Recommendations of HANYS' Task Force on Improving New York State's Medicaid Program

November 2010

MAIN HEADQUARTERS: One Empire Drive / Rensselaer, New York 12144 / (518) 431-7600 / fax (518) 431-7915 / www.hanys.org
WASHINGTON, D.C. OFFICE: 499 South Capitol Street SW, Suite 405 / Washington, D.C. 20003 / (202) 488-1272 / fax (202) 488-1274

CONTENTS PAGE

Executive Summary

New York State's decades-long effort to control Medicaid spending has failed to adequately address the core issues that plague the system, leaving the program structurally wasteful and fiscally unsustainable. In the balance are billions of tax dollars and 4.4 million New Yorkers (23% of the state's population) who depend on the Medicaid system.

The next Legislature and Administration in Albany must face with conviction what every learned provider, policy maker, and academic has known for many years: New York's Medicaid system must be fundamentally redesigned. We must jettison inefficient models of reimbursement and care, and invest in proven models that will yield a more efficient and sustainable system, and healthier beneficiaries.

HANYS' members responded to this challenge by impaneling a Statewide Task Force on Improving New York State's Medicaid Program, charged with recommending structural changes necessary to achieve a more efficient, effective, and sustainable system. The Task Force, comprised of health care provider leaders, examined not only specific changes government must enact, but also those that providers must embrace. The effort was comprehensive and soul-searching.

The Task Force's effort yielded numerous structural recommendations, including those designed to:

- improve care delivery and reduce costs;
- improve care coordination for high-cost populations;
- implement innovative payment and delivery system reform;
- improve quality;
- reform an outdated, counter-productive regulatory system; and
- reform the medical malpractice system.

This document includes specific recommendations generated by the Task Force.

Numerous rounds of hospital and nursing home Medicaid rate cuts have not resolved spending growth because these rates are not the primary drivers of spending growth. Amid the myriad factors that have driven costs upward, two stand most prominent:

- **Enrollment growth.** Prudent state policies designed to expand Medicaid enrollment have been successful, driving enrollment up by 56% (more than one million new enrollees) between 2000 and 2008. State Medicaid spending over the same time grew by 64%.
- **High-cost populations.** Just 21% of Medicaid enrollees account for 75% of New York's Medicaid expenditures.

We must eschew short-term approaches, such as rate cuts, that fail to resolve these core issues and impede providers' ability to care for all New Yorkers. Would we address explosive growth in student populations by repeatedly cutting state school aid? Of course not. Yet, this has been the government's approach to Medicaid.

Successful structural redesign will require the collaboration of policy makers, providers, and other stakeholders. Providers bear the responsibility of caring for 19 million New Yorkers in an era of diminished resources. Our stake in the outcome of this effort is clear.

We are unified and prepared to do our part to design and implement the necessary changes. With a government partner willing to truly embrace redesign and ready to abandon failed approaches and instead invest in proven strategies, we will succeed.

We have kicked this can down the road for too long. It is time to act.

Reform Medicaid to Improve Care Delivery and Reduce Costs

Improve Care Coordination for High-Cost Populations

Potential Impact:
Care coordination can reduce hospitalizations, reduce the rate of complications from chronic conditions, and help eliminate health disparities. Structured appropriately, care coordination can improve outcomes and reduce costs.

Recommendations:

- Policymakers must develop robust policies to improve care coordination for high-cost populations. It is time to move beyond studies and demonstrations; sufficient knowledge and evidence exists to move forward on reform.
- The state must position itself in the 2011-2012 state budget to take advantage of any innovative initiatives and resources available through the new Federal Coordinated Health Care Office.
- Providers, payers, and practitioners must be supported and encouraged to create local partnerships and systems to best meet the needs of high-cost patients. A "one-size-fits-all" solution will not work; the appropriate entities to oversee care management of high-cost populations will therefore vary.
- The state must end population exclusions from Medicaid managed care and, by 2012, include all high-cost populations in a managed care, care-coordination program. Quality scores for health plans should include measures related to care coordination.
- Regulatory, legal, and payment impediments to care coordination within and between provider settings must be addressed.
- Personal responsibility is critical and warrants consumer-focused incentives and disincentives.
- Successful models of care coordination should be replicated, such as the medical home model, chronic care demonstrations, managed long-term care, and long-term home health care. At the same time, innovation and a re-thinking of current practice models must occur.

Rationale:
Most high-cost Medicaid beneficiaries receive care within the fee-for-service system. Their needs are complex and expensive, and they are often dually eligible for Medicare and Medicaid and/or require long-term care or behavioral/mental health services. Services and financing are difficult to coordinate and often subject to conflicting incentives and rules.

The presence of multiple chronic conditions increases the complexity of caring for patients, affects quality outcomes, and drives up health care costs. The Institute of Medicine of the National Academy of Sciences identifies care coordination as a key strategy to address this.

- According to the New York State Department of Health (DOH), 21% of Medicaid enrollees account for 75% of Medicaid expenditures.
- Individuals dually eligible for both Medicare and Medicaid account for about 14% of enrollees and more than 40% of Medicaid spending in New York State.
- The United Hospital Fund estimates that the 400,000 Medicaid beneficiaries using long-term care in New York State incur about $23 billion annually in Medicaid spending for all services.
- These patients generally have multiple chronic, medical, and behavioral/mental illnesses and may not be well connected to the health care system.
- A large percentage of health care use occurs during the last year of life.

Recommendation Details:

Innovative Payment Approaches—HANYS recommends aggressive efforts to expand and/or develop innovative payment models to promote advances in care coordination through:

- shared savings arrangements;
- care management fees;
- capitation arrangements;
- enhanced support for primary care;
- support for co-location of health and mental health services;
- incentives to nursing homes to strengthen services to minimize transfers to hospitals;
- support for telemedicine and telehomecare expansion; and
- enhanced rates for clinics with evening and weekend hours.

Managed Care

There is very limited coordination between Medicaid and Medicare for the care of the state's 600,000 dually-eligible beneficiaries. The state developed the Medicaid Advantage and Advantage Plus programs to coordinate with Medicare managed care plans. Unfortunately, only 5,771 individuals were enrolled in these plans in 2010.

In November 2009, The Lewin Group issued a report in collaboration with the New York State AIDS Institute on New York's Medicaid HIV Special Needs Plan (HIV SNP) program. It found that HIV SNP reduced overall Medicaid expenditures, primarily through a significant reduction in inpatient costs (fewer admissions, shorter length-of-stay, and a shift of admissions to lower-cost hospitals).

Medical Homes

Medical home models encourage cooperative, collaborative, and integrative arrangements between providers and payers. Medical home multi-payer programs are an important method of improving access, patient care continuity, and coordination of health services, including the care of individuals with chronic conditions. New York State adopted the National Committee for Quality Assurance (NCQA) Physician Practice Connections®—Patient-Centered Medical Home Program (PPC-PCMH™). To participate, hospitals must receive PCMH certification through

one certifying entity. Additional options must be available and HANYS recommends that the state recognize certification of other entities, such as The Joint Commission, that are developing their own versions of a medical home model.

Three Targeted Approaches to Chronic Conditions

By focusing on care for patients with chronic conditions, the state can achieve the greatest cost reduction. For example:

- New York established a demonstration project to improve care for patients with chronic diseases. It identifies Medicaid beneficiaries at high risk of hospitalization for medical or behavioral health conditions and enrolls them in comprehensive care coordination programs. The demonstration currently provides funding for five providers to collaborate with community-based social service organizations on projects; they have had limited success in enrolling beneficiaries so far.
- Under programs implemented to better manage care in Oklahoma, patients at highest risk for poor outcomes and increased costs are provided case management services, and patients with high emergency room use are educated to encourage appropriate use of primary care services.
- More than 1.7 million New York State residents have diabetes, which, uncontrolled, can lead to serious complications. HANYS, working under a grant sponsored by the New York State Health Foundation, found that diabetes contributes substantially to rising health care costs and noted a statistically significant higher rate of readmissions for such patients. The state must incentivize adoption of evidence-based practices for primary care management of diabetes.

Managed Long-Term Care Programs and Long-Term Home Health Care Programs

These programs have a record of managing care for long-term care populations; obstacles to expansion must be eliminated.

Targeted Approaches to Pre-Hospital Care

Every community has "frequent flyer" patients who use emergency medical services as a gateway to health care and other services. Several cities have tackled this problem. An analysis of 911 calls in Washington, D.C., revealed that 30 people called for assistance more than 2,000 times in total, during 2008. To address this issue, emergency responders formed a unit dedicated to working with repeat 911 callers to help them solve their problems before calling, and thereby avoid unnecessary ambulance transport and emergency room visits. Calls from "frequent flyers" were reduced by 60%. In Memphis, Tennessee, five patients who called ambulances more than 200 times in six months called only 21 times in the calendar year following a similar intervention.

Opportunities for Savings in Medicaid Services, Benefits, and Design

Potential Impact:
As part of an effort to identify Medicaid savings, all areas of the Medicaid program must be examined, including management of care, scope of services, state benefit management rules and processes, and administration.

Recommendations:

- A comprehensive review of the design, structure, and operation of all aspects of New York's Medicaid program must be completed to determine which refinements would yield savings. However, this review must not slow down action where immediate change is appropriate; where sufficient knowledge and evidence exist to move forward on reform, do so.
- A workgroup should be established to participate in this review, including government officials, health care providers, consumers, and policy experts.
- This review must examine administration; the urgent need to better manage the care of beneficiaries, particularly those who are enrolled in the fee-for-service system; and "optional" services.
- The State Legislature must maintain, and preferably enhance, its oversight of Medicaid reimbursement and rate-setting. The legislative branch provides important checks and balances on funding decisions that have economic, geopolitical, and health policy consequences.
- The safety net must be preserved to provide care for vulnerable populations and to ensure access to vital services, such as burn and trauma services, for Medicaid beneficiaries and the general population.
- The state should work with New York's congressional delegation to ensure any revisions to the Medicaid Disproportionate Share Hospital (DSH) allocation formula do not disadvantage New York. In addition, the state and the workgroup should review the structure of the current Medicaid DSH program and consider how state DSH funds, combined with diminished federal funds, are used to support the program's policy goals.

Rationale:
Given Medicaid's evolving role, the anomalous structure of our state's Medicaid program, and New York's impending escalating budget deficits, it is imperative that a comprehensive review of New York's Medicaid program be completed to consider changes in its design, structure, and operation. It is time for a deliberate, comprehensive process of policy analysis and decision to take advantage of opportunities for cost savings, to rationalize and coordinate Medicaid services, benefits, and design.

During this review, particular attention must be paid to DSH funds, which are used to mitigate uncompensated care losses, offset Medicaid shortfalls, support safety net providers, and ensure access to necessary services for Medicaid and uninsured populations. The federal government allocated $1.6 billion in Medicaid DSH funds to New York for 2011. Combined with state funds, the DSH total is $3.2 billion. The federal health care reform legislation mandates

substantial reductions to federal DSH allocations beginning in 2014. The distribution of the remaining funds to states will be based on a revised formula.

Many safety net hospitals are heavily dependent on DSH payments to remain operational. New means must be found to continue support of safety net providers in the redesigned Medicaid system and care must be taken to avoid putting these already financially fragile hospitals at additional risk. Safety net providers include hospitals with high levels of services to Medicaid and uninsured populations; and hospitals that require support to maintain services that would otherwise be unavailable in their community.

Recommendation Details:

Administration

- The five-year plan to be developed by the state to assume control of the local administration of Medicaid must identify ways to improve eligibility determination and ensure greater consistency in counties across the state.
- The Medicaid claims processing system (eMedNY) must have flexibility to adapt to changes in payment, ensure that third-party insurance is billed properly, and detect payments that do not conform to state guidelines.
- Beneficiary fair hearings must be expedited to reduce the amount of time applicants must wait for a determination of eligibility for benefits.

"Optional" Services

Services considered "optional" represent more than $13 billion of New York State's Medicaid spending, according to the Governor's office.

State Medicaid programs must provide physician services, hospital inpatient and outpatient care, nursing facility care, laboratory and x-ray services, and other services. States may choose to provide an array of optional services. The federal government considers services such as prescription drugs, personal care, clinic, intermediate care facilities for people with disabilities, rehabilitative services, dental care, and transportation to be optional.

Other states cover many of the same optional benefits as New York, but manage their programs in different ways, in some cases funding them outside of Medicaid.

While spending amounts vary depending on the source, the following provides an estimate for the largest categories of optional services.

Largest Categories of Spending on Optional Services Annual Spending in New York State	
Drugs	$4.1 billion
Intermediate Care Facilities for People with Mental Retardation	$3.3 billion
Personal Care	$2.3 billion
Clinic	$1.2 billion

Source: The Governor's Office

In further reviewing data from the Centers for Medicare and Medicaid Statistical Information System, spending related to the blind, disabled, and aged comprised more than 83% of the amount spent on optional services in New York State in 2007. Spending on "mandatory" services by the elderly and disabled is closer to 60%.

HANYS recommends the following improvements:

Drugs

- Reassess the state's prescription drug purchasing, and implement provisions authorized in the 2009-2010 state budget for the Department of Health (DOH) to negotiate directly with prescription drug manufacturers to achieve additional savings through better rebates on drug purchases. The savings from this program have yet to be realized, but are estimated by the state to be at least $167 million.
- Examine state policies regarding generic drugs and their interchangeability with other therapeutic drugs in the same class.

Personal Care

- The personal care program is one of the largest and most costly optional services in New York State. According to DOH, Medicaid spending on personal care increased by about 28% from 2003 to 2008, while the number of personal care recipients declined 8.3%. DOH cites similar spending and recipient trends for several other long-term care programs.
- Virtually all of personal care spending is related to the aged, blind, and disabled. Given the extremely high utilization of personal care by the elderly and people with disabilities, and the apparent lack of case management, initiatives should be implemented to manage the care of individuals receiving personal care, many of whom are also dually eligible for Medicaid and Medicare and could benefit from care coordination.

Dental

A recent audit by the State Comptroller highlighted shortcomings in the Medicaid claims processing system for dental visits. Actions must be undertaken to ensure that the system is appropriately up to date.

Transportation Managers

The state budget authorized DOH to assume responsibility from a local social services district for provision and reimbursement of transportation costs through Medicaid, and to contract with a transportation manager to manage transportation services in that district. HANYS will follow the progress of this initiative, which offers potential Medicaid savings and should be pursued statewide.

Manage Care for Dually-Eligible Beneficiaries

Potential Impact:
Many individuals who are dually eligible for Medicare and Medicaid have multiple chronic conditions and could benefit from care coordination. Every one percent reduction in Medicaid spending resulting from the coordination of care for people who are dually-eligible saves the Medicaid program $175 million.

Recommendations:

- HANYS will work with the state to obtain federal approval for the Federal-State Medicare Shared Cost Savings Partnership Program already authorized in the 2010-2011 state budget. HANYS will advocate for appropriate reimbursement and mechanisms to allow providers to share in savings generated by more effective and efficient care for the dually-eligible population. A shared savings mechanism is critical to improve the alignment of incentives for providers, the state, and the federal government. This misalignment between Medicaid and Medicare promotes cost-shifting and a waste of resources and can lead to lack of coordination and less than desirable outcomes.
- The state should build on the existing Medicaid Advantage and Advantage Plus programs to enroll dual-eligibles in managed care programs that are coordinated and integrated with Medicare managed care plans.

Rationale:

- The dually-eligible population comprises a significant portion of the high-cost Medicaid population.
- The high-cost Medicaid populations include 682,000 individuals who are dually eligible for both Medicare and Medicaid.

	Number of Beneficiaries	**Annual Expenditures**
Aged 65 and over	463,200	$10.6 billion
Under age 65	218,486	$6.9 billion
Totals	681,686	$17.5 billion

Source: Department of Health

- Dual-eligibles represent 14% of enrollees, but account for more than 40% of Medicaid spending, with much of that spending for long-term care services.

Annual Medicaid Spending on Dual-Eligibles in New York State	
Institutional Long-term Care	$5.4 billion
Rehabilitation Services	$3.6 billion
Non-institutional Long-term Care	$3.4 billion
Intermediate Care Facilities for People with Mental Retardation	$1.9 billion
Managed Long-term Care	$900 million
Hospital Outpatient	$580 million
Hospital Inpatient	$560 million
All Other	$1.2 billion

Source: Department of Health

- While the state developed the Medicaid Advantage and Advantage Plus programs to enroll dual-eligibles in managed care plans in coordination with Medicare managed care plans, only 5,771 individuals were enrolled in these plans in 2010.
- Their health care needs can be complex and expensive, and there has been limited coordination between Medicaid and Medicare for the care of dual-eligibles. Neither Medicaid nor Medicare assumes responsibility to coordinate patient care or to align payment incentives (in general or with evidence-based practices).
- In its November 2008 review, Health Management Associates determined that well designed management programs can generate a positive return on investment and that there are "certain consistent patterns of care management through which savings can be achieved on a predictable basis." These patterns include strong individualization of interventions customized to the particular patient, frequent face-to-face contacts between patients and providers, early access to physicians, and sustained follow-up. These follow-up contacts should include "telephonic interventions that are time-sensitive, frequent, and individually engage the patient regarding clinical metrics and subjective assessments of conditions over time."

Recommendation Details:

HANYS recommends implementation of state and federal initiatives to better manage and coordinate care delivery and reimbursement for services provided to dually-eligible beneficiaries:

- The state budget authorizes the state to seek federal approval for a Federal-State Medicare Shared Cost Savings Partnership Program that would provide incentives to promote acute or long-term cost savings and efficiencies to the Medicare program related to dual-eligibles. Under this program, the state would accept risk for the delivery and financing of Medicare-covered services. The program would include an incentive to permit health care providers to share in demonstrated Medicare savings.
- The federal reform law encourages alignment of Medicare and Medicaid programs to develop integrated systems for dually-eligible beneficiaries.

Restructure Long-Term Care

Potential Impact:
There is a tremendous opportunity to realize efficiencies and reduce costs by improving long-term care management, particularly for people eligible for both Medicare and Medicaid and for those at risk of hospitalization.

Recommendations:

- State policymakers must work with health care providers and draw upon their expertise to reduce costs and improve care. Areas of focus must include care coordination, people eligible for both Medicare and Medicaid (dual-eligibles), and nursing home transfers to hospitals.
- Strengthen existing programs with a proven record of care management, including managed long-term care, the Long Term Home Health Care program, and the Program for All Inclusive Care for the Elderly (PACE).
- Identify and remove regulatory, workforce, and fiscal barriers to expand palliative care and relieve suffering, enhance care for seriously ill patients, and reduce hospitalizations.
- Implement a standardized, patient-specific assessment tool for long-term care services that meets clinical standards of practice.
- Ensure appropriate management of care for individuals receiving community-based long-term care.
- Streamline Medicaid eligibility for long-term care needs, including shortening the timeframe to determine eligibility ("Medicaid pending" cases), enforcing standardized processes for making determinations, and implementing accountability measures for local decisions about eligibility and services.
- Encourage personal financial responsibility in paying for long-term care by removing barriers to obtaining long-term care insurance, addressing politically sensitive issues related to asset divestiture, allowing people to access personal resources, and incentivizing the use of informal supports.

Rationale:

- Individuals using long-term care services (institutional and non-institutional) require significant amounts of health care resources, and often have multiple chronic medical conditions that increase health care costs and complicate care coordination.
- New York's Medicaid program spends about $23 billion each year for long-term care, which includes nursing home and home care, or about 30% of the Medicaid budget.

Recommendation Details:

"Rebalancing" Long-Term Care
For several years, policy initiatives have been geared toward rebalancing spending on nursing home and home- and community-based services (HCBS). The established national target is for

total long-term care expenditures to be evenly allocated between institutional and non-institutional services and supports.

The federal health care reform law incentivizes home- and community-based services by encouraging new optional benefits and providing a financial incentive (increased Federal Medical Assistance Percentage rate) for states to reach a 50% HCBS spending target by 2015. Three structural reforms would be required: a "No Wrong Door—Single Entry Point System; adoption of conflict-free case management; and application of core standardized assessment instruments.

The federal health care reform law also includes the Community First Choice Act, extension of the Money Follows the Person Rebalancing Demonstration, and an appropriation for Aging and Disability Resource Center initiatives.

HANYS recommends:

- Enhance consumer information, education, and navigation assistance, focusing on patient-centered choice and decision-making, and efficient access to the appropriate level of care and services.
- Expand long-term care options, such as assisted living and home- and community-based services.
- Identify spending on out-of-state Medicaid placements and seek to repatriate these individuals.
- Eliminate unnecessary nursing home and home care documentation requirements; other requirements must be streamlined.

Uniform Assessment Tool for Long-Term Care

The lack of a standardized patient-specific assessment tool is a significant and persistent impediment to continuity of care for both Medicare and Medicaid beneficiaries, especially those who are dual-eligible. Despite federal and state policy and reimbursement changes that continue to push for collaboration and coordination between providers and continuity of care across settings, these systems still have no uniform, single assessment tool for measuring a beneficiary's clinical, functional, and psychological health status. The separate and distinct assessments required for Medicare/Medicaid nursing home residents and home care patients use conflicting definitions, have different meanings between settings, and prevent data from being shared as the patient receives care.

Long-Term Care Financing Options and Eligibility

A recent Center for Health Care Strategies report, *Systems of Care: Environmental Scan of Medicaid-Funded Long-Term Supports and Services*, states that nearly two-thirds of Americans can afford less than one year of nursing home care. HANYS recommends that:

- Individuals and families should contribute appropriately to the cost of long-term care and not use legal loopholes to shelter/transfer income or assets and shift the burden to the public.
- Expand access to long-term care insurance to help individuals and families contribute to the cost of care.

- Promote the Community Living Assistance Services and Supports (CLASS) voluntary long-term care insurance program, established by the federal health care reform law.
- Individuals should be able to accelerate benefits from life insurance policies to subsidize long-term care and health care costs.

Local Coordination and Administrative Simplification

In many counties, the length of time it takes to determine eligibility for long-term care is excessive. Counties do not appear to interpret and make Medicaid eligibility determinations in a uniform and consistent manner across the state, nor is there a mechanism for holding counties accountable for their determinations. Process and/or policy changes are necessary to streamline eligibility determination. Additionally, the Department of Health and State Office for the Aging should work more closely at the local/regional level to better coordinate and integrate all services.

Improve Delivery of Behavioral and Mental Health Services

Potential Impact:
As shown by a number of demonstrations, it is possible to reduce costs and improve care delivery. These initiatives need to be replicated where possible, and modified to meet community needs. One demonstration saved as much as $28,000 per person, per year.

Recommendations:

- Replicate proven coordinated case management models. Emergency room visits, days spent in a hospital, arrests, physical harm to others, suicide attempts, and self-harm have all decreased under current demonstration programs. Expand the New York Care Coordination Program model to the upstate region by the end of state fiscal year 2011-2012, and expand downstate in subsequent years. Expand the Managed Addiction Treatment Services (MATS) model to several counties upstate in 2011-2012, and throughout the state in subsequent years.
- Invest in demonstration programs statewide in fiscal year 2011-2012 to better integrate physical and behavioral health services. Expand in subsequent years.
- Reduce duplication of regulatory and oversight activities for Article 28 programs among the Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and Office of People with Developmental Disabilities through a continued review and consolidation of requirements.
- Expand upon the social health maintenance organization model and re-evaluate Medicaid "carve-outs" to include coverage for mental health services and ancillary social services like nutrition programs and housing for Medicaid recipients.
- Immediately re-establish a multi-stakeholder workgroup to make recommendations on housing shortages that impact patients with mental health, chemical dependency, or developmental disability diagnoses.

Rationale:
Nineteen percent or $9.7 billion of the state's total 2010-2011 Medicaid budget is projected to be spent on mental health services. Numerous studies have shown that individuals with mental illness tend to have poor health outcomes and more complications related to chronic physical conditions. Care integration will be a critical component of health care reform, focusing on quality improvement and patient-centered medical homes.

Recommendation Details:

Care Management
While the state invested in small demonstration programs to reduce spending through care coordination, these programs have not yet been expanded statewide.

The New York Care Coordination Program is a collaboration of county mental health departments, service providers, and patients in Chautauqua, Erie, Genesee, Monroe, Onondaga, Wyoming and soon Westchester counties that promotes recovery and conserves resources to improve the health of people with serious mental illness. Originally created in 2000, this program has demonstrated health improvements for individuals, while reducing demand on

government resources. Emergency room visits, days spent in a hospital, arrests, physical harm to others, suicide attempts, and self-harm have all decreased. For example, in 2005, emergency room visits declined 55% and the days spent in a hospital decreased 58%.

New York City's MATS program, established in 2007, provides comprehensive clinical case management for intensive users of Medicaid-funded alcohol and drug addiction services who are on public assistance. By May 2008, MATS enrolled nearly 1,100 individuals, with an active caseload of 738 clients. The program is a partnership in which the client and case manager identify the full spectrum of needs that influence a patient's ability to successfully complete his or her service plan. The program identifies and facilitates access to needed services and other available public and community resources, while avoiding unnecessary or duplicative services.

By ensuring clients transition to lower levels of treatment and connecting them with other needed services, MATS is expected to save as much as $28,000 per person per year in Medicaid costs, saving $20 million.

Integration of Physical and Behavioral Health Services

Coordination of medical, mental, and psycho-social needs for high-cost beneficiaries will reduce administrative redundancies, integrate care delivery, and ultimately lead to improved quality, better outcomes, and lower costs.

One example that could be replicated across the state is the Primary Care and Mental Health Services Bridge Program developed in New York City in 1997 to improve access to care for Asian Americans by integrating mental health services in a primary care setting. The Bridge Program enhances the skills of primary care providers in the identification and treatment of mental disorders, and provides community-based health education about mental health issues.

The program received the Bureau of Primary Health Care "Models That Work" award in 2000 and was cited in the Surgeon General's *Special Supplement on Mental Health: Culture, Race, and Ethnicity* report as an example of bringing mental health care to the primary health care system to "strengthen the capacity of these providers to meet the demand for mental health services and to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve."

The Bridge Program continues to identify a growing number of mental health patients and has seen dramatic improvements in the rate of successful referrals to off-site specialty treatment.

Multi-Stakeholder Housing Workgroup

In its 2007 publication, *Guiding Principles for Housing*, the Office of Mental Health observed, "Safe, decent and affordable housing is a cornerstone of recovery from mental illness, as well as a mainstay of 'the American Dream.' Stable access to good housing is a fundamental problem for many people with mental illness because of their poverty, the limited supply of very-low-income housing, the rising cost of rental market housing and discrimination." At that time, only 14% of people with serious mental illness had access to state assisted housing: one-third lived with families; the rest lived in state psychiatric centers, adult homes, jails, prisons, shelters, and in the streets.

Hospitals are unable to discharge patients due to the lack of safe or decent housing. While multi-year commitments have been made for additional housing units and the New York/New York III program's promise to designate units for those with mental illness, there continues to be a serious lack of housing for these individuals.

Legislation has been introduced by the Legislature that would establish community housing waiting lists within the Office of Mental Health service system. These waiting lists would begin to identify the magnitude of the shortage of housing; however, the Governor has consistently vetoed the bill.

Innovative Payment and Delivery System Reform

Guiding Principles of Reimbursement and Administrative Reform

Reimbursement and Rate-Setting

- Medicaid demonstration projects must be voluntary, but include incentive payments to ensure broad provider participation.
- Health care providers cannot be expected to perform functions currently delivered by health insurance plans without adequate resources to do so or sufficient time to develop those capabilities. Health insurers and public programs must compensate providers for medical management.
- Ensure transparency in determining payment rates, risk adjustment, and reporting requirements for any payment reform.
- Avoid paying providers less than the cost of providing high-quality services to patients based on their health care conditions and other needs.
- The state must be willing to share savings that result from innovative payment and delivery system demonstrations with providers.
- Reward providers for keeping their patients healthy.
- Avoid penalties or across-the-board reductions in payment when trying to promote rapid transitions in health care delivery.

Administrative Simplification

- Give providers maximum flexibility to design innovative payment and delivery systems.
- Demonstration projects must not entail unnecessary duplication of services or impose unnecessary or excessive administrative burdens that increase providers' operating costs without fair compensation.
- Regional and geographic variation, physician supply, population size, facility type, and patient utilization habits must be considered when designing demonstrations.
- To maximize efficiencies and care coordination, Medicaid enrollees who are participating in innovative payment demonstration projects must obtain care within the assigned demonstration project.

Other Considerations

- Health care providers must not be expected to reduce or deny services that patients were promised under existing health benefits plans.
- Exceptions to "Stark," anti-kickback laws, and anti-trust laws are vital to the success of innovative payment and delivery reform.

Expand Patient-Centered Medical Homes

Potential Impact:
The Lewin Group estimates that a mandatory expansion of the medical home program could save the state as much as $33.66 billion from 2011 to 2020, or about 2.1% of current spending. A voluntary, expanded medical home program is expected to save the state approximately $9.11 billion from 2011-2020 or approximately 0.6% of current spending. Expanding the criteria for participation in the Statewide Patient-Centered Medical Home Program could increase the potential savings that may be realized through coordination of care.

Recommendation:
Introduce legislation in the 2011-2012 session to expand the current Statewide Patient-Centered Medical Home Program to more payers and broader patient participation. The legislation must do the following:

- Incentivize hospital-based outpatient clinics and primary care practices to participate in the medical home program.
- Assign all Medicaid recipients a primary care provider.
- Allow commercial payers to participate.
- Permit reputable accrediting bodies, such as Bridges to Excellence or The Joint Commission, to develop Patient-Centered Medical Home standards and offer an alternative to the current National Committee for Quality Assurance (NCQA) certification process.
- Consider reimbursement models that include enhanced fees for services, case management fees, and pay-for-performance/incentive payments.

Rationale:
On July 1, 2010, the New York State Medicaid program began offering incentive payments to office-based practices recognized by NCQA as Physician Practice Connections-Patient Centered Medical Homes. Patient Centered Medical Homes encourage better medical management and care coordination by designating a team to manage all aspects of a patient's care.

Support and Expand Accountable Care Organizations

Potential Impact:
The Lewin Group estimates the state would save $49.8 billion, or 4.5%, between 2011 and 2020 if all public and private payers were to adopt an Accountable Care Organization (ACO) program with mandatory participation. Savings of $14.59 billion, or 1.3%, would result during the same period if the program included only Medicaid beneficiaries and state and local government employees, and participation in the program was mandatory. If the program was voluntary but included all public and private payers, The Lewin Group estimates the state would save $10.71 billion, or 1%. A voluntary program that included Medicaid beneficiaries and state and local government employees would save $3.11 billion, or .3%.

Recommendations:

- Develop statute or regulations to expand global payment and ACO demonstration projects.
- Establish a multi-stakeholder task force, including hospitals, physicians, health plans, regulators, and consumers, to properly frame and implement expanded demonstration or payment programs.
- Assist willing providers who want to start their own ACOs, to maximize the shared savings that may result from these reform models.
- Design chronic care ACO models.

Rationale:
The federal health care reform law authorizes Medicaid global payment demonstration projects for safety net hospitals in up to five states beginning in 2010, and demonstration projects for pediatric ACOs beginning in 2012. These demonstrations are intended to test innovative payment and service delivery models to improve the coordination, quality, and efficiency of health care services provided to Medicaid beneficiaries.

Expand Testing of Bundled Payments

Potential Impact

The Lewin Group estimates if the state implemented a bundled payment program that was adopted by all public and private payers, and included only 26% of current reimbursed conditions, the state would save $6.3 billion between 2011 and 2020. If the program only included Medicaid beneficiaries and state and local government employees, the same 26% of conditions would yield approximately $1.56 billion between 2011 and 2020. If the state included 100% of currently reimbursed conditions, the savings grow to $24.2 billion, assuming all public and private payers participated. A program that included 100% of conditions and included only Medicaid beneficiaries and state and local government employees could save the state up to $6.2 billion.

Recommendation:

Expand upon the Medicaid bundled payment demonstration authorized by the Patient Protection and Affordable Care Act (PPACA) of 2010, by introducing legislation to authorize such a demonstration and establish a multi-stakeholder task force to design a state-sponsored Medicaid bundled payment demonstration project (the task force must establish conditions including a methodology for calculating the bundle, and expenses covered under the bundled payment).

Rationale:

Bundled payments have the potential to reduce costs and improve efficiency by incentivizing new and better ways to coordinate and deliver care. PPACA creates Medicaid bundled payment demonstrations to evaluate integrated care around a hospitalization in up to eight states beginning in 2012. If New York is not selected as a demonstration state, the state must enact a new law to create its own bundled payment demonstration. Reimbursement would cover all services, such as hospital services, physician services performed during the hospitalization, and post-acute care provided within 30 days of hospitalization.

Eliminate Inappropriate Emergency Department Use

Potential Impact:
Recent pilot projects and studies show that redirecting non-emergent Medicaid emergency department (ED) patients, particularly "frequent flyers," to more appropriate settings or to earlier treatment in less intensive settings results in dramatically improved outcomes, better use of ED resources, and significant savings. One such demonstration project that focused on early interventions to re-direct patients to collaborative social models resulted in a 30% drop in ED visits by frequent flyers after one year and 61% after two years. ED costs for these patients dropped 17% in the first year and 59% after two years. Admissions decreased 14% in the first year and 64% in the second. The alternative treatment models suggested by HANYS in this report look to achieve similar savings and improved outcomes.

Recommendations:

- Legislate provider and patient incentives that encourage the use of office- and hospital-based primary care providers for routine care and urgent care centers for after-hours care.
- Enhance payments to Medicaid providers to keep them in the program and ensure they continue to accept new patients.
- Provide incentive payments to urgent care centers and office- and hospital-based providers to encourage extended office hours so Medicaid recipients have greater access to routine care in an appropriate setting.
- Require urgent care centers to provide patients with a referral to a primary care provider for follow-up and routine care.
- Allow Certificate of Need flexibility so hospitals can build or convert units into urgent care centers, as appropriate.
- Incentivize patients to seek care in more appropriate settings by reducing or eliminating copayment requirements for those who present at urgent care centers after traditional office hours.

Rationale:
Frequent users of emergency departments often present with underlying problems like homelessness, poor nutrition, or a history of domestic violence that exacerbate the medical condition for which care is sought. Unless and until the underlying problem is addressed through collaborative care models, frequent emergency department users are likely to continue to access care inappropriately. Models for addressing these underlying problems in a cost-efficient manner must be explored.

Non-traditional care settings present an opportunity for the state to achieve real cost savings by treating patients outside of the emergency department. School-based health centers and mobile health clinics have been successfully implemented across the country.

Deploy a Fleet of Mobile Health Clinics Across the State

Potential Impact:
Providing primary and preventive care via mobile clinics will provide the medically vulnerable access to care, reducing the use of emergency departments for non-emergent care.

Recommendation:
Introduce legislation to provide financial and logistical support for a fleet of mobile health clinics to service vulnerable populations. Funding must be renewed annually.

- Form public-private partnerships with organizations like the Robert Wood Johnson Foundation, Children's Health Fund, Bureau of Primary Health Care, and Ronald McDonald House Charities to defray start-up costs associated with buying and stocking mobile health clinics.
- During peak times, strategically place mobile health clinics outside hospitals with high rates of inappropriate emergency department use.
- Establish routes for mobile health clinics in under-served areas like inner cities and rural communities.
- Ask employers who offer limited health benefits or none at all to allow mobile health clinics to operate at their place of business before or after shift changes to facilitate access to care for employees.

Rationale:
Mobile health care clinics bring primary and preventive care to those who need it most but have difficulty finding time or arranging transport to visit an office-based health center. When mobile health clinics are strategically deployed into under-served areas, the medically vulnerable are able to access care and less likely to use emergency departments for non-emergent care.

Enhance Access to School-Based Health Centers

Potential Impact:
Expanding school-based health centers will enhance access to primary care and reduce inappropriate use of hospital emergency departments.

Recommendation:
Fund the expansion of School-Based Health Centers (SBHCs) and increase their care capacity. Specific options include:

- Educate parents and students about appropriate settings for care and availability of services at SBHCs.
- Enable mature minors to give informed consent for care accessed at SBHCs during school hours.
- Require all payers to contract with local SBHCs.
- Apply for grant money to purchase new equipment for SBHCs as authorized by Section 4101(a) of the Patient Protection and Affordable Care Act.

Rationale:
Children who have regular access to a range of high quality health care services are healthier and less likely to use the emergency room inappropriately for non-emergent care. Providing regular access to primary care services to children through SBHCs can reduce the inappropriate use of emergency departments after school hours.

Advocate for Changes to EMTALA

Potential Impact:
Reforming the Emergency Medical Treatment And Labor Act (EMTALA) will decrease unnecessary emergency room care for patients whose conditions are not emergent, increasing efficiency and reducing costs.

Recommendation:
The state should join with the health care provider community in advocating for change to EMTALA that will enable hospitals to triage patients and redirect non-urgent care seekers to more appropriate settings.

Rationale:
Since it was enacted more than 20 years ago, EMTALA has been subject to ever-broadening interpretation by the Centers for Medicare and Medicaid Services, forcing New York's hospitals to provide high-cost emergency department care to any patient seeking treatment, even when emergency care is not appropriate. This approach is inefficient, costly, and inconsistent with the intent of federal health care reform.

Direct Non-Emergent Patients to Appropriate Care Settings

Potential Impact:
Simple steps and incentives can reduce the use of hospital emergency departments by non-emergent patients, reducing overall health care costs.

Recommendation:
Introduce legislation to give providers greater flexibility so that non-emergent care seekers receive care in appropriate care settings.

- Apply for a Medicaid waiver to require collection of a copayment before rendering non-emergent services in emergency departments to Medicaid recipients with incomes greater than 100% of the federal poverty level. A sliding fee scale may be used to assess a mandatory copayment up to the maximum amount allowed by federal law.
- Encourage hospitals to create "fast-tracks" within or near their emergency departments and allow triage nurses to direct non-emergent patients to the fast-track.
- Require hospitals to provide literature to patients at discharge explaining the difference between emergency, urgent, and primary care services to promote more efficient utilization in the future.
- Provide incentives and reimbursement provisions for outpatient clinics and primary care sites, particularly the National Committee for Quality Assurance Patient-Centered Medical Home model, to provide "24/7" or "16/7" service to patients.
- Revisit Emergency Medical Treatment And Labor Act regulations.

Rationale:
Waste can be eliminated and costs reduced if Medicaid enrollees do not use emergency department visits for non-emergent conditions.

Change Medicaid Reimbursement Rules

Potential Impact:
Reimbursement innovation will reduce costs by changing incentives to increase the efficiency of care delivery and the cost-effectiveness of the health care workforce.

Recommendation:
The state should design and implement innovative payment reform to reward cost-effective care models:

- Provide direct reimbursement to nurse practitioners and physicians' assistants.
- Allow reimbursement for diagnostic telemedicine.
- Permit reimbursement for group treatment of chronically ill patients.
- Pay for case management of the chronically ill and patients with comorbidities.
- Reimburse patient navigators who help Medicaid recipients obtain care in the most appropriate setting and the social/community support necessary to restore and maintain health.

Rationale:
Reimbursement innovation—for new models of treatment and for specific health care professionals—will reduce costs by increasing the efficiency of care delivery and the health care workforce.

Improve Quality

Adopt Guiding Principles for Developing Quality-Related Payment Policies

The state must adhere to a set of guiding principles when implementing any quality-related payment reform policies. By promoting, incentivizing, and rewarding patient-centered, evidence-based care, these principles will better align reimbursement with quality of care.

Well designed, quality-based payment reform policies can improve quality of care, encourage health care providers to meet standardized quality measures, and create a more efficient health care system. However, if poorly designed, such policies can lead to unintended consequences. Outdated and misaligned payment policies promote overutilization and waste, and mis-allocate scarce hospital resources. Moreover, inconsistent or misguided penalties can unfairly penalize providers for outcomes that are outside of their control, or prevent underperforming organizations from improving.

It is imperative that these pay-for-performance policies correctly incentivize positive outcomes, hold providers appropriately accountable for adhering to evidence-based practices, recognize factors beyond the control of providers, and support shared responsibilities between patients and providers.

The guiding principles for developing policies to align quality and reimbursement must include:

1. **Alignment**
   State approaches should be consistent internally with other state programs and with federal policies. The state must be required to report to the Legislature on the alignment of state quality-based payment proposals with other initiatives and justify any difference in method or approach that warrants an additional burden on providers. The Medicaid program must adopt a payment approach that incentivizes and positively rewards providers for performance excellence.

2. **Evidence-Based Care**
   Policies and programs designed to influence care practices must be based on a standard of care or evidence-based science. Only by adhering to this principle will such policies meet the goals of improving the quality of care and creating a more efficient health care system.

3. **Performance Payment**
   State policies should be crafted based on an accurate identification of those aspects of care that are under the health care organization's control. Associated pay-for-performance incentives or penalties must include only outcomes that are supported by an evidence base.

4. **Patient-Centered Care**
   State policies should promote patient participation and responsibility in health care decision making. Patients are partners in health care. The state should provide education and promote practices that encourage patient participation and responsibility for appropriately using the health care system and achieving positive health outcomes.

5. **Stakeholder Involvement**
   The provider community must have input into policy development. A fundamental understanding of health care operations and evidence-based science is needed to develop efficient systems. Input from experts in the field will help ensure policies are appropriately developed without unintended consequences for patients and the delivery of care.

Align State and Federal Quality Reporting Policies

Potential Impact:
Quality reporting is not without cost to hospitals and the state. Streamlining and aligning reporting requirements will allow the state to focus on collecting data for the most critical quality and patient safety issues and conducting comprehensive analyses of those data. Such analyses, if shared with health care organizations across the state, could be a vital resource to improve patient care, thereby reducing costs to the health care system.

Recommendations:

- Harmonize state and federal quality reporting systems to avoid unnecessary duplication.
- For efforts that extend beyond federal requirements, the state must streamline its quality reporting requirements and only collect data that it is able to analyze and use to improve care.
- Data collection must be efficient, standardized, and based on scientific evidence or accepted standards of care that support its use for quality improvement. Requirements for data reporting that do not meet these criteria must be eliminated.

Rationale:
Every new reporting requirement adds cost to the delivery of care and consumes resources that could otherwise be directed toward institutional performance improvement priorities or direct patient care. HANYS has long advocated for uniform quality reporting requirements that enable health care organizations to leverage evidence-based knowledge, maximize the use of limited resources, and continually improve quality and patient safety.

There has been a proliferation of quality reporting requirements for hospitals at the state and national level. Hospitals must report the same or similar data to New York State that they report to federal agencies. In addition, hospitals are required to report to numerous Department of Health databases. Many of these requirements are duplicative and have inconsistent definitions and reporting methods. Inconsistent approaches to quality reporting waste resources, undermine efforts to enhance quality improvement, and confuse stakeholders and the public.

Some of these measures have not been effective in improving outcomes for patients. Before providers are required to report measures, the measures must be required to meet certain criteria, particularly the ability to improve health outcomes for patients.

New York State's hospitals are committed to reporting, but their data must be analyzed, shared, and used to make meaningful quality improvements. Reporting systems can be powerful tools if the measures directly impact health outcomes and if the information is used to educate providers on emerging patterns and on methods for improving care delivery.

Recommendation Details:
The state must abandon quality reporting initiatives that are duplicative of nationally-recognized alternatives and accept similar national initiatives as evidence of compliance with state

requirements. This recommendation is not intended to negate the state's ability to influence, test, or model measures for national consideration.

The state must develop a workgroup of stakeholders to recommend areas where quality reporting can be consolidated and streamlined across state agencies and departments and ensure consistency in reporting across the continuum of care, including physician practices. This workgroup would also recommend sunsetting measures whose collection is no longer yielding information that significantly contributes to quality improvement or promotion of public health.

Advance Health Information Technology Solutions

Potential Impact:
Effective use of health information technology (HIT) systems has the potential to improve the quality and efficiency of care delivery across settings while advancing public health and medical research.

Recommendation:
Help the provider community successfully implement HIT and health information exchange (HIE) solutions that promote the delivery of efficient, high-quality care for patients.

Rationale:
Health care organizations need up-front funding to support the transition to an e-enabled health care system. New York's hospitals continue to characterize lack of access to capital as the most significant barrier to broad electronic health record (EHR) system procurement. To date, providing access to capital for hospitals to procure EHR systems has not been a state priority.

The American Recovery and Reinvestment Act (ARRA) Medicare and Medicaid EHR incentive program will make temporary funding available, as soon as 2011, to hospitals and physicians that "meaningfully use" EHR systems under rules established by the Centers for Medicare and Medicaid Services (CMS).

However, achieving "meaningful use" will be beyond reach for most New York hospitals as the program begins. Medicare incentive payments can only be drawn down after a hospital has the technology in place and is a meaningful user. HANYS has encouraged the state to exercise its authority to provide as much Medicaid incentive money in year one as is allowable under the law—50% of total projected Medicaid incentive payments over the course of the program.

New York's Office of Health Information Technology Transformation (OHITT) and the New York eHealth Collaborative (NYeC) developed a plan that represents a shift toward flexibility in the design of regional HIE within the state. The plan allows for the possibility of entities such as Health Information Organizations (HIOs) and Regional Health Information Organizations (RHIOs) to meet criteria to be designated as a Qualified HIT Entity (QHITE) and to connect to the Statewide Health Information Network for New York (SHIN-NY). HANYS encouraged the inclusion of this design flexibility and supports the proposal that QHITEs be required to meet privacy, security, and interoperability standards. The state is expected to develop regulations to define those entities and establish a QHITE accreditation process. HANYS expects to be a partner in the development of these regulations, which should be based upon a market approach to ensuring regional exchanges provide measurable value.

Through enhanced funding, the health care system will be able to implement widespread use of EHRs and HIE to improve clinical care through analytical tools, better coordination of care, informed and engaged patients, and improved public health. It will also give health care organizations better tools to analyze their quality of care and use that information to make improvements.

Recommendation Details:

- The state should take advantage of the authority it has under ARRA to distribute 50% of projected Medicaid EHR incentive funding to eligible hospitals in year one.
- The state must actively engage HANYS and its members as it fleshes out a definition of QHITEs, embracing market-based solutions to ensure HIEs provide value.
- The state must proactively engage the Department of Health and Human Services to fully realize the potential of programs established by ARRA to build the infrastructure for an HIT-enabled health system.
- The Department of Health (DOH) and NYeC must fully engage and support the hospital provider community with a clear, updated strategic plan for implementing SHIN-NY and the Medicaid EHR incentive payment program. DOH and NYeC should provide tangible tools and guidelines for implementation and ample opportunity for input from the provider community.
- DOH and NYeC should continue to collaborate with the provider community as the state moves forward to implement ARRA's Medicaid HIT incentive program and develops plans to foster HIE.

Facilitate Development of New Delivery Models

Potential Impact:
Risk-sharing models that provide consistent, coordinated care will reduce adverse outcomes and other negative consequences associated with fragmented care delivery systems, streamline care processes and patient transitions, and reduce overall costs.

Recommendation:
Develop innovative pilots and demonstration projects to identify, test, and enable new care delivery models that reduce cost and promote patient-centered care.

Rationale:
Federal health care reform will accelerate formation of care delivery systems that reduce costs and improve quality. The state may need to remove regulatory barriers to allow health care organizations to implement new delivery models through pilot or demonstration programs. The state must also align its efforts with information gained from the Center for Medicare and Medicaid Innovation and Center for Comparative Effectiveness to learn about promising new models and effective approaches, and to maximize opportunities for New York's providers to participate in these initiatives.

Recommendation Details:
The pilots and demonstration programs must include provisions for:

- collaboration and alignment among governmental agencies overseeing health care and social delivery systems;
- innovation in health care delivery models with well-aligned payment, quality, and fiscal accountability systems;
- evidence-based quality measurement that effectively incentivizes care management, coordination of services, and positive patient outcomes; and
- innovation of federal and state rules, regulations, and payment protocols that optimize performance, rewards, and outcomes.

Improve Patient-Centered Palliative Care

Potential Impact:
The involvement of a palliative care team enhances the quality of care provided to the patient and the experience of the family. Studies show that palliative care programs lead to increased patient satisfaction, improved quality, a significant reduction in both emergency room visits and hospitalizations, and overall reduced costs.

Recommendations:

- Identify and remove barriers in the regulatory, workforce, and fiscal arenas to expand palliative care in New York State.
- Develop and promote palliative care training opportunities for health care providers, other professionals, and the public. Education for the public must include decision-making and autonomy, advanced directives, palliative and hospice care, and end-of-life care across the continuum.
- Ensure that palliative care approaches do not conflict with nationally-endorsed palliative care guidelines.

Rationale:
Palliative care is an interdisciplinary specialty that aims to relieve suffering and improve the quality of life for seriously ill patients and their families. Palliative care involves addressing a patient's physical, intellectual, emotional, social, and spiritual needs across the continuum of care. Palliative care facilitates patient autonomy, access to information, and choice for the patient and family.

Palliative care assists an increasing number of people with chronic, debilitating, and life-limiting illnesses and is provided in a variety of settings including hospitals, outpatient settings, community programs within home health, and hospices. Currently, 57% of hospitals in New York State provide some type of palliative care services, the outcomes of which have demonstrated improvements in physical and psychological management of patient symptoms, improved well-being of the caregiver, and satisfaction of both the patient and family.

Recommendation Details:
Palliative care has been shown to reduce hospital length of stay and total costs per admission, while improving the quality of care and patient satisfaction. This is due to the clarification of the patient's and family's goals for care with discussions about the different options available to meet those goals. The palliative care team's support, instructions, and guidance can improve the experience of the patient and family.

Support for the education of health care professionals in the specialty of palliative care is needed to meet current and future demands. National certification of palliative health care professionals is advancing, based on the *National Consensus Project*, a National Quality Forum (NQF)-endorsed document describing core precepts and structures of clinical palliative care programs. This is particularly relevant as federal quality measures pertaining to end-of-life care will be

based on NQF definitions. It is important that the state not "reinvent" or conflict with this established work.

Educating the public about palliative care is key to transforming and improving the care of patients with chronic and advancing illness and the well being of their families. When hospice care was introduced to the U.S. in the late 1970s, very few families were aware of this unique option. Today, due in part to extensive community education, many patients and families know about hospice care and request it—this level of public awareness is now needed for palliative care.

Improvements are needed to make hospice and palliative care more accessible within the health care system, more flexible in terms of eligibility requirements and payment, and more recognizable by consumers and families as a patient-centered, compassionate component of care that offers multiple options to better manage a patient's multiple chronic conditions and quality of life.

Regulatory Reform Opportunities

Strengthen the Health Care Workforce

Potential Impact:
As more New Yorkers join the ranks of the insured because of health care reform, they will need access to care. We must strengthen the health care workforce to provide that access. Without an adequate supply of providers—especially primary care practitioners, long-term care, and home care workers—newly insured patients will add to the workload of the state's already stressed hospital emergency departments, where care is expensive. Appropriate use of the workforce's skill level will result in a more efficient health care system and improved access to care. Salaries for physician assistants, nurse practitioners, social workers, and pharmacists are generally lower than those of physicians. Prudent enhancements to practitioners' scope of responsibilities will avoid substantially greater costs for treating worsening conditions and complications associated with inadequate access and delays in care.

Recommendations:

- Modify or eliminate regulatory barriers to retention and recruitment of needed health care workers, including physicians, nurses, and allied health care professionals.
- Expand the scope of practice for licensed professionals to reduce unnecessary barriers to the provision of quality health care.
- Expand workforce capabilities and population health management through supportive care practices such as asthma coordinators, certified diabetes educators, cardiovascular disease educators, and community health workers.

Rationale:
New York's health care providers face significant workforce shortages, and the need for an adequate health care workforce becomes even more important as federal health care reform is implemented. The reform experience in Massachusetts demonstrated that when more individuals become insured, demand for services increases. As this happens, under-served urban and rural communities, already struggling to recruit adequate workforce, will be quickly overwhelmed.

Physicians are routinely called upon to address matters that can be appropriately treated by non-physicians with specialized training. Many patient services unnecessarily rely on physician authorization and approval for purposes of payment. These administrative and care coordination requirements consume a significant amount of a physician's time that could otherwise be used to provide direct clinical care to patients. Minor expansions in scope of practice for physician extenders could improve patient access to primary care services. For example, effective October, 2010, the Centers for Medicare and Medicaid Services revised its requirements to allow nurse practitioners and physician assistants to order rehabilitation services in a hospital setting without requiring a physician counter-signature, in accordance with state law and hospital policy.

State agency regulations and processes impede retaining and recruiting an adequate health care workforce, inhibiting the provision of patient-centered care and contributing to congestion in

emergency rooms and primary care settings. For example, providers in primary care clinics are unable to conduct home visits, while Federally Qualified Health Centers providing the same services have authority for their primary care practitioners to be reimbursed for home care visits.

The state must find ways to rely on less costly primary care providers and systems to maximize the capacity and efficiency of the health care delivery system. A number of innovative models for extending the reach of primary care physicians and using interdisciplinary health teams to increase access to ambulatory services have already been identified. These models offer opportunities for improved patient assessment and management with increased access to care, particularly in patients suffering from complex medical conditions, depression, and other physical disabilities—which are common among Medicaid patients suffering from these conditions.

Recommendation Details:
Address any rule or process that impedes the ability to retain and recruit needed health care workers. Examples include:

- Recognize that hospitals are employing more physicians out of necessity in upstate rural and suburban settings and develop policies to ease physician employment.
- Eliminate duplicate credentialing requirements for physicians who are already credentialed at a New York hospital and seeking credentials with additional institutions, including telemedicine providers.
- Facilitate sharing of specialist physicians among rural providers.

The state must provide additional flexibility with regard to scope of practice in selected areas to eliminate barriers to providing quality health care. While the State Education Department (SED) defines the scope of individual licensed practitioner practice in general, DOH must be given the ability to grant waivers to expand certain scopes in regulated settings where individuals practice as part of a team of caregivers. For example, certified registered nurse anesthetists (CRNAs) are registered nurses in the eyes of SED. In a DOH-regulated environment, properly credentialed CRNAs under the supervision of anesthesiologists or surgeons administer anesthesia as part of the surgical team.

Revamp the State Certificate of Need Program

Potential Impact:
Redesigning the Certificate of Need (CON) process has potential to save the health care delivery system many millions of dollars, including direct costs for state and provider staff resources to prepare and process applications for projects that should not require CON review. CON reform would yield indirect savings from reconfiguration of care delivery.

Recommendation:
Substantially overhaul and refocus the state's CON program.

Rationale:
National health care reform, ongoing state budget shortfalls, reductions in reimbursement, and a reimbursement shift to outpatient/primary care are helping reconfigure health care delivery in New York. Because the state CON process prevents providers from reacting quickly to these pressures, CON acts as a barrier to needed change that is increasing the costs for health care delivery.

The state CON process increasingly creates an unlevel playing field, constricting development, modernization, and change by regulating health care facilities, while leaving private practices unchecked—at a time when the entire delivery system must function like a single entity. The CON system creates "silos" within the regulated portion of the delivery system. For example, long-term care facilities can operate transitional care units (TCUs), but only a few hospitals under a demonstration program can provide that same level of service. In addition, when multiple state agencies are involved in reviewing the same project, applicants are "ping-ponged" between agencies.

Delays inherent to the CON process add unnecessary costs for all payers, both government and private insurers. While health care planning at a certain level is necessary, the current CON process falls short of affording real health planning on nearly all levels.

Recommendation Details:
With state resources inadequate to manage the current CON process in a timely manner, CON must be restructured substantially to reduce the state's workload, stop long delays in approvals, and promote industry-wide reconfiguration.

Rather than impede primary care and needed infrastructure upgrades, CON should focus more on broad regional or statewide planning needs. For example, the need to upgrade health information technology (HIT) across the state is crucial under federal health care reform. Instead of delaying facilities' progress in achieving compliance with federal "meaningful use" requirements, the state should let national requirements drive the effort, with an exemption from CON for all HIT-related expenditures. Delays caused by CON only invite future federal reimbursement penalties for New York State's health care facilities.

The CON system redesign must build in incentives for reshaping the health care system. An example might include funding support for a voluntary rightsizing effort to reduce excess inpatient bed capacity.

The CON process must facilitate health care planning to ensure the health care infrastructure is sufficient in rural communities and urban centers. Establishment of duplicative, for-profit new facilities such as freestanding ambulatory surgery centers must be prohibited.

The state must create new capital financing opportunities for health care providers. Many hospitals and health systems with no opportunity to raise capital have a backlog of deferred maintenance projects for aging facilities, which has delayed projects and denied patients the latest services and treatment modalities.

The timely processing of CON applications is a critical issue. This is further compounded when there is an additional waiting period for state inspections to be made of new facilities and services. During this delay, hospitals must continue debt service without the benefit of offsetting revenue, and patients are deprived of access to new, more modern facilities and services. Utilizing independent experts to certify compliance upon project completion would save the state staffing resources and complete certifications in a more timely fashion.

The authority already exists for DOH to implement most of the needed system restructuring through policy and regulatory amendment.

Reduce Survey Duplication

Potential Impact:
By recognizing national accrediting body surveillance and taking advantage of other oversight organizations' findings, the state can save money by conducting less surveillance using state staff, and better cope with its ongoing reduction in personnel resources. This would result in direct personal cost savings to the state and reduce operational burdens on regulated facilities.

Recommendation:
The state must cease conducting facility surveillance activities that are duplicative of national oversight or that are not funded through federal contractual obligation, and must develop broader collaborations with recognized accrediting bodies.

Rationale:
Since the mid-1990s the state has delegated routine hospital inspection activities to The Joint Commission (TJC) through a collaborative contractual relationship. The Department of Health (DOH) continues, pursuant to contract with the federal government, to spot-check the effectiveness of this arrangement. DOH and TJC have in place a detailed information-sharing relationship. This is a proven and effective model that fulfills an activity that the state can no longer afford. This same model must be extended to hospital-operated laboratories—where DOH and TJC (and for some hospitals, the College of American Pathologists) conduct duplicative and costly inspections at similar time intervals. Similarly, the Office of Mental Health conducts inspection activities duplicative of TJC inspections in hospitals.

This survey duplication is costly to the state and disruptive to hospital operations. Hospital staff are taken away from their patient care responsibilities to respond to surveyor inquiries and to provide access to documentation.

Recommendation Details:
The state has the option of accepting accreditation by national accrediting bodies as evidence of compliance with standards or entering contractual relationships like the one in place with TJC for hospitals.

DOH has regulatory authority in place for the contractual relationship with TJC. OMH is seeking similar authority through statute. The Wadsworth Laboratories Division within DOH should review existing mandates and authority to determine how to provide authority for reduction of survey duplication.

End Unfunded Mandates

Potential Impact:
Mandate relief will save health care dollars because provider costs are absorbed by all payers, including Medicaid. Depending on the magnitude of relief effected, many millions of dollars can be saved.

Recommendation:
The state must re-assess the many unfunded mandates placed on health care facilities over the years, and advocate for relief from federal unfunded mandates.

Rationale:
New York State health care provider facilities have been burdened by regulations imposed by the state over the years, above and beyond national requirements. These New York State-only regulatory mandates have associated costs for compliance and reduce hospital operational flexibility. Based on New York's placement in national ratings, this additional state "overhead" has not proven to improve quality of care. At a time when efficiency and flexibility are being mandated by federal health reform, New York can no longer afford this overhead and still meet the health care needs of it residents.

Similarly, the Centers for Medicare and Medicaid Services, largely through expanding interpretations of existing rules, has imposed substantial unfunded mandates on hospitals. The state cannot afford to continue to pay for these unfunded burdens any more than individual facilities can afford them during this period of severe fiscal constraint and deficits.

Recommendation Details:
At the request of the health care provider community, the state has begun to assess, and in some cases modify, some New York State-only hospital regulations, many of which have been in place for more than two decades and no longer reflect modern practice. With continued provider input, the state must continue and expand this effort to modify and update state-specific requirements to allow for more efficient, flexible health care facility operation to be successful under federal health care reform.

Malpractice

Reform the Medical Malpractice System

Potential Impact:
The malpractice reform HANYS recommends would eliminate millions of dollars in expenses from the health system. Medicaid would experience significant savings, particularly from reducing defensive medicine and establishing a fund to support care for neurologically-impaired infants.

Recommendations:

- Establish broader court-directed early resolution tribunals.
- Encourage early acknowledgement to patients that a compensable event has occurred.
- Create a new method for compensating neurologically-impaired infants.

Rationale:
New York's medical malpractice resolution system significantly drives up health care costs. As currently structured, the system necessitates the practice of defensive medicine to minimize the risk of even the smallest oversight. Litigation costs (i.e., defense attorney and expert witnesses, the diversion of staff to consult with counsel, and other associated costs) account for more than 40% of the paid malpractice premium. The trend toward larger average awards ("case severity") continues.

A large percentage of filed malpractice lawsuits conclude with no payment to the plaintiff; yet, defending against such baseless claims of wrongdoing strains the health and insurance system. Defense costs, regardless of whether an award is made, drive up premium dollars paid by hospitals, physicians, and other providers.

Recommendation Details:
It is possible to resolve cases faster, reduce defense costs, and provide fairer compensation to those who deserve it. A pilot program by the New York City Health and Hospitals Corporation and the Office of Court Administration in the Bronx bears this out. In this program conducted by Supreme Court Justice Douglas McKeon, cases are voluntarily resolved in significantly less time than the typical multi-year litigation cycle. Programs like this would provide significant relief without altering any litigant's rights or obligations.

The Office of Court Administration and Chief Justice of the Court of Appeals have administrative authority to expand the establishment of early resolution judicial forums. The Legislature has enacted a precedent: protections around quality assurance documents and activities are largely shielded from plaintiff lawyers and the public.

Numerous studies demonstrate that "Sorry Works" programs, first spearheaded by the Department of Veterans Affairs and the University of Minnesota, improve patient-family-

practitioner relations, enhance outcomes, and quickly resolve meritorious potential claims while avoiding the acrimony, time, and expense of litigation. Prompt, forthright, and genuine communication from a physician to a patient and family about a medical incident may often result in immediate compensation to a patient. Such a public acknowledgement promotes physician interest and participation in quality improvement efforts to reduce the likelihood of recurrence. Legislation must be enacted to protect physician statements of remorse or acknowledgement of error from litigation discovery.

The extraordinary costs to compensate for damage to neurologically-impaired infants are borne by relatively few individuals and entities. Since these cases almost always involve obstetricians, the cost of insurance premiums to finance cases falls on a small physician pool. Premiums for obstetricians are in the hundreds of thousands of dollars, forcing many physicians to drop obstetrics, leaving many New York communities without safe and accessible birthing providers.

Neurologically-impaired infants require multiple medical and social supports. Funding for such supports should be spread over a larger population base than obstetricians and hospitals to reflect that caring for these individuals is a social issue. Legislation is needed to establish a fund for the care of neurologically-impaired infants.

Revenue and Cost Savings

Establish a Sugar-Sweetened Beverage Tax

Potential Impact:
A sugar-sweetened beverage tax would raise an estimated $1 billion over a full fiscal year.

Recommendation:
HANYS supports taxing sugar-sweetened beverages to decrease consumption, combat obesity, and fund health care.

Rationale:
New York State has an unacceptably high rate of obesity, and sugar-sweetened beverages are the food category most strongly linked with obesity. Today, 60% of New Yorkers are overweight and 25% of children are obese. Obesity is a primary cause of serious health problems, such as diabetes, heart disease, kidney disease, and hypertension. Medical care associated with diabetes in New York State costs $8 billion per year, and diabetes costs billions of dollars in lost productivity.

A tax on sugar-sweetened beverages could deter consumption, thereby improving the health of New Yorkers, reducing Medicaid spending and overall health care costs, and providing much-needed revenue that could be dedicated to health care programs.

Hospitals are acutely aware of the cost of obesity and diabetes. One and a half million New Yorkers have diabetes and more than 600,000 hospital stays in New York State—more than one-quarter of all hospitalizations—had a principal or secondary diagnosis of diabetes and/or obesity in 2008. The cost of health care for a person with diabetes is more than five times the cost of care, on average, for those without diabetes. Hospital patients with diabetes are more likely to suffer complications and be re-admitted to the hospital.

Recommendation Details:
The Governor proposed a sugar-sweetened beverage tax in 2010. HANYS supports this proposal.

Reinvest Excess For-Profit Health Care Insurance Profits

Potential Impact:
Many health insurers incur substantial profits and have excess reserves, while health care providers struggle financially. Reinvestment would help ensure that communities continue to have access to the highest quality care.

Recommendation:
HANYS supports requiring for-profit health insurance plans, which annually generate profits significantly greater than their reserve requirements, to reinvest a portion of those funds in the core health infrastructure of the communities where they do business.

Rationale:
Three New York State health insurers or their subsidiaries issued dividends of more than $1.2 billion to out-of-state corporate parents at the end of 2009. This followed dividend action from the same three insurers in 2008 that totaled $948 million. These dividends ranged as high as 18.7% of premiums.

Excessive insurer profits come at the expense of a weakened health care system for all New Yorkers. At a time when all interests are being asked to contribute to stabilizing and improving the health care system, these insurers have put profits ahead of the delivery of health care.

A substantial investment in the health care system could be made by forcing or incentivizing the reinvestment of a portion of these excessive profits into infrastructure needs. These health care plans must partner with the provider community to identify the needs in their communities and make strategic investments, such as assisting providers with the adoption of health information technology, procurement of more efficient medical technology, and upgrading facilities to better deliver effective primary care.

Recommendation Details:
Legislation should be developed that incentivizes for-profit health insurance plans to reinvest in the core health care infrastructure in the communities where they do business. The State Insurance Department should be given authority to block excessive redistribution to out-of-state parent corporations and set guidelines for community reinvestment.

Achieve Savings in Government Operations

Potential Impact:
Various reports have identified hundreds of millions of dollars in savings and revenue from implementing recommendations put forth by commissions established by the state and from comprehensively reviewing state government.

Recommendation:
New York State established commissions in recent years to examine ways to achieve savings and improve operational efficiencies in state government. It is time to implement the many viable recommendations put forth in these reports.

Among the proposals are recommendations to achieve savings and generate revenue through government shared services initiatives; leveraging the state's purchasing power for all goods, including prescription drugs; and maximizing state-owned assets through public-private partnerships.

All aspects of government need to be reviewed and the state should create a commission with the specific charge of undertaking such an examination of the operations of state government, with a specific focus on its costs, restructuring if appropriate, and a prioritization of government activities.

Rationale:
Many commissions established in New York State identified reform measures that would achieve savings across state government. In most cases, the evaluation and quantitative analysis has already been completed, leaving only the directive to put these recommendations to work.

Specifically, numerous recommendations from state agencies, commissions, and reports identify potential savings by focusing on shared services, aggregate purchasing, and asset maximization. The state has a menu of options to decrease the cost of doing business and generate previously unrealized revenue from state-owned properties.

Recommendation Details:
The Governor should establish a task force to develop an expeditious implementation plan after thoroughly reviewing the work of the following commissions.

- ***21st Century Local Government.*** Report of the New York State Commission on Local Government Efficiency and Competitiveness (chaired by the Honorable Stan Lundine)
- **The New York State Commission on State Asset Maximization.** (chaired by the Honorable H. Carl McCall)
- ***Shared Services Among New York's Local Governments***. A Report by the Office of the New York State Comptroller, Division of Local Government and School Accountability
- **New York State Commission on Property Tax Relief.** Final Report to Governor David A. Paterson (chaired by Thomas R. Suozzi)

- **New York State Senate Task Force on Government Efficiency.** (chaired by Deputy Majority Leader Senator Jeff Klein)
- ***Centralization of the New York State University Police*:** A Report by the New York State University Police Officers Union

The Governor should also appoint a workgroup to study and report back during 2011 with recommendations on the following specific topic areas:

- **Shared Services.** Reports from the Office of the New York State Comptroller Division of Local Government and School Accountability and the New York State Commission on Property Tax Relief identified significant savings potential by sharing administrative and "back office" business functions by local governments, as well as pursuing cooperative administrative efforts through joint programmatic activities.
- **Aggregate Purchasing.** The state should leverage its size and associated market power to aggregate state purchasing to negotiate lower prices for goods and services purchased by all state agencies and departments. A group purchasing cooperative for all state agencies should be established through the Office of General Services. With respect to prescription drugs, the state can realize significant savings by implementing a state budget provision authorizing the Department of Health to negotiate directly with prescription drug manufacturers to achieve better rebates on drug purchases.
- **Asset Maximization.** Generating revenue through asset maximization and privatization should be considered. Privatizing roads, bridges, and other transportation assets, and the sale or lease of developable state lands, such as currently unused state campuses, would generate new revenue. Asset maximization is discussed in detail in the report of New York State Commission on State Asset Maximization. One recommendation is a targeted pilot program for several State University of New York schools to lease campus lands to private entities. Many public universities around the nation do this. The report estimates that millions of dollars in additional operating funding can be generated annually by allowing state-operated campuses to pursue public-private partnerships through land lease agreements.