee-for-service beneficiaries assigned to it; (2)enter into an agreement with the Secretary of Health and Human Services (Secretary) to participate in the program for not less than a 3-year period; (3) establish a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers; (4) include primary care ACO professionals that are sufficient for the number of beneficiaries assigned to the ACO; (5) provide the Secretary with such information as the Secretary deems necessary regarding professionals participating in the ACO; (6) establish a leadership and management structure that includes clinical and administrative systems; (7) define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care; and (8) meet patient-centeredness criteria specified by the Secretary.

There are several different ways to structure an ACO. In order to determine the potential savings created by implementing an ACO, a payment model and method of participation must be developed.

An ACO may be reimbursed under either a partial capitation or fee-for-service payment model. Under a partial capitation payment model, an ACO would assume financial risk for some, but not all, of the services it provided. In contrast, under a fee-for-service payment model, an ACO would receive a shared savings incentive payment in addition to its regular fee-for-service reimbursement.

Participation in an ACO may be either voluntary or mandatory. Physicians may elect to participate in an ACO under a voluntary model whereas physicians would be assigned to an ACO that includes at least one hospital under a mandatory model. The potential for savings is greater under a mandatory model. Patients retain the choice of provider, including those providers not participating in the ACO, under both models.

Final Financial Impact (Dollars in Millions):

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

Benefits of Proposal:
Implementation of the ACO model has the potential to create significant Medicare and Medicaid cost-savings through the coordination of care. The ACO model provides financial incentives to curb fee-for-service spending while simultaneously encouraging improvement in the quality and efficiency of health care services. Furthermore, the ACO model establishes the framework through which other cost saving measures (e.g., medical homes, bundled payments, partial capitation and HIT) can be implemented.

In addition, certain New York hospitals, such as Montefiore and NYC Health and Hospital Corporation (HHC), are well positioned to quickly and effectively implement the ACO model.

Concerns with Proposal:
The ACO model will need to be well defined before it can be implemented and may require amendments to state and/or federal laws and regulations. This is of particular concern with issues related to patient privacy and anti-trust laws. Full implementation may take a significant amount of time, hindering the realization of any meaningful short-term savings.

Impacted Stakeholders:
Providers of services to Medicare and Medicaid beneficiaries as well as industry associations (e.g., Healthcare Association of New York State, Greater New York Hospital Association and other trade organizations) will be impacted by the implementation of the ACO model.

Savings associated with the establishment of ACOs are reflected in the commitment to implement pay-for-performance, health homes and other such initiatives. ACOs may, however, create potential for additional provider savings in the long-term, especially as relating to the Medicare program.

Additional Technical Detail: (if needed, to evaluate proposal)
Implementation of the ACO model will require significant restructuring of the current health care delivery system in New York State. For example, health care providers will need to form new legal entities that will satisfy objectives of the ACO model while maintaining compliance with state and federal laws. Furthermore, patient information will need to be accessible to a greater number of providers administering a broader range of services.

System Implications:
There are no immediate eMedNY implications.

Metrics to Track Savings:
A comparison of historical Fee-for-Service utilization and expenditures versus utilization and expenditures under the ACO.

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Viability: S/L

Modified Delphi Scoreable:	True
Modified Delphi Score:	