

NATIONAL HEALTH REFORM

Through the Lens of New York Medicaid

**United Hospital Fund Conference
Medicaid and National Health Reform
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Federal and State Health Reform Goals Are the Same

- Expand coverage & access
- Enhance quality
- Control costs

Expanding the Public Programs

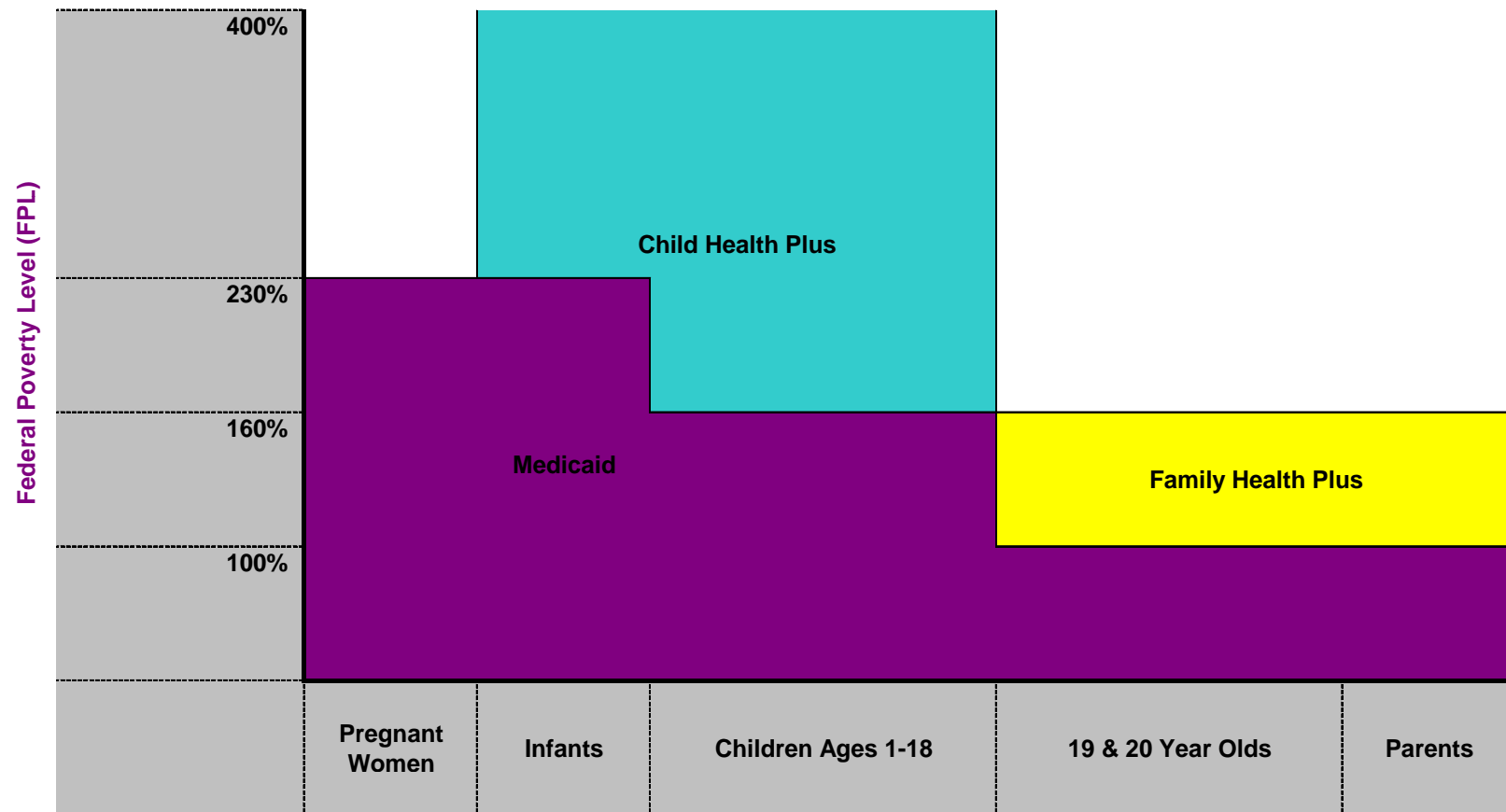
- **Children**

- CHPlus to 400% of the FPL
- Single Medicaid eligibility level for children (under age 21) based on gross income up to 160% of the FPL
- Foster care children remain eligible up to age 21

- **Adults**

- Eligibility for parents and children aligned at 160% of the FPL based on gross income
- FHPlus expanded to 200% of FPL through federal waiver
- FHPlus Premium Assistance and Buy-in Programs authorized

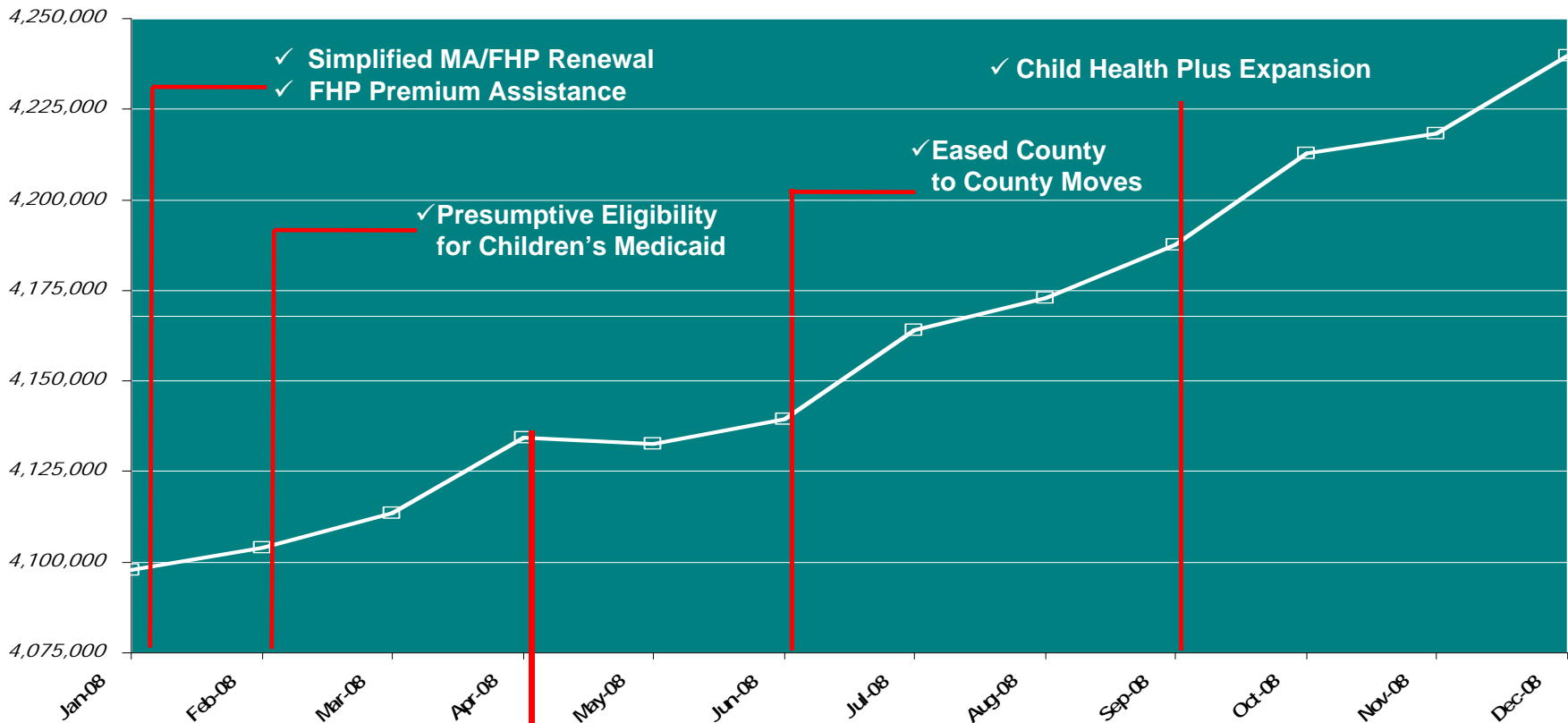
Aligning Coverage for Children & Parents



Simplifying Enrollment and Renewal

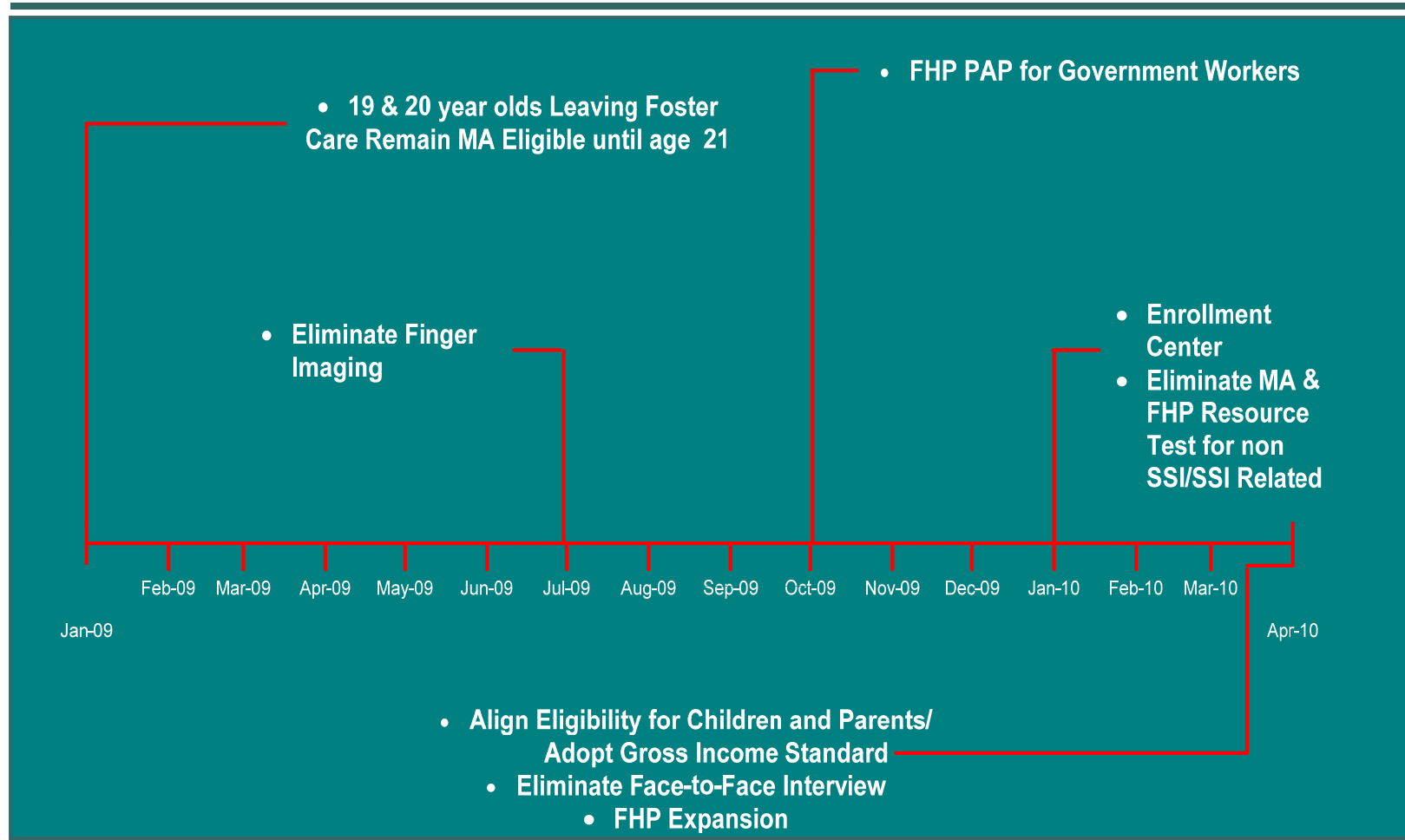
- Self declaration of income/residency at renewal
- 12-month continuous coverage for adults
- No asset test for most Medicaid applicants
- No face-to-face interview requirement
- No finger-imaging requirement
- Authority for Statewide Enrollment Center

Medicaid Enrollment 2008



- FHP Buy-In
- Medically Needy Levels
- Statewide Standard of Need
- Aligned MA/FHP Resource Levels
- Eliminated Link between PA/MA Link for Single Adults
- Eliminated MSP Asset Test
- Medicaid Suspension for Incarcerated Individuals

Making Coverage More Accessible 2009/10 Implementation Timeline



Making Coverage More Accessible

Federal Wish List

- Eliminate categorical eligibility; base eligibility on gross income
- Provide federal financial support up to mandated minimum eligibility level
- Streamline relationship between Medicaid/CHIP and Exchange
- Increase federal matching rate for eligibility system improvements
- Explicitly permit greater flexibility in income verification
- Allow states to deem all food stamp recipients Medicaid eligible
- Permit 12-month continuous coverage for adults
- Modify requirement for annual renewal
- Eliminate requirement of original documentation of citizenship

Buying Quality, Cost-Effective Care

Payment Policies are Key

Sector	Reform
<ul style="list-style-type: none">● Ambulatory Care<ul style="list-style-type: none">● Hospital● Ambulatory Care● Physicians/Practitioners● Emergency Services● Ambulatory Surgery● Hospital Inpatient● Nursing Home● Home Healthcare	<p>FY 08/09 Budget</p> <p>FY 09/10 Budget</p> <p>FY 09/10 Budget</p> <p>FY 10/11 Budget (?)</p>

Reform Payment Methodologies

- Straightforward and transparent
- Based on costs of serving Medicaid patients
- Incentivize efficiency and rewards quality
- Recognize complexity/severity of illness
- Position NY for federal payment reforms

Reform Payment Levels

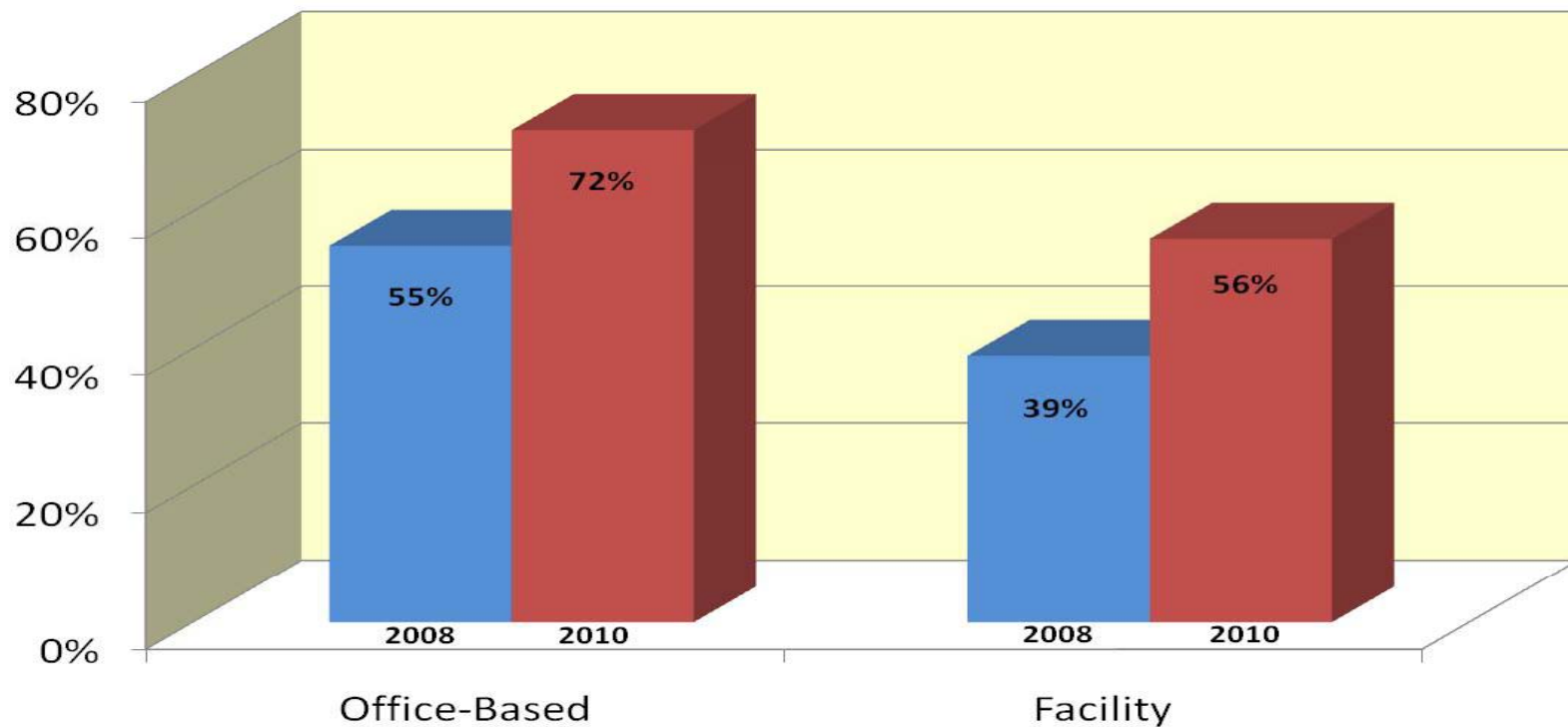
- **The 2008-09 Budget Began Reform**
 - Reduces inpatient rates, including inpatient detox
 - \$178 million invested in hospital clinics, ambulatory surgery and ER
 - Additional investments in D&TCs and physicians
 - Enhancements for weekend/evening hours, and diabetes/asthma educators
- **The 2009-10 Budget Builds on these Reforms**
 - Further reduces inpatient rates
 - Increases investment in hospital and community clinic rates
 - ✓ Medicaid will cover approximately 90% of average hospital clinic costs
 - ✓ Medicaid will cover approximately 90% of average D&TC costs
 - Increases investment in physician fees
 - Enhances payments for providers that meet medical home standards

NY is Investing Over \$600 M in Ambulatory Care

(Gross \$ in Millions)	<u>Approved in SFY 08/09</u> Budget (Full Annual)	<u>Additional Funding</u> Approved in SFY 09/10 Budget (Full Annual)	<u>Total Investment SFY</u> <u>10/11</u> (Full Annual)
Hospital Programs	\$178.0	\$92.0	\$270.0
Outpatient Clinic	\$88.0	\$92.0	\$180.0
Ambulatory Surgery	\$40.0	\$0.0	\$40.0
Emergency Room	\$50.0	\$0.0	\$50.0
Freestanding Programs	\$12.5	\$37.5	\$50.0
Primary Care Investments	\$38.0	\$90.1	\$128.1
Asthma and Diabetes Education (08/09 Enacted)			
Expanded "After Hours" Access (08/09 Enacted)			
Social Worker Counseling (08/09 Enacted)			
Smoking Cessation (08/09 Enacted)			
Nurse Family Partnership (08/09 Enacted)			
Cardiac Rehabilitation (09/10 Enacted)	N/A		
SBIRT (09/10 Enacted)	N/A		
Smoking Cessation (09/10 Enacted)	N/A		
Primary Care Standards/Medical Home (09/10 Enacted)	N/A		
Adirondack Medical Home (09/10 Enacted)	N/A		
Physicians	\$120.0	\$68.0	\$188.0
Mental Hygiene Enhancements	N/A	\$2.7	\$2.7
Detoxification Services Reform			
TOTAL	\$348.5	\$290.3	\$638.8

Physician and Practitioner Fees Up 80% Still not at Medicare Levels

NY Medicaid Fee Schedule as Percentage of Medicare



Note: Calculations include fee schedule enhancements only. These do not include the following primary care enhancements: (1) asthma and diabetes education; (2) expanded 'after hours' access; (3) smoking cessation; and (4) medical home enhancements.

Hospital Clinic Rates Up 55%



Hospital Am Surgery Rates Up 72%



Hospital ED Rates Up 48%



GME Payment Policies Seek Transparency and Accountability

- 100 NY hospitals have training programs
 - NYS trains 16% of the nation's residents
 - 40% of national Medicaid GME spending is in NY
- Accurately capture Medicaid GME costs
 - Medicaid will pay over \$1 billion for GME
- Retain more residents in NY
 - 55% of residents leave the State upon graduation
 - Build on Doctors Across New York
- Address PCP shortage in NY and nationally

DSH Payment Policies Seek Transparency and Accountability

- NY spends \$3.1 billion on DSH payments to public and voluntary hospitals
- DSH supports
 - Services to uninsured patients
 - Added costs of disproportionately large numbers of low-income patients
 - Bad debt (unpaid co-pays and deductibles)
 - Difference between Medicaid costs and Medicaid payments

Rationalizing Payment Policies

Federal Wish List

- Enhance FMAP for primary/preventive care
- Align Medicaid and Medicare payment policies for both acute and LTC services
- Maintain GME and DSH funding; align with national and state health care priorities
- Streamline state plan approval process
- Establish a national Medicaid data base

Health Care Reform

What's Next for New York Medicaid

- Align with federal reforms
 - Maximize federal EHR (“meaningful use”) funding opportunities
- Continue payment reforms that incentivize quality and efficiency
- Link DSH payments more directly to care to uninsured
- Continue LTC reform
 - Rationalize home care payment system
 - Better integrate care and financing of services for dual eligibles
 - Operationalize LTC Assessment Center pilot
- Continue coverage reforms
 - Operationalize Enrollment Center
 - Upgrade eligibility systems
 - Expand and test FHPlus Buy-in
- Develop payment and program policies for high-need patients
 - Better integrate physical and behavioral health
 - Evaluate foster care “per diem” policy
- Address med mal impact on OB capacity
- Address racial disparities