

Medicaid Reform in New York

Expanding the Role of Nurses, Improving the
Quality of Care and Lowering Costs

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Introduction

New York's Medicaid program is a vital component of the state's healthcare system, providing health insurance coverage to approximately 4.7 million New Yorkers. The New York State Nurses Association and its members have long recognized the crucial role that Medicaid plays as the safety net for the state's most vulnerable populations. The cost of providing this care however, is growing at an average annual rate of 7 percent.¹ Combined federal, state, and local spending for Medicaid for the 2009-2010 fiscal year was \$50.04 billion, up from \$29.9 billion in 2000.² The state and local contributions to Medicaid costs for 2009-2010 were \$13.91 billion and \$6.3 billion, respectively. The local contribution to Medicaid costs is capped at a 3 percent annual increase and with the expiration of the enhanced federal matching funds to states (the result of the American Recovery and Reinvestment Act of 2009) state Medicaid costs will increase in June 2011. In addition to the rising costs of Medicaid that are reflected in per capita costs, the overall number of Medicaid enrollees in the state has also been growing. New York can ill-afford this escalation; the budget deficit for New York's 2011-12 fiscal year is estimated to be between \$9 and \$10 billion, and the budget gaps for subsequent years are projected to be even greater.

New York's Medicaid program provides some of the most generous benefits in the country; the state has made a commitment to "[T]he aid, care and support of the needy."³ Despite the generosity in eligibility, services covered and dollars spent, New York's Medicaid program has inconsistent quality outcomes. The 2009 Commonwealth Fund State Scorecard ranks New York 50th (of the 50 states) in "potentially avoidable use of hospitals and costs of care." Included in this overall score, are rankings of 35th for rates of

¹ Ravitch, R. (2010). *Lieutenant Governor's report on controlling increases in the cost of New York Medicaid*.

² Birnbaum, M. (2010). *Medicaid in New York: Current roles, recent experience, and implications of federal reform*. Medicaid Institute at United Hospital Fund.

³ New York State Constitution. (Current through January, 2011). *Article XVII Social Welfare*. Retrieved from <http://www.dos.state.ny.us/info/pdfs/Constitution.pdf>

hospitalization resulting from pediatric asthma, a ranking of 31st for the percent of adult asthmatics that visited the Emergency Department or urgent care within the past year and a rank of 49 in the percent of home care patients that are admitted to the hospital. New York is 18th in overall indicators that reflect access to care, 22nd in overall indicators reflecting prevention and treatment and ranks 17th in indicators that reflect healthy lives (for example, infant mortality rates, death rates from certain cancers, suicide rates and rates of smoking or obesity).⁴

Medicaid reform in New York must focus on reducing costs through better coordination of care, improved outcomes, and the control of fraud, waste and abuse of the program. The future of the Medicaid program must include healthcare homes that provide coordinated, primary and preventive health care for even the most complex and fragile recipients, and a process that holds plans and providers accountable for not meeting established quality outcomes. Additionally, New York will serve itself well, in light of federal healthcare reform implementation, if the Medicaid reforms it enacts today are in line with goals set forth in the Affordable Care Act. The services whether acute, sub-acute, residential, or ambulatory, must be accessible and community-based and must include sufficient numbers of registered nurses to ensure they are safe and effective. New York must ensure that mental health services are provided on par with other services. The care teams can be responsibly and accountably managed by registered nurses and at a minimum, the care teams must include advanced practice registered nurses practicing to the full extent of their education and without the arbitrary restrictions that “create barriers to achieving the [nation’s] goal of providing efficient, cost-effective primary care to all.”⁵

⁴ Commonwealth Fund. (2011). *New York State: Commonwealth Fund State scorecard on health system performance, 2009*. Retrieved from http://www.commonwealthfund.org/~media/Files/Chart%20Maps/2009%20State%20Scorecard/New_York_combined_tables_v2.pdf

⁵ Pohl, J.M., Hanson, C., Newland, J.A. & Cronenwett, L. (2010). *Unleashing nurse practitioners’ potential to deliver primary care and lead teams*. *Health Affairs*, 29(5), 900-905.

Recommendations

Seek Alternatives to Across-the-Board Rate Cuts

Across-the-board cuts to reimbursement rates are not the solution to New York’s budgetary challenges. Medicaid providers, healthcare workers and Medicaid recipients have endured across-the-board reductions in reimbursement rates year after year and the results are closed facilities; under-staffing; poorly coordinated care, fumbled care transitions from acute to sub-acute care to residential care and to the community; cuts in community supports and decreased access to health care among the state’s neediest residents. Across-the-board rate cuts are short-term solutions that fail to motivate the structural realignment that is required to transform New York Medicaid into a high-quality, cost-effective program that provides for the health of the state’s most vulnerable residents. There are alternate strategies to achieving cost savings and improving the quality of care provided. The solution is not dismembering the healthcare safety net, increasing the number of vulnerable residents without access to care, and alienating the next generation of the nursing workforce, who can’t find employment as a result of shuttered facilities and hiring freezes.

Expand Enrollment in Medicaid Managed Care

In the late 1990s, New York began requiring certain Medicaid recipients to enroll in Medicaid managed care programs. The goal of enrolling more recipients in managed care through mandate, the result of a waiver granted to the state from the Center for Medicare & Medicaid Services (CMS), was to provide recipients “with medical homes and access to high quality primary and preventive care services.”⁶ The Medicaid managed care programs have been successful in improving the quality of care for the recipients enrolled, as measured by the state’s Quality Assurance Reporting Requirements (QARR) system. The New York State Medicaid managed care programs’ care exceeds national averages in

⁶ New York State Department of Health. (1999). *State begins Medicaid managed care program (1115 Waiver) in New York City: Millions of Medicaid recipients to receive high quality preventive health care*. Retrieved from <http://www.nyhealth.gov/press/releases/1999/nyc1115.htm>

quality indicators reflecting adult and pediatric preventive care; management of acute illness in adults, children and adolescents; in many disease-specific indicators and in areas of behavioral health care.⁷

There are just over 3 million Medicaid and Child Health Plus enrollees in managed care programs at a cost of approximately \$8 billion in premiums. The health plans are responsible for delivering a specific set of benefits to the enrollees and for making regular reports to the state. In April 2008, the Department of Health adopted a risk-adjusted capitation methodology that is based on patient encounters. This process has allowed for the establishment of a regional premium which is then adjusted based on the actual health risk of the plan's members to set the rate for each plan. With these methods, variations in reimbursement are more closely related to the health status of the enrollees, rather than based on inherent waste or inefficiency.⁸ The focus on evidence-based rate setting allows the state to move towards paying for quality, not quantity, in the provision of care for Medicaid recipients. The challenge, however, is that the majority of the state's most costly Medicaid populations are either not enrolled in managed care programs, or the most expensive portions of their care are carved out of the managed care program and are reimbursed on a fee-for-service basis.

More of New York's high-cost Medicaid populations, e.g. those with multiple, chronic comorbidities; with persistent, severe mental illness; the disabled and the frail elderly, must be enrolled in managed care programs. Eighty percent of New York's adult and child Medicaid recipients are enrolled in managed care; only 24 percent of New York's elderly and disabled Medicaid recipients are enrolled in managed care programs. The remaining 76 percent of the elderly and disabled Medicaid recipients have their care reimbursed

⁷ New York State Department of Health. (2011). *Medicaid health plan performance: Statewide region*. Retrieved from http://www.nyhealth.gov/health_care/managed_care/reports/eqarr/2010/statewide/medicaid/

⁸ Frescatore, D. (March 17, 2010). *Public Hearing: Reforming Medicaid - Investigating Current Strategies Targeting Waste, Fraud and Abuse*. Retrieved from http://www.nyhealth.gov/commissioner/testimony/2010-03-17_reforming_medicaid.htm

based on fee-for-service. Increases in spending between 2000 and 2009 for Medicaid populations clearly shows the necessity of having more Medicaid recipients enrolled in managed care programs. Medicaid spending for elderly and disabled recipients (11 percent of enrollment) increased by 55 percent, or by \$10.7 billion dollars between 2000 and 2009. During that same period, Medicaid spending on adults and children (89 percent of enrollment), 80 percent of whom are now enrolled in managed care programs, increased by 28 percent and 11 percent, respectively, or \$5.4 billion and \$2.1 billion. Medicaid managed care is responsible for only 17 percent of all Medicaid services spending.⁹

Seek Innovative Solutions that Achieve High Quality Care

New York must do a better job coordinating the care it provides through the Medicaid program and that care must be accessible and comprehensive. Particular attention must be paid to coordinating mental health with physical health services. Medicaid managed care programs have made strides in this direction, but more can be done. Healthcare homes are intended to provide patient-centered, coordinated, primary and preventive care. As defined in the federal health reform law, a health home must include a team that provides comprehensive care management, care coordination, comprehensive transitional care, patient and family support, referral to community and social support services if necessary, use of information technology to link services, and must report on quality measures to the state.¹⁰ Advanced practice registered nurses are uniquely positioned and qualified to lead health care homes and must be allowed to practice to the full extent of their education and without arbitrary restrictions that create barriers to achieving efficient, cost-effective primary care for all. The State Health Department launched an initiative in 2006, targeted to those enrolled in fee-for-service Medicaid, which created six regional demonstration projects to “promote the development and implementation of innovative approaches to providing disease and care management services in the areas of ... chronic illness to New

⁹ Birnbaum, M. (2010). *Medicaid in New York: Current roles, recent experience, and implications of federal reform*. Medicaid Institute at the United Hospital Fund.

¹⁰ Patient Protection and Affordable Care Act, H.R. 3590. (Signed March 23, 2010). *Section 2703*

Yorkers enrolled in Medicaid.”¹¹ In 2008, the Health Department made \$10 million available for “providers to demonstrate innovative and replicable approaches to address the complex health needs and social barriers to care for the chronically ill beneficiaries.”¹² These projects are focused on addressing the concern that 75 percent of the Medicaid budget is spent on 20 percent of the recipients – those that are complex and have multiple co-morbidities that cross service areas. A thorough examination of any promising approaches that have resulted from these initiatives is in order.

Additional efforts to develop alternative methods for delivering cost-effective care to the most complex and costly Medicaid populations have been pursued by the United Hospital Fund. In 2005, the United Hospital Fund established the High-Cost Care Initiative (HCCI). Grant funding was provided from 2005 – 2008 to seven New York City provider organizations (Bellevue Hospital Center, Woodhull Medical and Mental Health Center, Montefiore Medical Center, New York-Presbyterian Hospital, Bronx Lebanon Hospital Center, Maimonides Medical Center, and Visiting Nurse Service of New York) and they were tasked with analyzing patterns of service use in their facilities; researching patient and provider perspectives on the current delivery system; developing, testing and implementing new approaches to delivering care to high-cost Medicaid beneficiaries; and meeting regularly to review the process.¹³

Interesting outcomes from the High Cost Care Initiative were generated by a number of the provider organizations. The Visiting Nurse Service of New York (VNS) model focused on efforts to reduce hospital re-admissions. They developed a tool to predict those patients, within a group of their patients that typically have a 30 percent readmission rate during

¹¹ New York State Department of Health. (2006). *State health department launches new health care initiatives*. Retrieved from http://www.nyhealth.gov/press/releases/2006/2006-04-18_at_risk_patients.htm

¹² New York State Department of Health. (2008). *Health Department Seeks Proposals to Improve the Care of Chronically Ill Medicaid Patients*. Retrieved from http://www.nyhealth.gov/press/releases/2008/2008-02-21_health_department_seeks_proposals_to_improve_care_of_chronically_ill.htm

¹³ Birnbaum, M. & Halper, D.E. (2009). *Rethinking service delivery for high-cost Medicaid patients*. United Hospital Fund.

the first 60 - 180 days following hospitalization, that are at highest risk for re-admission. Using this statistics-based tool, the VNS can more effectively target their resources and reduce the costs related to hospital re-admissions.

Maimonides Medical Center developed a model to focus on care coordination of mental health and primary care. They established an approach in which mental health and primary care clinics were co-located, the mental health and primary care providers held regular patient care and coordination meetings, nurse case managers were engaged, and inter-clinic referrals were generated.

Bellevue Hospital Center and Montefiore Medical Center (in collaboration with Bronx Lebanon Hospital Center) developed models that fundamentally altered their care delivery systems for high-cost Medicaid recipients, leading to significant financial savings and improved quality of care delivered. The common elements of the two models included intensive inter-disciplinary care management; integrated delivery for medical, mental health, and substance abuse services; collaboration with community-based social services and data sharing. Bellevue's approach to care delivery integrated supportive housing solutions to stabilize the patients' insecure housing situations, and Montefiore's model utilized financial risk/reward incentives. These models resulted in dramatic decreases in Emergency Department utilization and in-patient hospitalization rates, both of which save money for the Medicaid program. Bellevue Hospital Center, Woodhull Medical and Mental Health Center and Elmhurst Hospital Center have received additional grant funding from the Department of Health, building off of the United Hospital Fund experiences, to implement a "model of care that integrates physical and behavioral health services with community-based organizations, working on issues from health care to housing."¹⁴

¹⁴ Birnbaum, M. & Halper, D.E. (2009). *Rethinking service delivery for high-cost Medicaid patients*. United Hospital Fund.

Support Nursing Home Quality Incentive Pools

The introduction of financial risk or reward for providers of care adds the element of accountability for the providers. In New York state, there have been efforts to tie a portion of the reimbursement that nursing homes receive to the quality of care that the facility provides (for example, the hours of RN care provided, the percentage of residents that develop certain infections, whose functional status declines, or who lose excessive amounts of weight, and the results of re-certification surveys). Medicaid spending on nursing homes is \$8.1 billion or 14 percent of total Medicaid spending. Determining the appropriate quality benchmarks for various, complex populations is a challenge, but continuing to pay for high-cost, sub-optimal care is not an acceptable alternative.

Promote Accountable Care Organizations

The concept of accountable care organizations (ACOs) is a mechanism for promoting the integration of cost savings and the achievement of specific quality outcomes into the services provided. There are various conceptualizations of ACOs, but one basic definition is that accountable care organizations “consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.”¹⁵ Accountable care can be utilized with various payment models and there have been demonstration projects in Indiana and North Carolina among Medicaid providers that link bonus payments to the achievement of quality outcomes and reductions in spending. The combination of health care homes with concepts of accountable care makes for an intriguing approach to managing complex Medicaid enrollees. Primary care providers will play a central role in the implementation of “accountable health homes” and registered nurses, including advanced practice nurses, must be a critical component.

¹⁵ McClellan, M., McKethan, A.N., Lewis, J.L., Roski, J. & Fisher, E. (2010). *A national strategy to put accountable care into practice*. Health Affairs, 29(5), 982-990.

The Role of Nurses in Medicaid Reform

Encourage the Utilization of Nurse Managed Health Centers

Nurse managed health centers present an opportunity to provide coordinated, accessible and cost-effective care for Medicaid recipients. The nurse managed health centers, like the Federally Qualified Health Centers, provide comprehensive primary care services to populations living in medically underserved areas. These centers are essential safety net providers and there is federal funding available to support nurse managed health centers in the federal health reform law. Research from the National Nursing Centers Consortium in Pennsylvania demonstrates that nurse managed health centers provide high quality, cost-effective care with high rates of patient satisfaction.¹⁶ The care model generally practiced in these health centers focuses on wellness promotion, disease prevention and chronic disease management, and research has found that their patients have lower rates of hospitalization when compared to other safety net providers. Nurse managed health centers provide accessible, patient-centered, comprehensive and cost-effective care; New York must incorporate this valuable resource into its reform.

Expand the Utilization of School-Based Health Centers

In addition to federal funding for nurse managed health centers, there is also funding available to support school-based health centers. School-based health centers utilize multidisciplinary teams of providers including nurse practitioners, to provide comprehensive primary care, preventive care, and early intervention services to underserved elementary and high-school age children. A series of papers in the *American Journal of Public Health* highlighted some of the outcomes that are associated with access to school-based health centers. These include: an increase in the use of primary care services, a reduced use of the Emergency Department, fewer hospitalizations, expanded access to and improved quality of physical and mental health care, greater engagement in health-promoting behaviors, and improved resiliency among the children and

¹⁶ Hansen-Turton, T., Bailey, D.N., Torres, N. & Ritter, A. (2010). Nurse-Managed health centers. *American Journal of Nursing*, 110(9), 23-26.

adolescents.¹⁷ The “improved resiliency” outcome is significant because resiliency is measured through important quality of life factors: attending and applying oneself in school, expressing feelings and emotions, expressing a feeling of hope in one’s life and in the future, involvement in organized recreational or vocational activities, and motivation to participate in counseling. School-based health centers can significantly and positively alter the course of a vulnerable child’s life and registered nurses play a key role in that process.

Increase the Use of Advanced Practice Registered Nurses

Primary care requires a team and cannot be provided by just one person or just one profession. All providers must be allowed to practice to the full extent of their education. The Institute of Medicine-Robert Wood Johnson Foundation report, *The Future of Nursing: Leading Change, Advancing Health*, recommends that advanced practice registered nurses should practice to the full extent of their education and training.¹⁸ New York must remove the arbitrary restrictions and barriers that exist to practice and embrace these highly qualified, cost-effective providers as full partners in care, as well as team leaders. Many of these restrictions could be addressed if the Medicaid provider language was provider neutral, as the NYS Department of Health is already using in many of its other regulations.

Pursue Federal Grants Available from Affordable Care Act

There are many opportunities for funding available in the federal health reform law that would help New York test strategies to achieve its goals for Medicaid. For example:

- State option to provide health homes for Medicaid enrollees with chronic conditions (*Sec. 2703*)
 - State planning grants available beginning January 1, 2011

¹⁷ The Role and Value of School Based Health Care. (September 2010). *American Journal of Public Health*, 100(9).

¹⁸ Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2010). *The future of nursing: Leading change and advancing health*. Robert Wood Johnson Foundation.

- 90 percent FMAP for first 8 fiscal quarters the State plan amendment is in effect
- Graduate Nurse Education Demonstration (*Sec. 5509*)
 - Demonstration project from 2012-2015
 - \$200 million available for 5 hospitals/nursing schools/community health centers
- Nurse Managed Health Clinics (*Sec. 5208*)
 - \$15 million available for operation of 10 Nurse Managed Health Clinics that will also assist in education of Nurse Practitioners
- School Based Health Centers (*Sec. 4104*)
 - \$100 million available to support School-Based Health Clinics that serve a large population of Medicaid-eligible children
- Pediatric Accountable Care Organizations – Medicaid Pilot (*Sec. 2706*)
 - HHS will provide incentive payments for the pediatric ACOs that meet the federal performance guidelines and the state savings levels
- Independence at Home Medical Practice Demonstration (*Sec. 3024*)
 - \$5 million/year available for 2010-2015
 - Nurse practitioner or physician-directed home-based primary care teams
 - Model focuses on providing “comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings” (p. 286).
- New York has already been awarded \$4.1 million to fund optional coverage for visiting nurses for maternal, infant, early childhood for low-income/high-risk families (*Sec. 2951*)
 - Anticipate improvement in maternal/child outcomes among at-risk maternal/child populations

Promote Nurse Residency Programs to Help Financially Strained Facilities

Nurse turnover is a persistent challenge for nursing and hospital executives. High rates of turnover, particularly among first-year nurses, costs facilities from \$62,000 to \$88,000 per

nurse; costs patient access to safe and quality care; and costs the nursing profession by exposing new nurse graduates to high-stress, unsupportive work environments. In 2007, the average nurse turnover rate in hospitals was 8.4 percent and 27.1 percent of *newly-hired* nurses left their jobs within one year of hire.¹⁹ There are estimates that up to 40 percent of *new nurse graduates* leave their hospital jobs within one year of hire.²⁰ A 2007 report produced by Pricewaterhouse Coopers' Health Research Institute estimated that annually, healthcare organizations spend \$300,000 in nurse turnover costs for every 1 percent increase in turnover; an average turnover rate of 8.4 percent translates to an annual cost of turnover for healthcare organizations of \$2.52 million.²¹

Nurse Residency Programs fill the gap between school and practice by providing continuing education, mentoring, reduced patient loads, and support that enables the new nurse graduate to successfully navigate the transition from novice to competent practicing nurse. Nurse Residency Programs generally last one year and research shows that they: lower the rates of nurse turnover; improve the quality of patient care through the development of nurses' critical thinking, prioritization skills, professionalism, and improved ability to function in healthcare teams; and improve the retention rates of new nurse graduates.²²

The Institute of Medicine-Robert Wood Johnson Foundation report on the *Future of Nursing* recommends the implementation of Nurse Residency Programs after the completion of a prelicensure program, of an advanced practice degree program, or when nurses are

¹⁹ Residency program for first-year nurses eases entry into profession, producing well-above average retention rates. (2010). *AHRQ Health Care Innovations Exchange*. Retrieved from <http://www.innovations.ahrq.gov/content.aspx?id=1842>

²⁰ Harasim, P. (November 28, 2010). Nurse residency program hones skills. *Las Vegas Review-Journal.com*. Retrieved from www.lvrj.com/news/nurse-residency-program-hones-skills-110930569.html

²¹ PricewaterhouseCoopers. (2007). *What works: Healing the healthcare staffing shortage*. PricewaterhouseCoopers' Health Research Institute.

²² Hendren, R. (August 31, 2010). Nurse residency programs pay for themselves. *HealthLeaders Media*. Retrieved from <http://www.healthleadersmedia.com/content/NRS-255844/Nurse-Residency-Programs-Pay-For-Themselves>

transitioning into new clinical practice areas.²³ Many hospital systems are in fact, beginning to implement residency programs, but more need to be encouraged including developing them in community settings. As Mary Beth Campo, the Chief Nursing Executive for Kaleida Health in Western NY stated in relation to the implementation of a collaborative Nurse Residency Program for Kaleida Health, Erie County Medical Center, Roswell Park and the VA medical Center, “Nursing leaders realize that the success of new nurse graduates is critical to the future of health care in our community and has become a priority for area health providers.”²⁴

New York state finds itself at the edge of a financial precipice; the choices that are made with regard to Medicaid reform will greatly impact how effectively the state navigates the peril and how well the state’s residents endure the journey. As Atul Gawande explains,

[T]here is no insurance system that will make the two aims [the needs of the patients and maximizing revenue] match perfectly. But having a system that does so much to misalign them has proved disastrous. As economists have often pointed out, we pay doctors [and other providers] for quantity, not quality. As they point out less often, we also pay them as individuals, rather than as members of a team working together for their patients. Both practices have made for serious problems.²⁵

New York has an opportunity to reform its Medicaid program so that it provides coordinated, cost-effective care for even the most complex and fragile recipients, as well as including a process that holds providers accountable for that care. We must not lose this

²³ Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. (2010). *The future of nursing: Leading change and advancing health*. Robert Wood Johnson Foundation.

²⁴ New nurse residency program set to launch. June 24, 2010. *Buffalo General News*. Retrieved from http://bgh.kaleidahealth.org/news/news_display.asp?artID=2260

²⁵ Gawande, A. (June 1, 2009). *The cost conundrum: What a Texas town can teach us about health care*. The New Yorker.

opportunity to realign our Medicaid system to one that serves New York’s residents well while maximizing the tremendous talent and skill that New York’s registered nurses have to offer.