RECOMMENDATIONS OF KALEIDA HEALTH and GREAT LAKES HEALTH OF WESTERN NEW YORK

TO THE NEW YORK STATE MEDICAID REDESIGN TEAM

1:30 p.m.
January 19, 2011
Roswell Park Cancer Institute

Kaleida Health is a member of the Greater New York Hospital Association (GNYHA). GNYHA has developed a series of recommendations that we believe will provide a more efficient Medicaid program while preserving access to essential health care services.

The recommendations are as follows:

I. *Managing High Cost Populations* – Individuals with multiple chronic conditions comprise a significant portion of State Medicaid expenditures. Some of these patients are enrolled in Medicaid managed care plans; others remain in the fee for service (FFS) system. Many have mental health co-morbidities and/or are utilizing long term care services. Improving care coordination for these patients can result in both better quality and reduced costs over time, but Medicaid cost-containment initiatives to date have focused on more short term, easily scored savings such as provider reimbursement cuts. It is critical that the State take action now to implement long term, sustainable solutions including the following:

   a. Health Homes – The State should establish a health home program for patients with multiple chronic conditions and/or serious and persistent mental illness. The program's focus should be provider-based, integrated care coordination teams responsible for providing or coordinating all of their enrollees' required health care services as well as connecting their enrollees to social support services. Teams would vary in makeup and the intensity of care coordination provided, depending on patient need, but in general would be composed of nurses, social workers, and outreach workers.

      Each home would be reimbursed a monthly care coordination fee, the funding of which is available at a 90% matching rate under the Affordable Care Act (ACA). The State should also identify all existing expenditures on care management programs that could be eligible for this enhanced matching rate, resulting in savings to the State. One example could be care management expenditures included in Managed Long Term Care Plan premiums.

   b. Mental Health Services for Managed Care Enrollees – Medicaid managed care plans currently provide mental health services for most enrollees. However, for these plans' SSI enrollees, the benefit is provided through the FFS system. State regulators have considered carving mental health services out of the plan benefit package for all enrollees and instead contracting with a Behavioral Health Organization (BHO) to provide care management. This expanded fragmentation is problematic given the importance of integrating mental and physical health care. While GNYHA supports comprehensive health plan benefit packages so that health plans are accountable and can better manage patients, the many challenges of coordinating services for the behavioral health population at the provider level can be made even more complex by myriad health plans with different behavioral health subcontractors and

administrative procedures. Plans also have limited experience managing care for patients with the most serious behavioral health conditions. A compromise suggestion is to have plans cover this benefit but require that they come together on at least a regional basis to contract with a single BHO that meets standards established by the State Departments of Health and Mental Health and provides care management services that are eligible for the 90% Federal match. This could be made a contracting requirement for plans. Additionally, it's likely that this approach could be accomplished more quickly than if the State did a competitive procurement for a statewide BHO.

c. Client Records - To facilitate quality and efficiency improvements through new coordinated service strategies, the State should develop personal client records to link utilization and State spending on health care, special education, welfare, housing, corrections, and all other services rendered to specific clients. This would facilitate the ability of health care providers to care for defined populations in partnership with public and community-based organizations. It would also enable the State to track and score the full savings associated with the new coordinated service program and develop reimbursement models to support such programs. To this end, the State should also try to reconcile the conflict between restricting the exchange of client information for privacy reasons and fostering improved service coordination and outcomes.

d. Long Term Care Services – New York spends approximately $14 billion annually on long term care services provided to the frail elderly and the disabled. The five major categories of long term care services are Nursing Home, Personal Care, Certified Home Health Agencies (CHHA), Long Term Home Health Care (LTHHC), and Managed Long Term Care (MLTC). While these programs vary considerably, there appears to be no clear rationale as to which program a patient enters. MLTC and LTHHC provide care management and also require that patients receive nursing home level care. The CHHA and Personal Care programs do neither. New York must develop a more systematic and rational approach to delivering long term care services. Important components include:

    i. Finalizing the development of a single, standardized, automated assessment, a service plan, and an authorization process that could be applied to both nursing home and community residents (allowing for comparisons across groups).
    ii. Requiring that patients needing higher levels of care, as determined by the assessment, be enrolled in a program that includes care management.
    iii. Expanding programs that provide care management, such as MLTC and LTHHC.

iv. Reforming the Personal Care program to standardize eligibility determinations and service authorization. This should include additional training of Community Alternative Systems Agency (CASA) staff to ensure uniform application of standards. In addition, the payment methodology for Personal Care should be reformed to incorporate incentives for appropriate service utilization. Consideration should also be given to including Personal Care services in the managed care plan benefit package.
v. Expanding palliative care and end-of-life support. Effective palliative care and pain management services must be part of any system of care, but are ineffectively used in the State, even for individuals with chronic conditions and complex medical needs who usually have time to express their wishes concerning end-of-life care. Efforts should be made to ensure access to these services, including expanded consumer and provider education.
vi. Implementation of balanced long term care eligibility reforms with the potential to reduce inappropriate asset transfers and curtail the practice of "spousal refusal" while promoting greater personal responsibility for payment of long term care expenses.

e. Dual eligibles (duals) – Most users of long term care services are dually eligible for Medicare and Medicaid. In New York, duals account for 40% of Medicaid spending but only 13% of enrollees. A significant portion of this spending is for long term care services—both in the community and in institutions. The State has long recognized the high costs attributed to this population and the misaligned incentives that exist between states and the Federal government based on primary payment responsibility. This misalignment results in numerous potentially avoidable hospital admissions, particularly for patients residing in nursing homes.

   New York has attempted innovative programs to improve care coordination and cost efficiency by integrating care and financing through Programs of All-inclusive Care for the Elderly (PACE) programs and the Medicaid Advantage and Medicaid Advantage Plus programs. But several factors have limited enrollment in these models, including model restrictions and scalability (PACE) as well as administrative complexity and certain market dynamics (Medicaid Advantage). Fortunately, the need to address care coordination for the duals is a prominent theme in Federal health reform and the ACA provides numerous opportunities for both providers and states to develop new initiatives to integrate both care and financing. GNYHA strongly recommends that the State take advantage of this opportunity by working with health plans and providers to more effectively care for the needs of duals. One potential framework would be to pursue a Federal waiver for a dual eligible demonstration that would allow the State to share in Federal savings

resulting from improved care coordination and reductions in avoidable hospital admissions. This could include expansion of existing integrated programs such as Medicaid Advantage Plus and PACE but under a shared savings umbrella. While Federal law does not permit mandatory enrollment for Medicare beneficiaries, the State could provide strong incentives for duals to receive both Medicaid and Medicare services from the integrated entity. One possibility would be to only provide coverage for certain Medicaid-optional services to those duals that enroll. Another possibility would be a soft mandate—requiring duals to enroll for Medicare and Medicaid services but permitting an opt-out after a period of time.

II. *Improving Management of Pharmacy Services* - All prescription drugs are currently provided on a FFS basis under Medicaid, even for Medicaid managed care enrollees, partly because in the past States could not claim rebates for drugs provided through Medicaid managed care plans. But this is no longer true under the ACA. We therefore recommend that the New York State Department of Health (DOH) consider including both prescription and over-the-counter medications in the benefit package provided by managed care plans for both Medicaid and Family Health Plus (FHP) enrollees. Another alternative would be for the State to contract directly with one of the national pharmacy benefit management companies that have significant purchasing power and sophisticated clinical management tools. This alternative would likely require a longer lead time for implementation.

III. *Preserving Access to and Improving Efficiency of Hospital Services* - State budget actions in the past four years have reduced hospital revenue by $1.2 billion on a recurring, annual basis and resulted in aggregate Medicaid payments significantly below the cost of providing many services. This has exacerbated the underlying financial fragility of many hospitals serving primarily indigent and underserved populations. Short-sighted budget initiatives that seek to close the deficit through additional provider rate cuts will unquestionably lead to additional hospital closures and capacity shortages in many communities. While some closures may be feasible if the recommended care coordination program succeeds in reducing inpatient bed need, essential hospitals must be identified and preserved. The 2011-12 State budget must include initiatives to preserve essential hospitals in low-income communities and must also facilitate the following:

a. The impact of budget-driven Medicaid rate cuts to hospitals is exacerbated by the ripple effect of these cuts to other payers. Medicaid rates should be decoupled from other payer rates such as Workers' Compensation, No Fault, and the FHP Employer buy-in program. Options could include adding a differential to the Medicaid inpatient and outpatient reimbursement rates for payers required to use the Medicaid rates, or allowing providers to negotiate these rates.

b. DOH should develop a robust, data-supported process to identify the essential provider infrastructure in each community and take selective action to sustain essential services amid budget cuts. In particular, DOH must ensure that obstetrical services are available in every community. Facilities that are not viable and potentially no longer needed should also be identified. In the near term, DOH should use its knowledge of local communities and service providers to stabilize a limited number of at-risk essential hospitals through across-the-board or service-specific restorations of funding cuts. This could be accomplished through a variety of mechanisms and with non-Medicaid funding, such as unallocated HEAL funds. Using such funding for this purpose would be appropriate because essential community providers should be viewed as a public good. Additionally, the State should consider the appropriateness of requiring private payers to pay this limited hospital cohort the same rates recommended for Workers' Compensation and other payers.

c. DOH should participate in and support independent hospital applications to participate in Medicare and Medicaid demonstrations of new reimbursement strategies, such as bundled payments, shared savings, and global budgets to support the development of client- and patient-centered care. GNYHA is especially interested in supporting a bundled payment demonstration as a potential way to improve incentives to reduce potentially avoidable readmissions and to conduct research into the impact of socio-economic and environmental risk factors on health care utilization and geographic variation.

d. DOH should convene a workgroup charged with identifying regulatory reforms that will reduce the administrative burden for both itself and providers.

IV. *Redesigning the Inpatient Psychiatric Infrastructure* - Federal law prohibits freestanding psychiatric hospitals (Institutions for Mental Diseases) from billing Medicaid for services provided to Medicaid-eligible, non-elderly adult patients. Since this exclusion does not apply to psychiatric units in general hospitals, treating the same patients in a general hospital unit instead of a freestanding hospital would generate Federal funding that can substitute for State funds. Since the State receives Medicaid disproportionate share hospital (DSH) payments for losses incurred in running IMDs, the Federal funds leveraged for Medicaid would have to exceed Federal DSH payments to generate net savings to the State. However, even if these savings are limited, if transferring patients from State psychiatric hospitals to qualifying psychiatric units permitted the State to close some facilities, it would save the fixed costs of running them. Although this proposal has been made in the past but not moved forward, a new opportunity presents itself from the high-cost population initiative. The chief way to better manage high-cost Medicaid patients and save money for the State is by avoiding

hospital admissions and readmissions. This will free up beds in general hospitals and thus better facilitate a transfer initiative.

V. *Reforming Medical Malpractice* – The medical malpractice system diverts enormous resources from the health care system in general and from state Medicaid programs in particular. This is due not only to the high cost of malpractice coverage, but also to the extraordinarily high cost of defensive medicine practiced to avoid potential liability, particularly in New York State where hospitals and physicians suffer from exceptionally high malpractice costs that worsen hospitals' poor financial conditions. Almost half of these malpractice costs relate to the delivery of obstetrical services alone. While this is a major problem for the State's health care system at large, it is an exceptionally critical problem for the State's Medicaid program and its largest Medicaid providers: New York State's Medicaid program covers nearly 50% of all deliveries in the State, nearly 60% of all deliveries in New York City, and over 70% of all deliveries in Brooklyn and the Bronx. Equitable and innovative approaches to reforming the State's medical malpractice system will improve the financial viability of the State's Medicaid providers and improve the delivery system for all New Yorkers. It will also reduce the overall cost of the Medicaid program by reducing the unnecessary costs and burdens of defensive medicine.

VI. *Advancing Implementation of Health Information Technology (HIT)* – The American Recovery and Reinvestment Act (ARRA) provides Federal funding for Medicaid incentive payments to hospitals to encourage the adoption and use of (EHRs). States may award 50% of that funding in 2011 to qualifying hospitals that are adopting, implementing, or upgrading EHR technology to assist in their efforts towards achieving meaningful use. The State is in danger of delaying hospital access to this critically needed Federal funding and must take all steps necessary to assure timely access to this funding in 2011. Investment in HIT is essential to improve both hospital quality and efficiency.

VII. *Ensuring Appropriate Data to Support Medicaid Cost Saving Initiatives* - The Medicaid Redesign Task Force should convene a workgroup to determine the data needs for supporting all cost containment programs. This workgroup would double as a forum to ensure alignment of DOH's HIT policy with the cost-saving imperative. Hospitals would gladly help finance additional DOH positions to ensure adequate data development and dissemination. In addition, the State should develop policies as soon as possible to enable installation of the PSYCKES system at all qualifying provider sites. Even though OMH developed PSYCKES as a quality improvement tool for mental health services, this outstanding system has immediate potential to improve patient safety and care coordination of all Medicaid services for all beneficiaries.

VIII. *Expanding the PSYCKES Quality Improvement Program to All Community- and Hospital-based Providers of Mental Health Services.* – The PSYCKES tool gives providers five years'

worth of Medicaid claims and managed care encounter data, along with virtually real-time pharmacy data, to facilitate improvement in the quality of care for mentally ill Medicaid beneficiaries. One important intervention is to identify patients taking more than one anti-psychotic drug. In order to improve the management of psychiatric prescription drugs (including the prevention of off-label use) and to avoid excessive Medicaid spending, the State should expand the PSYCKES quality improvement program to all community- and hospital-based mental health providers in New York State.

IX. *Preserving Medicaid DSH Funding* – The ACA requires the Secretary to reduce Federal spending through the Medicaid DSH program, starting with $500 million in 2014 and phasing up to $5.6 billion in 2019, with annual recurring savings of $4 billion thereafter. Furthermore, the Secretary has discretion as to how much to cut the Federal DSH allocation to each state. Among other criteria, the Secretary will favor states that distribute DSH funding based on Federal priorities. New York must ensure that its distribution aligns with the Federal priorities to avoid a disproportionate Medicaid DSH cut.