NEW YORK ASSOCIATION ON INDEPENDENT LIVING

Overview of the Medicaid Redesign Team's Initiatives and their Impact on People with Disabilities

February 8, 2012

CID-NY

Community Health Advocates

- Community Health Advocates (CHA) is a network of 31 organizations that assist consumers and advocates to navigate New York's healthcare systems and services. NYAIL and CIDNY partner to serve people with disabilities statewide through individualized counseling and group presentations. We help consumers to obtain and navigate coverage, and we help the uninsured to find free or low-cost care.

community health advocates

Outline

- Overview of the Medicaid Redesign process
- Phase 1 Recommendations
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  - **Behavioral Health Homes**
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- Next Step: Medicaid 1115 Waiver

Overview of 2011 Medicaid Redesign process

- Executive Budget/Executive Order in January 2011 to create a Medicaid Redesign Team (MRT), and reduce Medicaid spending by about $2.8 billion.
  - **Program wide spending has risen from $46 billion in April 2007 to the 2011 Medicaid budget of $53 billion.**
  - **New York's Medicaid program, the nation's largest, spends nearly $53 billion to serve 5 million people, which is twice the national average when compared on a per recipient basis.**
  - **New York ranks in the middle when it comes to health care quality.**

MRT Phase 1

- March 2011 – MRT agrees on over 200 initiatives to restructure the Medicaid program.
  - **Lowered immediate spending (state share savings of $2.2 billion in SFY 11-12) and proposed important reforms that will lead to improved health outcomes, as well as future savings in years to come.**
  - **“Care management” will be implemented for all who can benefit over the next three years.**
    - Small cohort of Medicaid enrollees who consume disproportionate share of Medicaid spending will be targeted for aggressive interventions to rationalize their care away from hospitals and emergency rooms.

Phase 1 Recommendations

- 2% across the board cut to Medicaid services
- Permanent elimination of the trend factor for Medicaid services
- Global spending cap on Medicaid annual growth
- Mandatory enrollment in Managed Long Term Care
- Implementation of Health Homes
- Establishment of Behavioral Health Organizations (BHOs) to manage carved out behavioral health services
- Uniform Assessment Tool for long term care
- CHHA provider caps, with episodic pricing to be implemented in 2012
- Reforms to personal care in NYC were proposed in a plan worked out with the NYC Mayor's office that includes management utilization controls of high service users (24 hr care), a change in Personal Care Level 1 from a 12 hour cap to an 8 hour cap (per week), and improved assessment of personal care recipients

Care Management for All

- Mandatory Enrollment in Managed Care
- Managed Long Term Care
- Behavioral Health Homes
- Health Homes

Expansion of Medicaid Managed Care
Mandatory enrollment and benefit changes

- "Mainstream" Medicaid Managed Care (MMC) plans serve only non-dual Medicaid recipients.
  - **August 1, 2011- personal care became a benefit for MMC.**
  - **October 2011 - pharmacy became a plan benefit for MMC.**
  - **January 2012 - Personal emergency response (PERS) became a plan benefit for MMC.**
  - **July 2012 – Consumer Directed Personal Assistance becomes a plan benefit for MMC.**
  - **October 2012 – nursing home placement becomes MMC benefit, and non-dual nursing home residents enroll in MMC.**

Medicaid Managed Care: Enrolling and Switching Plans

- Managed care through an insurance company.
- Primary care physician; specialist; network; referral; grievance; appeal; fair hearing.
- Have 30 days to choose plans once receive mandatory enrollment packet; otherwise, will be auto-assigned.
- May switch plans within first 90 days of enrollment, then locked in for rest of the year unless “good cause” (e.g. plan does not have providers who can treat consumer’s condition).

Medicaid Managed Care: Positive MRT Changes

- Spousal/parental refusal intact; however, 2013 Executive Budget proposes elimination.
- No asset transfer penalties for community-based Medicaid.
- MBI-WPD has expanded eligibility:
  - **Resource limit $20K single/$30K couple.**
  - **IRA/retirement accounts not counted.**

Personal Care Carve-In

- **Skilled care was already carved-in; now, home attendant services also carved in.**
- **Plans are contracting with some homecare agencies; some consumers could lose access to current aides not in a network agency. That is not "good cause" to switch plan.**
- **Plans receive flat rate (capitation) per consumer; may try to restrict hours.**

Pharmacy Carve-In

- Plans will have own drug formularies.
- Plans must have exception/prior approval process.
- If drug is not covered, doctor may prescribe equivalent drug.
- Appeal and fair hearing rights apply.
- If drug is not covered, that is not “good cause” to switch managed care plan.

Other pharmacy changes

- Some drug classes previously exempt may now may be subject to prior approval:
  - **antiretrovirals, anticonvulsants, antipsychotics, antidepressants, anti-rejection drugs.**
- Maximum 4 fills/month for opioids (unless get prior approval).
- For duals, limited Part D wrap ended.
  - If drug can be covered by Part D, must file any exception request/PA with Part D plan. Medicaid will no longer wrap when Part D restricts coverage.

Cuts to Medicaid Coverage

- Housekeeping maximum weekly hours reduced from 12 to 8.
- Orthopedic shoes/orthotics limited to children with growth and development problems, diabetics, when shoe is attached to lower limb orthotic brace.
- Compression stockings only covered for treatment of open wounds during pregnancy.
- Enteral formula limited to tube feeding and people with inborn metabolic disorder.

Physical/Speech/Occupational Therapy Limit on Number of Visits

- Physical therapy, speech therapy, occupational therapy limited to 20 visits per year, except:
  - **Duals, people with developmental disabilities, people with traumatic brain injury, children under 21.**
  - **Does not apply to care through CHHA, during inpatient hospitalization, or at nursing home.**

Managed Care Exemptions

- Exempt from Enrollment:
  - **Native Americans.**
  - **People with chronic condition under active treatment with specialist who accepts no MMC plan (duration of treatment or 6 months, whichever is less).**

Managed Care Exclusions

- Excluded from Enrollment:
  - **Dual eligibles.**
  - **Persons on Spenddown.**
  - **Persons with cost-effective 3rd party insurance.**
  - **Persons w/ limited coverage (cancer, TB, family planning, Emergency Medicaid).**

Mandatory Enrollment in Managed Care

- Exemptions/Exclusions that Ended:
  - **PCP who takes no managed care plan.**
  - **HIV+.**
  - **SPMI/SED.**
  - **People w/ transportation and language issues.**
  - **People living temporarily away from home.**
  - **Pregnant women.**
  - **Restricted recipients.**

Mandatory Enrollment in Managed Care

- Exemptions to be Phased out 2012-2013:
  - **ESRD (4/1/2012).**
  - **Homeless (4/1/2012).**
  - **Low birth weight infants (4/1/2012).**
  - **LTHHCP (Lombardi) & lookalikes (4/1/2012).**
  - **Nursing Home Residents (10/2012).**
  - **People in waivers or lookalikes (4/1/2013).**
  - **MBI-WPD (4/1/2013).**

Managed Long Term Care Population

- Managed Long Term Care (MLTC) plans currently serve individuals who are eligible for Medicare and Medicaid (duals) as well as non duals.
  - **In the future, primary target population for MLTC will be dual eligible.**
- April 2012 begins mandatory enrollment of dual eligibles in New York City who require community based long term services in MLTC or care coordination model.
- Upstate expansion will be county by county, as sufficient MLTC plan and care coordination model capacity is developed.
- July 2012 – Consumer Directed Personal Assistance in MLTC benefit.

Excluded from Initial Mandatory Enrollment

- Several groups are not eligible to enroll in MLTC or care coordination models until program features and reimbursement rates are developed.
- These include people in:
  - **Traumatic Brain Injury (TBI) Waiver.**
  - **Nursing Home Transition and Diversion (NHTD) Waiver.**
  - **Assisted Living Program (ALP).**
  - **Office of People with Developmental Disabilities (OPWDD) Wavier.**

Mandatory Managed Long Term Care Enrollment and Benefits

- Duals over age 21 who need personal care.
- Skilled care, personal care, visiting nurse, adult day care.
- PT, OT, PERS, home-delivered meals.
- DME, supplies, home modifications.
- Audiology, optometry, dental, podiatry.
- Non-emergency transportation.
- Nursing home.
- Capitation rate for above; rest fee-for-service.

Managed Long Term Care Procedures

- Upon enrollment, existing services continued until MLTC plan does own assessment.
- Initial assessment to be completed within 30 days of plan enrollment.
- MLTC plans then assess members every 6 months.

Changes to EPIC

- Eligibility: age 65 and over, NYS resident.
- Income < $35,000 single or $50,000 couple.
- Must have a Part D plan to qualify.
- Free to beneficiaries.
- EPIC pays only Part D cost sharing while in donut hole, subject to copay of $3 to $20.
- EPIC also pays Part D premiums if income < $23,000 single, $29,000 couple.

Behavioral Health Organizations (BHOs)

- Targeted to persons with serious mental illness and/or substance dependence who have a history of multiple psychiatric admissions/readmissions, emergency service use, dependence relapses and detoxifications, incarceration, and homelessness.
- Not managed care per se – the BHO in the first three years is intended to reduce fee for service utilization for the "carved out" (of managed care) Medicaid behavioral benefit (fee for service Medicaid).
- BHOs are not intended to interact with beneficiaries directly; rather, with inpatient/outpatient providers to improve their effectiveness.

BHOs

- BHOs will develop provider “report cards” to grade provider performance and responsiveness.
- Goal is eventually to convert “carved out” fee for service benefit into a managed care premium, paid either directly to a BHO or a managed care organization.
- One BHO will be selected for each OMH region.
- No company is planned to be awarded more than one BHO designations.
- Applications were submitted 8/5 and OMH decisions made.
- BHOs went live 1/2012 in Western, Hudson River, NYC regions.
- Long Island BHO expected to be fully operational early in 2012.

Health Homes

- Care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.
- This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital.
- Health records are shared (either electronically or paper) among providers so that services are not duplicated or neglected.
- Health home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively, they become a virtual “Health Home.“
- Begins February 1 in 10 counties.

Health Home Care Manager

- As needed, the care manager will work primary care, specialty, mental health, substance abuse, housing, and social service providers.

- Care manager will help patient find a doctor if needed, manage medication and other medical treatments, learn why to eat well and stay active, find ways to stop smoking, stay on schedule, and get to medical appointments.

From the SPA language

- “NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care.”

- Optional team members may include:
  - **nutritionists/dieticians,**
  - **pharmacists,**
  - **outreach workers including peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment).**

Who will be served by a health home?

- At least two chronic conditions, one chronic condition and at risk for another, or one serious and persistent mental health condition.

Chronic conditions include:

- **mental health condition (Serious Emotional Disturbance will be excluded from initial HH group)**
- **substance abuse disorder**
- **asthma**
- **diabetes**
- **heart disease,**
- **being overweight (BMI over 25)**
- **HIV/AIDS**
- **Hypertension**

How will health homes operate?

- Individuals will be able to choose a health home provider and can choose to opt out of a health home assignment altogether; however, DOH expects health home networks will work hard to engage, satisfy and retain high need enrollees.

- The State reserves the right to assign beneficiaries to a specific health home.

- There will be only one care plan for each patient enrollee. All members of the health home team will report back to the care manager on patient status, treatment options, actions taken, and outcomes.

Phase 2: MRT Workgroups

Work groups focusing on specific issues will be created to develop recommendations for the MRT. Work group membership will allow for even more stakeholder involvement.

- **Affordable Housing Work Group**
- **Basic Benefit Review Work Group**
- **Behavioral Health Reform Work Group**
- **Health Disparities Work Group**
- **Health Systems Redesign: Brooklyn Work Group**
- **Managed Long Term Care Implementation and Waiver Redesign Work Group**
- **Medical Malpractice Reform Work Group**
- **Payment Reform and Quality Measurement Work Group**
- **Program Streamlining and State/Local Responsibilities Work Group**
- **Workforce Flexibility and Change of Scope of Practice Work Group**

Affordable Housing workgroup

- Proposals for Investing in New Affordable Housing Capacity. *(Included in 2012-13 Executive Budget)*

- Identify and target existing and new resources to fund rental subsidies for all high-cost Medicaid populations.

- Evaluation of the State's implementation of Section 504 requirements for accessible housing.

- Ensure continuation of housing subsidies provided through the NHTD/TBI Medicaid Waivers after the transition to Managed Long Term Care (MLTC) and that these programs, and their housing focus, are fully incorporated into MLTC and other Care Coordination Models.

Health Disparities Work Group

- Data Collection/Metrics To Measure Disparities
  - **The Work Group recommended that NYSDOH implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status.**

- Payment for Interpretation and Communications Services.

- Promote Language Accessible Prescriptions.

(All included in 2012-13 Executive Budget)

Managed Long Term Care Implementation and Waiver Redesign Work Group

- Developed principles that will inform guidelines for the development of Care Coordination Models (CCM).
  - **Payment to the CCM will be based on the functional impairment level and acuity of its members. Payments shall incentivize community-based services.**
  - **A CCM must include a person-centered care management function that is targeted to the needs of the enrolled population.**
  - **The member and his/her informal supports must drive the development and execution of the care plan.**
  - **A CCM will provide services in the most integrated setting appropriate to the needs of qualified members with disabilities.**
  - **Existing member rights and protections will be preserved.**
  - **Prospective members will receive sufficient objective information and counseling about their choices before enrolling.**

MLTC Implementation and Waiver Redesign Work Group (cont.)

- Establish a Work group to advise the Department of Health on the integration of self directed program models, including the consumer directed personal assistance program (CDPAP), into CCMs and Managed Long Term Care

- Managed care plans and managed long-term care plans will be required to offer the consumer directed personal care program to their enrollees. *(Included in 2012-13 Executive Budget)*

Program Streamlining and State/Local Responsibilities Work Group

- Implement the Health Benefit Exchange in New York State *(Included in 2012-13 Executive Budget)*
- New York must have one eligibility determination and enrollment system for its Medicaid program and all Medicaid-eligible sub-populations, including those who need long term care services.
- State takeover of Medicaid that phases out reliance on local taxes (e.g., property taxes)

  (Included in 2012-13 Executive Budget)

Program Streamlining and State/Local Responsibilities (cont.)

Long Term Care Recommendation

- Disabled and elderly New Yorkers in need of long term care services should have the same access to enrollment and eligibility assistance as other applicants for Medicaid. New York's plan for meeting consumer assistance needs must include a focus on this vulnerable population, whether it is through the use of Navigators, Consumer Assistance Programs, Facilitated Enrollers or some other funded initiative. *(Included in 2012-13 Executive Budget)*

Next Steps

- Work Group final reports are available at: http://www.health.ny.gov/health_care/medicaid/redesign/
- A final report of the MRT is currently being finalized.
- Department of Health staff have combined the work of MRT Phase 1 and Phase 2 into a comprehensive Medicaid reform action plan.
  - ***This plan will take 3 to 5 years to fully implement.***
  - ***The action plan recommends the development of a comprehensive 1115 Medicaid waiver to ensure that the state has sufficient flexibility to enact all of the reforms.***

Additional Information

- DOH website for Medicaid Redesign - http://www.health.ny.gov/health_care/medicaid/redesign/
- More information on the MRT workgroups - http://www.health.ny.gov/health_care/medicaid/redesign/additional_info_wrk_grps.htm
- Supplemental Information on Specific MRT Proposals http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm

Additional Information (continued)

- Medicaid Health Homes - http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
- Behavioral Health Organizations – http://www.omh.ny.gov/omhweb/bho/
- Community Health Advocates website – www.communityhealthadvocates.org
- Community Health Advocates one pager - http://www.cidny.org/community-health-advocates.php

Questions?

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