Redesigning
THE MEDICAID PROGRAM

NEW YORK STATE DEPARTMENT OF HEALTH

Medicaid Redesign Team (MRT)

Basic Benefit Review Work Group

FINAL RECOMMENDATIONS

Medicaid Redesign Team
Basic Benefit Review Work Group
Final Recommendations – November 1, 2011

Work Group Charge:

- Conduct a thorough examination of the current list of covered benefits in the New York State Medicaid program.
- Extend the examination beyond the list of covered services to current copay, coinsurance and premium levels.
- Examine the latest cost-effectiveness research and value-based benefit design initiatives to see what lessons can be gleaned for New York State Medicaid.
- Develop a series of recommendations for modifications to the Medicaid benefit package and cost-sharing policies that will both improve health care quality and lower costs in the program.
- Focus on ways to monitor the impact of changes enacted in the budget regarding access to care and services.

The members determined that a full review of all benefit changes which could possibly be of value could not be conducted in the short period the group would exist. It was determined that it would be of more lasting value to develop guidance for not only the Group's current review of Medicaid benefits but for on-going benefit design. The Group adopted the following additional charges:

- Develop a recommendation regarding guiding principles which apply to any future reviews of benefit changes.
- Develop a recommendation regarding a process New York State Medicaid can follow in making future and on-going benefit decisions in response to new codes, new procedures, new technologies, and other advances in medical/behavioral knowledge regarding effectiveness and costs within the parameter of available resources in the Medicaid program.

Work Group Membership:

CO-CHAIR: Frank Branchini, President and CEO, EmblemHealth

CO-CHAIR: Nirav Shah, MD, MPH, New York State Commissioner of Health

Elisabeth R. Benjamin, Vice President of Health Initiatives, Community Service Society

R. Scott Braithwaite, MD, MMSc, Associate Professor of Internal Medicine, New York University School of Medicine

Kate Breslin, President/CEO, Schuyler Center for Analysis and Advocacy

Basit Chaudhry, M.D., PhD, Senior Researcher, Healthcare Analytics, IBM Research

Henry Chung, MD, Vice President and Chief Medical Officer, CMO Care Management Company, Montefiore

Robert M. Corwin, MD, FAAP, Pediatrician, former district chair, American Academy of Pediatrics

Douglas DeLong, MD, FACP, Governor-elect, NY American College of Physicians

Mark Gibson, Director, Center for Evidence-based Policy, Oregon Health & Science University

Eugene Heslin, MD, NYS Academy of Family Physicians

Paloma Izquierdo-Hernandez MS, MPH, President and CEO, Urban Health Plan, Inc

Ira B. Lamster, DDS, MMSc, Dean, Columbia University College of Dental Medicine

Eliot J. Lazar, MD, MBA, SVP & Chief Quality & Patient Safety Officer, NY-Presbyterian

David Lehmann, MD, PharmD, SUNY Upstate Medical University

Peter Newell, Director, United Hospital Fund's Health Insurance Project

Arnold Saperstein, MD, President/CEO, Metro Plus Health Plan

Kathleen Shure, Senior Vice President, Managed Care and Insurance Expansion, Greater NY Hospital Association

Joseph Stankaitis, MD, MPH, Medical Director, Excellus/Monroe Health Plan

Albert George Thomas, MD, Associate Professor of Obstetrics and Gynecology, Mount Sinai School of Medicine

Meeting Dates and Focus:

August 31, 2011 – The first meeting of the Work Group reviewed the group's mission, vision, guiding principles, and charge. The Department of Health provided an overview of the Medicaid program including information regarding mandated and optional services, co-payments, federal requirements, primary care enhancements, enacted MRT reforms, population specific benefits and waiver services. The Department also provided an overview of the way in which new technology is currently evaluated to determine whether or not it will be covered by New York State Medicaid. The processes other states follow in making determinations were also discussed. Some specific areas for potential benefit reform were reviewed. The group was asked to establish a process for on-going assessment of benefits against evidence going forward.

September 14, 2011 – The second meeting of the Work Group more closely examined the Group's charge and expected output. Plans to produce specific recommendations to the MRT which are budget neutral, evidence-informed and cost-effective were reviewed. Additionally, the Group planned to establish a process to do an on-going assessment of benefits against evidence. A draft of the Group's guiding principles was shared. Additionally, an overview of the benefit change research process was provided along with a discussion of the hierarchy of evidence. Examples of the ways in which other states use evidence were provided. Specific NYS benefits were examined as potential areas for reform.

October 4, 2011 – The Work Group reviewed and finalized the guiding principles and the benefit review process documents. The remainder of the meeting was spent reviewing specific benefit reforms for consideration in the final package of proposals.

October 19, 2011 – Final drafts of the principles and process documents were briefly reviewed and approved by all present group members. The remainder of the meeting was spent discussing the ten proposals for specific reforms to the Medicaid benefit package in detail. All of the Work Group members who were present at this meeting were in favor of advancing these recommendations with some suggested modifications and caveats to the MRT.

Outside Experts Consulted with:

The group was aided by a presentation by the Oregon Health & Science University (OHSU) with input from the State University of New York on the research process, the use of evidence, and the way in which other states use evidence in benefit design. OHSU also provided several examples of benefits which have recently been reviewed and/or considered across the nation by public and private payers.

Additionally, Edward L. Hannan, Ph.D., M.S., M.S., F.A.C.C., Professor of Health Policy, Management and Behavior at the SUNY at Albany School of Public Health, shared his expertise on Percutaneous Coronary Intervention (angioplasty) with the Work Group. Dr. Hannan has expertise in health services research; evidence-based medicine; outcomes research; cardiac surgery; angioplasty, trauma systems; carotid endarterectomy; volume-outcome relationships in health care; medical decision-making; risk-adjustment; medical errors; and patient safety.

Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report:

One of the Work Group's charges was to examine current co-pay, coinsurance and premium levels. The Group determined after discussion of possible co-payment changes there was significant concern, based on the literature, that even small incremental changes in co-payments can have unintended consequences in low income populations such as reducing utilization of important treatments and services. Also, since co-payments must be waived by providers if necessary, they are often an unintended 'tax' or reduction in payment to providers. It was decided to pend any co-pay change recommendation until a fuller analysis of positive and negative co-pays could be conducted.

Fiscal Note: In addition, because the Medicaid program is operating under a global cap, any benefit changes must be cap neutral.

Suggestions for specific benefit redesign came from the public, Work Group members, DOH contractors, NYC Department of Health and Mental Hygiene, and DOH staff from the Office of Health Insurance Programs (OHIP) and the Office of Public Health (OPH).

Summary Listing of Recommendations

A. ***Benefit Review Principles*** **–** The set of principles carefully crafted by the Work Group highlights the use of evidence and the value in prioritizing benefits based on population impact and overall value to the program.

B. ***Benefit Review Process*** **–** A detailed process which addresses the criteria used to determine if the benefit should be reviewed, the evidence to be considered, the clinical as well as financial review, and the final app*r*oval authority. Additionally, an expert advisory panel is recommended to provide consultation as needed.

C. ***Specific Benefit Reforms*** **–**The Work Group have made specific recommendations in the following areas:

1) *Podiatry for Diabetics*
2) *Knee Arthroscopy*
3) *Back Pain Treatments*
4) *Breastfeeding Support*
5) *PCI (Angioplasty)*
6) *Obesity Treatment*
7) *Elective Delivery (C-sections and inductions) < 39 Weeks Gestation without Medical Indication*
8) *Growth Hormone*
9) *Tobacco Cessation Counseling by Dentists*
10) *Nurse Family Partnership (NFP)*

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Recommendation: **(A)**

Recommendation Short Name: **Guiding Principles for Benefit Design**

Program Area: **OHIP**

Implementation Complexity: **Low**

Implementation Timeline: **Short Term**

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: The Work Group took considerable time and care in crafting the following set of guiding principles which were applied when developing their specific redesign recommendations and when conducting benefit reviews going forward.

The **guiding principles** recommended by the Work Group are as follows:

1) All Medicaid members will be treated equitably without discrimination so that they may attain the highest level of health.
2) If Medicaid budgets are insufficient to support all potential services, then priorities must be set by the program among services to be provided based on evidence and effectiveness.
3) Priorities in benefit design must maximize the health of the population served by the program and be based on an assessment of benefits, harms, and costs.
4) When assessing benefits, harms and costs, empirical evidence (when available and of high quality) will be critically appraised to determine its appropriateness for policy application and will be given more weight than subjective or expert opinion. The hierarchy of evidence used for coverage decisions includes:
    - Type I (highest): meta-analysis or systematic review of multiple well designed randomized controlled trials.
    - Type II: one or more well designed randomized controlled trials.

- Type III: well designed studies which could include nonrandomized controlled, pre-post, cohort, case-control, cross-sectional, observational studies.
- Type IV: expert panel opinion/ high quality professional guidelines.
- Type V (lowest): single expert, case report.

5) Criteria to be considered for evaluation of specific services and benefits follow those of evidence-based health care, and include:

   - Evidence that it is better than receiving no service for the specific clinical condition(s) or populations.
   - The added benefit per added cost compares favorably to other treatments for the same condition.
   - Evidence that access to less expensive interventions does not create undue burden for individuals.
   - Evidence that benefits outweigh harms in improving health.
   - The burden of presenting evidence for the above criteria lies with those advocating the use of the service.
   - Level of evidence will be specified in accord with typology described above and reassessed when sufficient new evidence would suggest a possible change in benefit coverage.

6) Considering cost and value as well as cost control through benefit design are legitimate as they support the ability of the state to provide the maximum number of services that are effective in improving the health of the population. This approach will make the most efficient use possible of available resources and maximize the public good. Criteria for excluding or limiting benefits should focus on those services in which:

   - Costs are high and evidence for clinical effectiveness is highly variable or low, or (the clinical intervention (product or service) is overused compared to evidence-based appropriateness criteria.
   - Evidence of additional value (benefits to cost) compared to other treatments for the same condition is low.

7) A highly limited number of benefit decisions may require an individualized approach including those pertaining to rare or emerging clinical conditions for which a high level of evidence is not realistic, certain experimental treatments where no 'standard of care' exists, and/or complex emergency circumstances.

8) In the evaluation of services and benefit design the outcomes of interest should include the preferences of patients, individual autonomy, and those outcomes generally of high value to patients such as survival, function, symptoms and quality of life.
9) Evaluation of benefit decisions on utilization, costs, and health outcomes (where feasible) should follow any 'major' benefit decisions in order to assess impact post-coverage decisions.
10) Every attempt should be made to eliminate any conflict of interest in the use of clinical experts.

Nothing in the benefit review principles or the process shall limit in any way the existing role or responsibility of the New York State legislature with regard to statutory authority over the NYS Medicaid program.

Financial Impact: A primary focus of the principles is to allow for cost control measures with the intent of ensuring funding is available to provide the appropriate level of necessary services to the maximum number of beneficiaries.

Health Disparities Impact: The principles are designed to ensure that Medicaid beneficiaries are treated equitably.

Benefits of Recommendation: Currently, the Medicaid program does not have a written set of principles to refer to when making decisions regarding benefit design. The consistent application of clear and relevant principles will serve to assist in the creation of an improved Medicaid program.

Concerns with Recommendation: None

Impacted Stakeholders: Providers, Health Plans, and Members

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Recommendation: **(B)**

Recommendation Short Name: **The Benefit Review Process**

Program Area: **OHIP**

Implementation Complexity: **Medium**

Implementation Timeline: **Short Term**

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: The Group also spent a great deal of time designing a detailed process for all benefit reviews. The process addresses the criteria used to determine if the benefit should be reviewed, the evidence to be considered, the clinical as well as financial aspects of the review, and the final approval authority. Additionally, it is recommended that an expert advisory panel be established to provide as needed guidance to the Medicaid program in regard to ongoing benefit design. There was a discussion regarding consumer/member input to the benefit process. The group agreed on the importance of this, but chose to use the general language of 'expert panel' which was intended to include consumers/members as well as others.

One aspect of the process which was considered by the group is the importance of evidence in the initial evaluation of benefits and the challenge of translating the evidence into specific benefit design.

The benefit review process recommended by the Work Group is as follows:

OHIP clinicians, consultants, and finance staff will perform a two-step review of Medicaid benefits beginning with a clinical review followed by a financial impact evaluation. Benefits or services to be reviewed will include existing or new technology with significant costs or utilization or health impact(s), requests external to the department, proposed new codes for services (CPT and HCPCS) and any new federal or state statute/regulatory changes that mandate review. Depth and breadth of reviews will be proportional to expense and/or potential health impact on population health.

- Most CPT and HCPCS reviews will not be given comprehensive reviews in situations of:
  - Low programmatic cost (considering both price and utilization);
  - Clear and known benefit;
  - Code clarification or update.
- Providers and manufacturers requesting coverage will be asked to assist OHIP in its process of understanding the safety and effectiveness of the proposed benefit by completing a standardized template of questions which describe the technology/service/device, its uses and health benefits, federal agency approvals (if any) such as the Food and such Drug Administration(FDA) , and a description and evaluation of the quality of the evidence base
- Review decisions for pharmaceuticals would remain within the authority of the Pharmacy and Therapeutics (P&T) Committee unless otherwise delegated to this process
- Experimental/Investigational requests would require humanitarian device exemption from the FDA and/or a local institutional review board protocol
- Reviews of existing benefits will occur on a regular and recurrent basis based on those services with high programmatic costs, high utilization, or new or emerging evidence

In the first step OHIP clinical staff will use the best evidence available to determine clinical effectiveness of the service/benefit proposed for review. Reviews may include (where available):

- Primary source documents;
- Clinical studies;
- Meta analyses;
- Coverage guidelines of major insurers (including Medicare);
- Clinical practice guidelines;
- Consensus panel or expert opinion statements;
- Academic consultants; and
- Current payment rules (APG logic).

Following review, recommendations from OHIP clinical staff may include:

- No coverage;
- Limited coverage (based on patient population, conditions, frequency/amount, indications, etc. and may be either prospective (prior authorization) or retrospective);
- Covered without limitations; or
- Deferred due to insufficient information.

For the second step, recommendations by OHIP clinicians that result in new benefits or services will be forwarded to finance staff to project anticipated costs (including any possible offsets through elimination or reductions in the need for other services) for Medicaid, including both FFS costs and impacts on health plan premiums. The clinical group will forward any information that may assist the finance staff in making their determinations.

Final determinations by OHIP regarding coverage will integrate clinical effectiveness results with impact on cost and cost effectiveness. Decisions that would result in an increase in annual Medicaid costs above $1 million will be reviewed by the State Medicaid Director for final approval.

Final determinations, along with the rationale for decisions (for or against coverage) will be made publicly available.

An external expert group on benefits will be created as an advisory group to Medicaid. The Medicaid advisory group will consist of an external group of experts that provides overall guidance to the review process as needed, reviews benefit design in light of policy and program goals, and provides specific input into benefit reviews that are particularly challenging, high potential impact, or controversial. This group would meet quarterly, agenda would be posted to Department's website in advance and meetings will be open to the public.

Individual denials of coverage based on medical necessity (including denials based on experimental/investigational determinations) will continue to be eligible for statutory based appeals processes which may include 'internal' appeals, access to the state external appeal process, and/or fair hearing reviews.

All meetings of the expert advisory committee on Medicaid benefit review shall be open and public.

Financial Impact: There will be some costs to implement the process but many required staff and resources are already in place. Details regarding funding for the external expert group have not yet been determined. This process should return savings to the Medicaid program by focusing benefit decisions toward evidence driven policy.

Health Disparities Impact: Neutral

Benefits of Recommendation: This formalized, documented process for benefit review will be beneficial in many ways. A uniform fiscal analysis process along with a more structured review of evidence will allow for more informed decision-making.

Concerns with Recommendation: None

Impacted Stakeholders: Providers, Health Plans, and Members

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Recommendation: **(C-1)**

Recommendation Short Name: Podiatry for Diabetics

Recommendation Long Name: Expand coverage of podiatry services to Include private office podiatrists for adults with diabetes mellitus

Premise: Medicaid should cover this evidence based, cost effective service in all settings to improve access and reduce complications of diabetes, including amputations.

Program Area: OHIP

Implementation Complexity: Medium

Implementation Timeline: July 1, 2012

Required Approvals: ☐ Administrative Action ☑ Statutory Change ☑ State Plan Amendment ☐ Federal Waiver

Proposal Description: Currently, MA covers the services of private practicing podiatrists only for children up to age 21 and for Medicare/Medicaid dually eligible recipients. Adults (age 21+) may obtain podiatry services in Article 28 hospital outpatient departments and free-standing clinics. Under this proposal, Medicaid will permit adult MA recipients who have a diagnosis of Diabetes Mellitus to obtain care from a private practicing podiatrist.

Financial Impact: In CY 2010, there were 58,000 Medicaid recipients (fee-for-service non duals) with a diagnosis of diabetes. Those recipients had 444 hospital admissions for lower limb amputations which cost the Medicaid program $10.6 million. Routine preventive foot care can reduce the number of amputations by 50%[1] and therefore yield savings of $5.3 million. The average payment for a routine podiatry visit is $38.97 (E&M at $30.97 and nail debridement at $8.00). Based on an average of 2 visits annually/diabetic patient for 20 percent of this population (20% of 58,000), total Medicaid fee-for-service costs are $0.9 million dollars. Based on this analysis, the net savings would be $4.4 million.

[1] Rogers, Lee C., DPM, Lavery, Lawrence A., DPM, and Armstrong, David G., Ph.D., (2008). The right to bear legs – an amendment to healthcare: How preventing amputations can save billions for the US health-care system. Journal of the American Podiatric Medical Association, Volume 98, No. 2, 166-168.

Note: Above fiscal does not include managed care or Medicare/Medicaid dually eligible enrollees; managed care plans presently cover all podiatry, and Medicaid fee-for-service covers deductible/coinsurance for dually eligible enrollees.

Health Disparities Impact: Type 2 diabetes is highly prevalent in certain Medicaid populations. Expanding Medicaid payment to private practicing podiatrists for the adult diabetic population will help to improve health outcomes for those populations where there is a higher incidence of adult onset diabetes.

Benefits of Recommendation: Studies show that routine foot care/examination in diabetic patients can identify risk factors predictive of diabetic complications, such as lower extremity ulcers, infections and amputations. Expanding podiatry coverage for adult diabetics will result in cost saving to Medicaid by decreasing the diabetic complications mentioned above. The American Diabetes Association recommends an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. Note: Medicare covers routine foot care performed by podiatrists in the presence of a qualifying diagnosis, of which Diabetes is one.

Concerns with Recommendation: Overutilization may be a concern. Appropriate payment edits will need to be put into place.

Impacted Stakeholders: Podiatrists, patients with diabetes, hospitals (lower amputation rates).

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Recommendation: **(C-2)**

Recommendation Short Name: Knee Arthroscopy

Recommendation Long Name: Eliminate coverage of arthroscopy of the knee for osteoarthritis

Premise: Medicaid should not cover the costs of knee arthroscopy for osteoarthritis because there is no evidence of benefit.

Program Area: OHIP

Implementation Complexity: Low

Implementation Timeline: April 1, 2012

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: This proposal would limit coverage for arthroscopic knee surgery when primary diagnosis is osteoarthritis of the knee (without mechanical destruction of the knee).

The American Academy of Orthopedic Surgeons (AAOS) Board of Directors adopted The Clinical Practice Guideline for the Treatment of Osteoarthritis of the Knee (Non-Arthroplasty) in December 2008. This evidence-based guideline recommends against performing arthroscopy with a primary diagnosis of OA of the knee.[2] There is evidence that arthroscopic surgery for removal of loose debris, cartilage flaps, torn meniscal fragments, and inflammatory enzymes results in minimal pain relief and no functional benefit in patients that have joint space narrowing on standing radiographs.[3]

Many patients with joint space narrowing are older with multiple medical comorbidities. Such patients are more prone to complications and, consistent with the recommendations of the AAOS, there is no proven clinical benefit to arthroscopy of the knee for osteoarthritis (in the absence of mechanical

[2] http://www.aaos.org/news/aaosnow/feb09/cover1.asp
[3] Howell, Stephen M., MD (2010). The role of arthroscopy in treating osteoarthritis of the knee in the older patient. *Orthopedics,* 33(9): 652.

destruction of the knee joint). Howell (2010) indicates that arthroscopic debridement of the osteoarthritic knee is no more effective than sham surgery and physical and medical therapy.[4]

Financial Impact: In CY 2010, Medicaid paid approximately $400,000 for the knee arthroscopy provided to patients with a diagnosis of osteoarthritis. Elimination of this service will result in modest cost savings to the Program. The State is exploring whether any savings might accrue for Medicare-enrolled patients for whom the State is paying coinsurance.

Health Disparities Impact: Neutral

Benefits of Recommendation:

- Savings created by limiting arthroscopies to only those patients for whom there is medical necessity and anticipated benefit post-procedure.
- Reduce medically unnecessary surgeries and potential for complications in medically complex patients.

Concerns with Recommendation:

- Although a patient's primary diagnosis is osteoarthritis, there may be comorbid conditions that are not evident on exam and that would warrant performance of this procedure.

Impacted Stakeholders: Physicians, patients with OA of the knee, hospitals, managed care plans

[4] Ibid.

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Recommendation: **(C-3)**

Recommendation Short Name: Back Pain Treatments

Recommendation Long Name: Eliminate payment for treatments for low back pain where evidence suggests no benefit or there is no evidence for benefit

Premise: Medicaid should end reimbursement for low back pain treatments that have no credible evidence of producing more benefit than harm.

Program Area: OHIP

Implementation Complexity: Low to Moderate

Implementation Timeline: April 1, 2012

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change**

☐ **State Plan Amendment** ☐ **Federal Waiver**

Proposal Description: This proposal would limit/exclude coverage of prolotherapy (see Note 1), intradiscal steroid injections, facet joint steroid injections, systemic corticosteroids and traction (continuous or intermittent) (see Note 2). Based on the current literature, intradiscal steroids offer limited clinical improvement in pain or function for patients with discogenic low back pain. Controlled trials have revealed minimal if any benefit.

Note 1: Prolotherapy is "natural" technique that claims to stimulate the body to repair a painful area. A sugar- based solution is injected into the affected ligaments or tendons, which leads to local inflammation. A wound healing cascade is purportedly triggered, resulting in the deposition of new collagen. New collagen shrinks as it matures and tightens/strengthens the ligament that was injected. Prolotherapy is not covered as a separate procedure (inactive code on eMedNY).

Note 2: Traction procedure codes are not active on eMedNY; however, traction may be provided in conjunction with physical therapy rehabilitation services.

Financial Impact: In CY 2010, Medicaid paid approximately $7.7 million dollars for the identified medical procedures to treat low back pain. Eliminating coverage will result in considerable savings to the Program. If Medicare Part B coinsurance is not covered, then an additional $378,000 in Medicaid savings would result.

Health Disparities Impact: Neutral

Benefits of Recommendation:

- Increased savings by limiting coverage of non-evidence based treatments for low back pain.
- Improved patient safety by limiting exposure to invasive procedures which can cause infections, steroid-related problems, and stretch injuries among others.

Concerns with Recommendation:

- Anecdotally, patients report temporary relief of back pain after steroid injections.
- Increased referrals for physical therapy (note: physical therapy is presently limited to 20 visits in a 12 month period).
- Potential co-insurance reductions would require further exploration and discussion.

Impacted Stakeholders: Physicians, patients, hospitals, Medicaid managed care plans

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Recommendation: **(C-4)**

Recommendation Short Name: Breastfeeding Support

Recommendation Long Name: Payment for specially trained lactation counselors

Premise: Medicaid should cover this USPSTF 'B' rated preventive service, which improves the health of infants, reduces short term health care costs, and can contribute to reductions in obesity.

Program Area: OHIP

Implementation Complexity: Medium

Implementation Timeline: September 1, 2012

Required Approvals: ☐ Administrative Action ☑ Statutory Change

☑ State Plan Amendment ☐ Federal Waiver

Proposal Description: Provide Medicaid reimbursement for International Board Certified Lactation Consultant (IBCLC) services for eligible pregnant women. The United States Preventive Services Task Force (USPSTF) recommends interventions during pregnancy and after birth to promote and support breastfeeding (Grade B - there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial). Additionally, ACOG guidelines promote exclusive breastfeeding for the first six months of life. In accordance with ACOG, practitioners are directed to provide counseling and education regarding infant feeding choices with the woman during prenatal visits and immediately postpartum.

Financial Impact: The NYS DOH Office of Public Health estimates that cost savings realized from breastfeeding are approximately $532 per infant per year due to lower incidences of treatment for otitis media, gastroenteritis, and necrotizing enterocolitis. Medicaid lactation counseling costs are estimated at $240 per birth (based on 115,311 Medicaid births annually at an average of three visits with an IBCLC - current private pay rates range from $50 to $110/hour).

New York State currently has 627 International Board Certified Lactation Consultants (IBCLCs). Of these, 70% also hold a NYS professional license (i.e., 394 RN, 3 RNC, 35 NP, 7 LPN, and 11 CNM).[5] In addition, there are 1,900 Certified Lactation Consultants (CLCs) in New York.[6] To assure access to this service, consideration may need to be given to approving trained registered nurses that are not certified, perhaps at a lower rate than that paid to IBCLCs.

Projected fiscal impact (at $240/birth for 115,311 births):

- 100% utilization - $27.67 million dollars gross.
- 50% utilization - $13.84 million dollars gross.
- 25% utilization - $6.92 million dollars gross.

*Net savings per infant/year ($532 savings/infant - $240 lactation counseling costs/infant):

- $33.67 million for 100% utilization.
- $16.84 million for 50% utilization.
- $8.42 million for 25% utilization.

Health Disparities Impact: 2007 CDC breastfeeding rates are significantly lower for African-American babies compared to the rates for the total population. Additional utilization of covered services or coverage for IBCLC could increase the numbers of African-American babies that are breastfed.

Benefits of Recommendation:

- Improved health outcomes for breast-fed babies (lower rates of acute and chronic diseases such as otitis media, atopic dermatitis, gastrointestinal infections, lower respiratory infections, asthma, overweight, type 1 and type 2 diabetes and childhood leukemia.
- Improved outcomes for the mother (reduced risk of ovarian and breast cancers, diabetes, metabolic disease, and heart disease).

Concerns with Recommendation: Care will need to be taken to ensure there is no duplication of effort and careful integration with Medicaid and other state/federal funded programs. For example, the WIC program is charged with the responsibility of providing nutrition and lactation counseling to all participants. Similarly, local county health departments that provide postpartum home visits do offer assistance with lactation counseling.

Impacted Stakeholders: Pregnant women, prenatal care providers (hospital outpatient departments, free-standing clinics, physicians, licensed midwifes, nurse practitioners), and CHHA/LHCSA.

[5] Marsha Walker, RN, IBCLC, Director Public Policy, US Lactation Consultant Association. Personal communication, 10/07/11.
[6] The Center for Breastfeeding, Certified Lactation Counselor® (CLC) Training; Healthy Children Project, East Sandwich, MA 02537. Personal communication, 10/07/11.

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Recommendation: **(C-5)**

Recommendation Short Name: PCI

Recommendation Long Name: Eliminate coverage of Percutaneous Coronary Intervention (PCI) in circumstance of no clear benefit

Premise: Medicaid should not pay for expensive cardiac invasive services when evidence and professional recommendations do not support benefit over less expensive, less invasive, medical therapies. Medicaid should support the collection of this information through the cardiac registries, which improves quality, safety, and costs for Medicaid members and others.

Program Area: OHIP

Implementation Complexity: High

Implementation Timeline: September 1, 2012

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: Limit coverage for PCI to only those patients who are not inappropriate for the procedure based on ACC/AHA appropriateness criteria. PCI is very effective for evolving heart attacks, but its value is less certain for patients with stable coronary artery disease (no recent heart attack or unstable angina). Studies have shown that for many people with stable coronary artery disease, coronary angioplasty is no better than optimal medical therapy at preventing future heart attacks or strokes, nor does it extend life.

Financial Impact: In CY 2010, there were 1874 Medicaid claims for PCI without a recent heart attack or unstable angina with enough information to obtain an appropriateness rating. A total of 206 of these patients (11.0%) were inappropriate for the procedure based on ACC/AHA criteria. The total average cost per Medicaid patient for patients without a heart attack was $14,066. Applying this cost to the inappropriate procedures yields an annual cost savings of 2.9 million dollars.

Savings from this proposal will be used first to directly support the cardiac services registry with additional savings to return to the overall Medicaid budget.

Health Disparities Impact: Neutral

Benefits of Recommendation: Increased savings and decreased risk of complications by limiting coronary angioplasty to only those patients for whom there is clearly established medical necessity based on national guidelines.

Concerns with Recommendation: It will be necessary to develop a prior authorization process to ensure that quality care and patient safety issues are appropriately addressed.

Impacted Stakeholders: Physicians, patients, hospitals, Medicaid managed care plans.

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Recommendation: **(C-6)**

Recommendation Short Name: Obesity Treatment

Recommendation Long Name: Coverage of intensive behavioral therapy (IBT) for obesity

Premise: Medicaid should cover this USPSTF 'B' rated treatment for this major public health epidemic.

Program Area: OHIP

Implementation Complexity: Medium

Implementation Timeline: October 1, 2012

Required Approvals: ☑ Administrative Action ☐ Statutory Change

☑ State Plan Amendment ☐ Federal Waiver

Proposal Description: Medicaid will cover intensive behavioral therapy for treatment of obesity. The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen all adults and children age 6 or older for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obesity. This proposal would incorporate recommendations of the USPSTF Grade B for children and adults (Grade B - there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial).

Criteria for coverage of Intensive behavioral therapy (IBT) for obesity in adults is a BMI > or = to 30kg/m2 and overweight is 25-29.9 kg/m2. Obesity among children is defined as a BMI at or above the 95th percentile of the sex-specific BMI-for-age growth charts.

Financial Impact:

ADULTS:

As of August 2011, there were 2,564,654 adults <65 years enrolled in NYS Medicaid. From the NYS Behavioral Risk Factor Surveillance System (BRFSS) (2006), the prevalence of obesity is 30%, making 769,396 eligible for participation in an intensive counseling and behavioral intervention as a reimbursable service through Medicaid. A projected 5% of eligible **beneficiaries** (38,470) will enroll in the first full year.

PROJECTED COSTS FOR THE NEW YORK MEDICAID PROGRAM

The projected annual cumulative costs of intensive behavioral counseling are $61.5 million.

- Assumes $80 per patient per visit x 20 visits = $1,600.
- $1,600 x 38,470 enrollees (5% of eligible) = **$61.5 million**.
- Economic impact may vary depending on eligibility criteria, rates of participation and drop-out, in addition to potential differences in intervention delivery and effectiveness.

Note 1: Savings may be longer term based on fewer chronic conditions (e.g., diabetes, heart disease, or hypertension) and related office visits, hospitalizations, etc. associated with obesity.

Note 2: Consideration may need to be given to visit limits. As an example, under preventive services, Medicare covers medically necessary nutrition services for people with specific conditions. . A physician's referral is required to access these services initially and yearly if treatment continues into another calendar year. Coverage includes three hours of one-on-one counseling services the first year and two hours each year after that, with the potential for additional hours with a doctor's referral.[7]

CHILDREN:

As of April 2008, there were 1,241,000 children and adolescents enrolled in Medicaid Managed Care (MMC) in New York State and In CY 2010, there were 819,000 children and adolescents (ages 6 to 19 y.o.) enrolled in Fee for Service Medicaid for an approximate total of 2,060,000 children. Estimates of obesity prevalence indicate that at least 17% of child and adolescent enrollees have a BMI percentile at or above the 95th percentile and that 58% of obese children have at least one co-morbid condition (adverse levels of lipids, blood pressure or insulin), making 203,116 eligible to enroll in comprehensive interventions as a reimbursable service through Medicaid. A projected 5% of eligible beneficiaries (10,155) will enroll in the first year.

[7] http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf

The projected annual medical costs of Comprehensive Multidisciplinary Interventions are $19,577,600.

- Assumes $200 per patient per visit with the obesity care team x 16 visits = $3,200.
- $3,200 X 10,155 enrollees (5% eligible population) = $32,496,000.
- Economic impact may vary depending on eligibility criteria, rates of participation and drop-out, in addition to potential differences in intervention delivery and effectiveness.

Health Disparities Impact: Clinicians will need to consider cultural norms when counseling patients.

Benefits of Recommendation: Intensive counseling—about diet, exercise, or both—together with behavioral interventions aimed at skill development, motivation, and support strategies with the goal of producing sustained weight loss will lessen the risk for developing diabetes, high blood pressure, coronary heart disease (CHD), hypertension, and stroke; type 2 diabetes; several types of cancer, including those of the colon, kidney, gallbladder, breast, and endometrium; sleep apnea; gall bladder disease; and certain musculoskeletal disorders, such as knee osteoarthritis. In addition, obesity is associated with decreased quality of life, including diminished mobility and social stigmatization.

Concerns with Recommendation:

- Competing demands affecting both clinicians and patients may get in the way of obesity counseling.
- Rates of patient non-compliance with plan of care.

Impacted Stakeholders: Providers, Managed Care Organizations, and Medicaid Recipients.

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Recommendation: **(C-7)**

Recommendation Short Name: Elective delivery (C-sections and inductions) < 39 weeks without medical indication

Recommendation Long Name: Reduce payments for elective Cesarean sections and inductions performed < 39 weeks without medical indication.

Premise: Medicaid should discourage this practice, which has compelling evidence of harm and is inconsistent with professional society recommendations.

Program Area: OHIP

Implementation Complexity: Medium

Implementation Timeline: September 1, 2012

Required Approvals: ☑ **Administrative Action** ☐ **Statutory Change** ☐ **State Plan Amendment** ☐ **Federal Waiver**

Proposal Description: Do not cover elective C-section deliveries or elective induction of labor less than 39 weeks unless a documented medical indication is present. Infants delivered prior to 39 weeks have an increased chance of complications and double the mortality rate of infants delivered at full-term. Babies born by C-section are at greater risk for respiratory problems, compared with those born vaginally, even at full term. Further, maternal concerns include an increased risk of infection, injury to other organs, and infertility, as well as anesthesia complications, and difficulty with breast-feeding. Life-threatening risks such as serious bleeding and blood clots or the need for an emergency hysterectomy are increased in cesarean section deliveries. In certain limited situations, C-sections or inductions may be appropriate even without a medical indication. Special consideration will need to be given to address this.

Financial Impact: In CY 2009, there were 121,533 Medicaid births. Of these, 26,101 (21%) were 36-38 weeks in estimated gestation age. 13,411 (51%) were delivered spontaneously; 8,147 (31%) were delivered by induction and/or C-section with indication; 4,543 (**17%**) were induced or C-section without indication.

If there is a 2% reduction in NICU stays related to avoiding induction or C-Section without indication (270 stays avoided against 13,450 NICU stays in 2007) at an average cost of $18,400 for a NICU stay, the savings would be almost $5M per year. Savings could be even greater if more NICU stays are avoided as has been the case in States like Ohio that implemented a very successful program to reduce the number of pre-term births. All State savings should come from reduced NICU admissions and reductions in other adverse events. Consideration will be given to either prospective prior authorization or retrospective review against approved criteria.

*Note: Data for C-sections and elective inductions are combined and the net effect is on reducing NICU admissions related to both interventions.

Health Disparities Impact: Neutral

Benefits of Recommendation:

- Avoidance of a pre-term delivery if due date calculation is inaccurate.
- Avoidance of health risks to mother and newborn.
- Reduction of NICU admissions.
- Reduced length of hospital stays.
- Reduced risk of neonatal respiratory problems.
- Decreased incidence of primary C-section rates will result in a decrease in repeat C-section (and associated costs).

Concerns with Recommendation: The reasons for increased C-section rates include: maternal preferences and characteristics, provider preferences and practice patterns, institutional factors, ambiguous indications and guidelines for C-section, and fear of litigation. Altering these attitudes and practice patterns will take considerable effort.

Impacted Stakeholders: Hospitals, physicians and other providers, managed care organizations, billing contractors, and Medicaid recipients.

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Recommendation: **(C-8)**

Recommendation Short Name: Growth Hormone

Recommendation Long Name: Eliminate coverage for treatment of Idiopathic Short Stature (ISS) with growth hormone

Premise: Coverage for ISS is not medically necessary but cosmetic in purpose and does not treat a medical condition defined by growth hormone deficiency.

Program Area: OHIP

Implementation Complexity: Medium

Implementation Timeline: July 1, 2012

Required Approvals: ☑ Administrative Action ☐ Statutory Change ☐ State Plan Amendment ☐ Federal Waiver

Proposal Description: Limit coverage of growth hormone injections for idiopathic short stature in children. Idiopathic Short Stature (ISS) is not considered to be a disease, but a term used to describe children two or more standard deviations below the mean for their age and gender and for who no alternate diagnosis can be made to account for this height. Insurance plans exclude coverage of growth hormones for short stature caused by heredity and not caused by a diagnosed medical condition. Coverage will remain available in cases of documented growth hormone deficiency (GHD) defined as a GH response of ≤ 20 mU/L confirmed by two growth hormone stimulation tests in children.[8]

Consensus guidelines published by the American Association of Clinical Endocrinologists (AACE) and the Growth Hormone Research Society (GRS) Consensus Committee state that the diagnostic test of choice for adults is the insulin intolerance test: a peak serum GH response less than 5 ug/L to insulin-induced hypoglycemia indicates GH deficiency. [9]

[8] _____. Author. (2003). Recombinant Growth Hormone Treatment in Children. https://www.hayesinc.com/subscribers
[9] _____. Author. (2002). Recombinant Growth Hormone Treatment in Growth Hormone-Deficient Adults. https://www.hayesinc.com/subscribers/displanSubscriberArticle.do?articleId=2185

Financial Impact: In CY 2010, 2,593 Medicaid children received growth hormone therapy. Fee-for-service program cost was $40 million dollars. There was a limited number of Medicaid managed care claims - growth hormone drugs are normally dispensed by a pharmacy and pharmacy drugs have been carved out of the managed care benefit. Note: pharmacy has been carved back into the managed care benefit effective October 1, 2011. If limiting coverage results in a 25% utilization decrease (one NYS managed care plan found 30 percent of the children using growth hormone were diagnosed with ISS), fiscal savings will be $10 million dollars gross.

Lee, et al. (2006) showed that for children, the estimated incremental cost-effectiveness ratio of GH treatment for ISS was $52,634 per inch (per 2.54 cm), with an incremental height gain of 1.9 in (4.8 cm) during 5 years at an incremental cost per child of $99,959. Alternate treatment strategies such as increased duration of GH treatment and high pubertal dosing of GH did not substantially improve the cost–effectiveness ratio.[10] Allen (2006) also indicates that use of growth hormone for ISS without evidence of underlying disease or growth hormone deficiency has uncertain benefits and significant costs.[11] Deodati and Cianfarani (2011) reviewed studies on use of growth hormone for ISS. The conclusions from this meta-analysis were that there is no study to date that has fulfilled the evidence-based medicine criteria for high quality evidence and a strong recommendation for use of GH for ISS.[12] Further, Deodati and Cianfarani (2011) found that the individual response to this therapy is highly variable and recommended further study to identify the responders. Cohen et al. (2008) concluded that further clinical research and development is warranted to ensure optimal management of children with ISS and to ensure that treatments are safe and beneficial.[13]

Health Disparities Impact: Neutral

Benefits of Recommendation: Considerable Medicaid cost savings will be realized and Medicaid policy will mirror that employed by other payers.

Concerns with Recommendation: Attention will have to be paid to assure that providers don't miscode claims to improperly indicate a growth hormone deficiency diagnosis in an effort to circumvent the new coverage policy.

Impacted Stakeholders: Primary care physicians, pediatricians, clinical endocrinologists, and Medicaid enrollees.

[10] Lee J, Davis M, Clark S. Estimated cost-effectiveness of growth hormone therapy for idiopathic short stature. *Arch Pediatr. Adolesc. Med.* 2006;160:263-269.
[11] Allen, David B. (2006). Growth hormone therapy for short stature: Is the benefit worth the burden? *Pediatrics,* Vol 118, 343-348.
[12] Deodati, Annalisa and Cianfarano, Stefano (2010). Impact of growth hormone therapy on adult height of children with idiopathic short stature: Systematic review. *BMJ* 2011; 342:c7157.
[13] Cohen, P., Rogol, A.D., Deal, C.L., Saenger, P., Reiter, E.O., Ross, J.L., Chernausek, S.D., Savage, M.O., and Wit, J.M. on behalf of 2007 ISS Consensus Workshop Participants (2008). Consensus statement on the diagnosis and treatment of children with idiopathic short stature: A summary of the Growth Hormone Research Society, the Lawson Wilkins Pediatric Endocrine Society, and the European Society for Paediatric Endocrinology Workshop. *J. Clin. Endocrinol Metab.* 93(11): 4210-4217.

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Recommendation: **(C-9)**

Recommendation Short Name: Tobacco Cessation Counseling by Dentists

Recommendation Long Name: Expansion of providers who can bill Medicaid for tobacco cessation counseling to dentists

Precedent: Medicaid should expand access to this evidence based, USPSTF 'A' rated, cost effective service which contributes to reductions in tobacco use.

Program Area: OHIP

Implementation Complexity: High

Implementation Timeline: October 1, 2012

Required Approvals: ☑ Administrative Action ☐ Statutory Change

☑ State Plan Amendment ☐ Federal Waiver

Proposal Description: Effective April 1, 2011, Medicaid expanded coverage of smoking cessation counseling (SCC) to all Medicaid beneficiaries. Each Medicaid beneficiary is allowed six counseling sessions during any 12 continuous months which must be provided face-to-face by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife either with or without an Evaluation and Management procedure code. SCC complements the use of prescription and non-prescription smoking cessation products. These products are also covered by Medicaid.

This proposal will enable dentists to be reimbursed by Medicaid for delivering smoking cessation counseling for an addiction that disproportionately affects Medicaid patients and is associated substantial healthcare costs.

Tobacco use is the leading cause of disease and premature death in New York State, responsible for more than 25,000 deaths annually. In 2010, personal health care expenditures attributable to smoking in New York totaled $8.2 billion including $3.3 billion in Medicaid expenses. The current adult smoking rate in New York is 15.5%. From 2003 to 2010, the prevalence of smoking declined faster in New York (29% decline) than in the United States as a whole (9% decline). While this overall decrease is significant, not every population group benefitted equally. Over the last decade, the prevalence of smoking has remained virtually unchanged for adults with lower levels of income and education.

Compared to the general population, smoking rates are considerably higher among those with less than a high school education (24.0%), those with household incomes less than $15,000 (22.6%), and those who report poorer mental health (30.9%). Smoking prevalence among Medicaid enrollees in New York State (NYS) has decreased from 39% in 2003 to 31% in 2010, but Medicaid prevalence is still much higher than the private health insurance population (10.8%). These large disparities argue clearly for further expansion of Medicaid's smoking cessation benefit so that greater reductions in smoking can be attained. Smokers who are covered by Medicaid are just as likely to make quit attempts, but less than half as likely to quit successfully when compared to those covered by private insurance One way to broaden delivery mechanisms is to ensure that more healthcare providers offer pharmacotherapy and counseling, the two components of effective smoking cessation treatment.

The *2008 U.S. Public Health Service Guidelines* report that the combination of pharmacotherapy and counseling doubles a smoker's chances of quitting, and that pharmacotherapy and cessation counseling are more effective than either approach independently.

In 2010, New York State Medicaid Managed Care reported that only half of Medicaid Managed Care enrollees in New York State discussed smoking cessation medications and strategies with their doctors. Additionally, a national survey found that less than one-fourth of Medicaid smokers received a prescription from their providers for smoking cessation aids.

DENTISTS

New York State Education Law (§6604-a) requires dentists to receive ongoing training and coursework regarding tobacco, including recognition and treatment of the oral health effects of tobacco usage. Specifically, the continuing education requirements for dentists include at least two hours of training on tobacco use and dependence. As such, dentists are the only clinicians in New York State who have a training requirement specifically related to tobacco.

A study funded by the Robert Wood Johnson Foundation to evaluate a tobacco-use cessation program delivered via public health dental practitioners illustrates the potential of reimbursing dentists for smoking cessation counseling. Two public health dental clinics participated in this quasi-experimental design study. First, all patients in one clinic who used tobacco (n = 178) received usual care. Next, the authors trained all practitioners to conduct a tobacco-use assessment and provide a brief cessation intervention. Subsequently, all patients in both clinics who used tobacco (N = 190) received the intervention. All enrolled patients had an income at or below the federal poverty level. The authors conducted follow-up assessments at six weeks and three and six months after enrollment. Differences in self-reported quitting by condition between participants in the two groups were significant across all endpoints. Patients in the intervention group were more likely to quit than those receiving usual care (15.5 versus 4.3 percent) and after 12 months (18.8 versus 4.6 percent). Controlling for enrollment differences between patients in the two groups (age, race/ethnicity, time to first cigarette after waking), the authors found that differences between groups were significant for quitting at three and six months.

The results of this study suggest the viability and effectiveness of delivering a tobacco intervention to low-income smokers via public dental practitioners.

A more recent and larger study sought to compare the effectiveness of a dental practitioner advice and brief counseling intervention to quit tobacco use versus usual care for patients in community health centers on tobacco cessation, reduction in tobacco use, number of quit attempts, and change in readiness to quit. Fourteen federally funded community health center dental clinics that serve diverse racial/ethnic groups in 3 states (Mississippi, New York, and Oregon) were randomly assigned to the intervention (brief advice and assistance, including nicotine replacement therapy) or usual care group. The study enrolled 2549 smokers. Participants in the intervention group reported significantly higher abstinence rates at the 7.5-month follow-up, for both point prevalence and prolonged abstinence than did those in the usual care group. The results of this study also suggest the viability and effectiveness of tobacco cessation services delivered to low-income smokers via their dental health care practitioner in community health centers.

A dental survey conducted by Medicaid managed care indicate that Medicaid enrollees regularly see the dentist; among about 1,000 adult Medicaid Managed Care enrollees in NYS, 71% had visited a dentist at least once in the past 12 months, and 60% reported having a dentist that they see on a regular basis. Integrating tobacco treatment within dental care will enable a greater number of Medicaid enrollees to receive smoking cessation services.

Financial Impact: It has been suggested that New York State could possibly incur $18.5 million in savings over a two year period if the utilization rate of Medicaid smoking cessation pharmacotherapy benefit rises to 40%. Forty percent was the benefit utilization rate achieved by the Massachusetts Medicaid program. These savings are based on avoidance of hospitalizations for acute myocardial infarctions and coronary atherosclerosis using 2009 Medicaid data.

A further breakdown of potential savings could yield the following: By increasing pharmacotherapy tobacco use by 20%, the projected two year cost savings would be $9,257,863; a 10% usage would be $4,628,932; and a 5% usage would be a $2,314,466 possible savings.

These cost-savings are based upon a recently published journal article by Tom Land et al. that detected an association between use of a comprehensive tobacco cessation pharmacotherapy benefit among Massachusetts Medicaid enrollees, and significant decreases in claims for hospitalizations for acute myocardial infarction and coronary atherosclerosis.

Costs for smoking cessation for dentists is still being developed but at $20 a session and two sessions per year the per person cost would be $40 for counseling. The Medicaid average cost per person for nicotine replacement therapy is approximately $300 per person for three month course of treatment. At a combined annual cost per person of $340 for counseling and medication the total impact to treat 25,000 patients annually under this proposal would be $8.5 million dollars.

Health Disparities Impact: Neutral

Benefits of Recommendation: This expanded service can provide greater access to effective, high quality smoking cessation treatment among Medicaid enrollees. Various meta-analyses have found that smoking-interventions delivered by non-physician clinicians are effective in increasing abstinence rates among smokers. Increased abstinence rates are associated with better health and lower cost.

Concerns with Recommendation:

- Replicating effects of the studies may be uncertain without proper training and outreach to dentists as well as enrollees.
- Potential scope of practice issues may need to be addressed.
- It is not clear if providing this service through dentists will increase the number of patients that access smoking cessation interventions.

Impacted Stakeholders: Medicaid members who smoke, dentists, managed care plans

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Recommendation: **(C-10)**

Recommendation Short Name: Nurse Family Partnership (NFP)

Recommendation Long Name: Statewide expansion of intensive nurse home visits for first-time mothers and infants

Premise: Medicaid should expand its support for this evidence based model to improve care for high risk mothers and infants, which has a documented return on investment (based on health, welfare, education, and criminal justice outcomes), and full support of CMS and HRSA.

Program Area: OHIP

Implementation Complexity: High

Implementation Timeline: Partial implementation – 1 year

Required Approvals:

- ☐ Administrative Action
- ☐ Statutory Change
- ☑ State Plan Amendment
- ☐ Federal Waiver

Proposal Description: Nurse Family Partnership (NFP) is a nurse home-visiting program in which registered nurses visit low-income pregnant women in their homes during the pregnancy and up to the second birthday of the child. It is nationally recognized as a cost effective means of achieving improved health outcomes, self-sufficiency and parenting skills. The program currently operates in two counties – NYC and Monroe. Medicaid presently covers only the targeted case management component of the program. While it was initially believed that this coverage would support 40% of program costs, this has not proven to be the case. Medicaid payment represents approximately only 15% to 20% of the total program costs. This proposal will expand Medicaid coverage for all services under the NFP, and will additionally expand coverage to the entire State, thereby offering all Medicaid pregnant women access to improved pregnancy outcomes.

Financial Impact:

Based on a 12% statewide patient enrollment, totaling 5,867 enrolled first-time mothers at an average cost/patient of $6,594 annually:

- $38.7 million dollars, and a five year cost of $193.4 million dollars (gross).

NFP has proven nationally to save $5.70 for every $1.00 invested.[i] However, these dollars are not all Medicaid dollars and are not realized for as many as 15 years.

Health Disparities Impact: As a visiting nurse program, NFP allows for a first-hand look at an expectant mothers total environment. These home visits provide a working knowledge of an expectant mothers access to and utilization of health care, as well as their educational, social and, economic needs. Improved bidirectional communication and education helps pave the way for a mom's partnership with the healthcare delivery system and thereby raises the bar on clinical outcomes for each first-time mother and her newborn.

Benefits of Recommendation: NFP reports evidence of improved pregnancy outcomes, reduction in childhood injuries/emergency room use, child abuse/neglect, reduction in childhood emotional, behavioral and cognitive problems, increased spacing between pregnancies, and reductions in arrest of the mother. In addition, there is evidence of reduced reliance on TANF, Food Stamps, and Medicaid and other social service programs. A reduced use of alcohol, cigarette, and marijuana use has been recorded for enrolled mothers and children, and increased father presence in the household.

Nationally, Nurse Family Partnership (NFP) has consistently evidenced its ability to achieve the following outcomes:

Improvements in pregnancy outcomes (including a 79% reduction in preterm births among women who smoke and 35% fewer hypertensive disorders during pregnancy);[2-4]

- Reductions in early childhood injuries (including 39% fewer injuries among children, and a 56% reduction in emergency room visits for accidents);[5-7]
- Reductions in child abuse and neglect by 48%;[8]
- Reductions in childhood emotional, behavioral and cognitive problems (including 50% reduction in language delays of child age 21 months, and a 67% reduction in behavioral and intellectual problems at child age 6);[9-11]
- Increased spacing between pregnancies for Medicaid-eligible women (including a 28-month greater interval between the first and second child, 31% fewer closely spaced subsequent pregnancies, and a 32% reduction in subsequent pregnancies);[12-16]

- Other achievements worth noting are:
  - Reductions in arrests of the mother by 61%;[17]
  - Reductions in criminal convictions for the mother by 72%;[18] and
  - Increases in father presence in household by 42%.[19]

New York City's NFP (First-time Mothers/Newborns (F/TMN) Program) has achieved the following outcomes as shown by data collected through June 2011:

- 91.2% of mothers initiated breastfeeding (vs. 87% citywide),[20]
- 41.6% of mothers were still exclusively breastfeeding at 2-months postpartum (vs. 33% citywide), [21].
- By four months of age, 80.8% of NFP infants received an ASQ assessment,[22]
- At 6-months postpartum, 87% of mothers use contraception (vs. 74% citywide),[23]
- At 18-months postpartum, 83% of mothers had no subsequent pregnancies (vs. 73% nationwide), [24]
- By program completion (24 months postpartum), 93.2% of infants were up-to-date with their immunizations (vs. 77% citywide),[25]
- 65.5% of 17-19 year old mothers completed their HS degree or GED (vs. 59% citywide), [26] and
- 52% of non-resident fathers were moderately to highly involved in their children's lives at 12-months postpartum (vs. 37% nationwide).[27]

The data from national studies of NFP and from New York City's F/TMN program all demonstrate similar and significant improvements in health outcomes for mothers and their children. Expansion of F/TMN to all of New York State will give all Medicaid-eligible first-time mothers the opportunity for improved pregnancy outcomes. Further exploration of implementation specifics will be needed.

Concerns with Recommendation: It is anticipated there may be difficulties finding enough registered nurses to meet the demand of the program. This may preclude implementation in all counties. Benefits, both financial and societal, may not be realized for many years. Some of these services are being provided by Medicaid managed care plans already.

Impacted Stakeholders: Prenatal care providers, and Planned Parenthood (assist with Medicaid enrollments and may do referrals to FTM/N), Medicaid recipients, child abuse services, emergency rooms, domestic violence services, juvenile justice and correctional services, the state TANF system and the Medicaid program including Managed Care Plans.

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