MEDICAID REDESIGN TEAM

WORKING TOGETHER TO BUILD A MORE AFFORDABLE, COST-EFFECTIVE MEDICAID PROGRAM

MRT Recommendations – Questions and Answers

What's included in the MRT recommendations?

Key MRT recommendations include: Enact a global Medicaid budget cap, allow 1 million New Yorkers to have access to patient-centered medical homes (PCMHs), major expansion in use of care management – virtually all Medicaid members will be enrolled in care management within 3 years, new controls in personal care and home health that will reign in out-of-control spending, reform Medical Malpractice and lower health care costs by $700 million, streamline/eliminate program regulations in ways that will lower costs for providers and make the program easier to navigate.

What's not included in the MRT recommendations?

The MRT recommendations do not include: eligibility cuts, wholesale elimination of optional benefits, immediate enrollment of all members in managed care plans, Medicaid in mainstream HMO's, rate reductions not linked to reform, elimination of patient protections in nursing homes and other settings, complete carve-in of all behavioral health services into mainstream HMO contracts, or elimination of targeted case management.

How is the Global Cap achieved?

- Payment/Program Reform: $1.138 billion
- Elimination of statutory cost drivers: $186 million
- 2% across-the-board rate reduction: $345 million
- Prepaying certain claims during enhanced ARRA FMAP period: $66 million
- Industry-led cost containment initiatives: $640 million (totaling up to)

TOTAL: $ 2.375 billion

*Note: DOB Medicaid re-estimate reduced MRT target by $475 million

Will the MRT recommendations mean that people with HIV and other chronic illnesses can't get the drugs they need?

People with HIV and other chronic illnesses will continue to be able to get the drugs they need. Many people with chronic illnesses are currently enrolled in Medicaid managed care plans and the plans are responsible for meeting their needs. With the bundling of the pharmacy benefit into the managed care plans, plans will have access to prescription drug utilization which will further enhance their ability to manage patient care. The State will provide strong guidance to plans to ensure that they continue to provide access to medically necessary prescription drugs.

People with chronic illnesses who are not currently enrolled in a managed care plan will remain in fee-for-service until they are transitioned to a managed care plan and/or care management; and will continue to obtain medically necessary medications through the Medicaid fee-for-service pharmacy program. Under the fee-for-service pharmacy program, prior authorization requirements for immunosuppressants or anti-retrovirals (drugs that are typically used to treat chronic illnesses) have not been proposed by the MRT nor are they envisioned by the Department of Health. The State recognizes that drugs in these classes do not lend themselves to an evaluation of clinical comparability or a prior authorization process.

In summation, Medicaid will continue to provide access to medically necessary drugs. The use of appropriate utilization management tools to ensure appropriate drug therapy at a reasonable cost will continue to be employed. Patient protections, including an escalation and appeal process and the right to a fair hearing, will ensure continued access to needed medications.

Will all disabled people have to be enrolled in managed care plans?

No, not all people with disabilities will be enrolled into managed care plans. The MRT recommended that all beneficiaries should be enrolled into some form of care management, not necessarily managed care. Care management opportunities exist in managed care but also exist in integrated service delivery systems such as health homes, which will allow a team of providers to oversee an individual's physical, behavioral and social support care needs. Other forms of care management include patient-centered medical homes, waiver services and behavioral health organizations, integrated service delivery systems and Special Needs Plans (SNPs). Beneficiaries will be placed in care management structures best suited to meet their needs.

What is the difference between care management and managed care?

Managed care is generally defined in the context of insurance plans as any system that manages health care delivery with the aim of controlling costs. Managed care systems typically rely on a primary care physician who acts as a gatekeeper through whom the patient must go to obtain any needed specialty services. Care management applies systems, science, incentives and information to deliver care that meets patients' comprehensive physical, behavioral and social support needs effectively. The goal of care management is to improve coordination of care while providing cost effective, non-duplicative services, and to ensure that the whole person is being treated. Health homes are an example of care management where a team of professionals is responsible for assuring an individuals' physical, behavioral and social support needs are met. Because patients are assigned a primary care provider, managed care can be viewed as a type of care management.

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Is the Lombardi program going to be eliminated?

No - the overall movement to managed long term care or other care management programs as specified by the Commissioner of Health may require some modification to the Lombardi program. However, the basic tenets of the Lombardi program will be retained.

What will happen to disabled children if the Neurologically Impaired Infants Fund runs out of money?

Children who will qualify for the Neurologically Impaired Infant Medical Indemnity Fund will have received a settlement or a jury award as a result of a lawsuit alleging medical malpractice. The Fund will pay for necessary medical expenses as they occur and only if the child's insurance does not cover the services. The Governor's proposal requires the Fund administrator to calculate on an annual basis whether there is adequate funding to pay for the medical expenses of currently enrolled children. When that calculation shows that for the coming year the estimated health care costs of presently enrolled children will require 80 percent of the resources in the Fund, the Administrator will stop enrolling children until more funds are available.
This assures that all enrolled children will continue to have their health care services covered by the Fund. If the Fund requires an enrollment moratorium, children with awards or settlements will receive payments for medical care as they do now either from insurance or from the award or settlement.

Will the elimination of spousal refusal mean that parents of disabled children are going to have to pay for the costs of their care?

Parental income and resources would continue to be disregarded for disabled children participating in a home and community based waiver program (e.g., Care at Home Program).
For disabled children under age 18 who are not participating in a waiver program, a portion of the parent's income and resources would be deemed available to the disabled child for purposes of determining the child's Medicaid eligibility

Is personal care going to be eliminated?

No, personal care is not going to be eliminated. The recommendations on personal care relate to both extremes in the program. For those with very high needs, the state and New York City will work on standards to help provide personal care and supports in a more rational way. For those who need level one care (housekeeping and other lower level service), the proposal is to cap that benefit at eight hours a week. For the vast majority of personal care cases, there will be no changes.

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What is in these recommendations for consumers of Medicaid funded services?

Two MRT recommendations provide for administrative renewal for the elderly and permanently disabled on fixed incomes, affecting about 300,000 Medicaid enrollees. DOH would automatically renew enrollees using the cost of living adjustment instead of asking enrollees to submit renewal applications each year. Another proposal would provide a housing disregard to Medicaid enrollees in nursing homes who could be discharged into the community if they had assistance with housing. To receive the housing disregard, enrollees would be required to enroll in Managed Long Term Care.
On the long term care side, there is a project to help prevent and reduce pressure ulcers across the health care system. There are also more options for long term care insurance. The development of a uniform assessment tool across community based programs, including managed long term care, will add needed infrastructure to reduce fragmentation and improve information about services delivered.

What is a medical home?

The primary care professional societies, including the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association, have jointly defined the medical home as a model of primary care in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for meeting the care needs of the patient. This includes providing for health care needs and, when needed, arranging for care from, and coordinating with, other physicians and providers. A medical home emphasizes enhanced care through open scheduling of appointments, expanded hours and means of communication between patients, providers and practice staff. Care is facilitated by patient registries, information technology, and health information exchange.
Currently the state is using a Patient Centered Medical Home recognition program developed by a national accreditation organization called the National Committee for Quality Assurance (NCQA) to qualify which practices and providers meet this definition for purposes of receiving Medicaid incentive payments.