

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Administration of Medicaid in New York State: Key Players and Their Roles

About the Medicaid Institute at United Hospital Fund

Established in 2005, the Medicaid Institute at United Hospital Fund provides information and analysis explaining the Medicaid program of New York State. The Medicaid Institute also develops and tests innovative ideas for improving Medicaid's program administration and service delivery. While contributing to the national discussion, the Medicaid Institute aims primarily to help New York's legislators, policymakers, health care providers, researchers, and other stakeholders make informed decisions to redesign, restructure, and rebuild the program.

About United Hospital Fund

United Hospital Fund is a health services research and philanthropic organization whose mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, clinics, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

Medicaid Institute at United Hospital Fund

James R. Tallon, Jr.
President

David A. Gould
Senior Vice President for Program

Paula Wilson
Vice President for Policy

Copyright 2006 by the United Hospital Fund
ISBN 1-88127-7798

Funded by the New York State Department of Health

For additional copies, write to the Publications Program, United Hospital Fund,
350 Fifth Avenue, 23rd Floor, New York, NY 10118-2300, or call (212) 494-0771.

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Administration of Medicaid in New York State: Key Players and Their Roles

PREPARED FOR THE MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND BY

Deborah Bachrach, Esq.
Karen Lipson, Esq.
Kalpana Bhandarkar

MANATT HEALTH SOLUTIONS

NOVEMBER 2006

Acknowledgments

This report would not have been possible without the participation and input of dozens of New York State government officials, former government officials, and Medicaid stakeholders who agreed to be interviewed for this project. In particular, we are grateful for the contributions of staff and former staff from the Governor's Office, Department of Health, Division of the Budget, Office of Alcoholism and Substance Abuse Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, Office of Children and Family Services, and Office of the Medicaid Inspector General. In addition, the information and feedback provided by a number of stakeholders in the Medicaid program, representing diverse perspectives, was invaluable.

Table of Contents

	Page
Executive Summary	v
The Medicaid Program	1
Overview of Medicaid in New York State	2
The Multiple Roles of the State and Local Governments in Administering the Medicaid Program	8
The State Agencies with Primary Responsibility for New York’s Medicaid Program	9
The Department of Health: The Single State Agency	9
The Department of Mental Hygiene Agencies: Using Medicaid to Serve People with Special Needs	25
The Governor’s Staff and the Division of the Budget	35
Implications of the Administrative Structure	36
Licensure and Rate-Setting	36
Program Development	41
Conclusions	44
Notes	45

Executive Summary

With over 4 million beneficiaries and an annual budget approaching \$46 billion, New York’s Medicaid program is a critical source of health insurance for low-income New Yorkers, an important source of revenue for the State’s health care delivery system, and a flashpoint for criticism based on its cost and complexity.¹ This complexity is, in many respects, inevitable. Medicaid is a multifaceted program, involving State and federal rules, diverse populations, multiple delivery systems, multiple regulators, and a wide array of benefits.

In New York State, and across the country, policymakers are focusing on Medicaid reform and striving to ensure that Medicaid dollars are spent wisely on high-quality and medically necessary services that promote optimal health outcomes. Their ability to develop and implement successful reforms, however, largely depends on the administrative structure of the program in their respective states. This structure determines the locus of power, the allocation of resources, and the capacity of the program to respond effectively to new information or changing conditions.

As a step on the road to Medicaid reform in New York State, this report examines the administration of the State’s Medicaid program and discusses the implications of the administrative structure the State has adopted. As used in this report, the term “administration” refers to the allocation of programmatic, fiscal, and enforcement responsibilities among governmental entities, the relationships among those entities, and how decisions are made when activities overlap or intersect. The report is not intended to describe the multitude of programmatic elements of the State’s Medicaid program. Nor does it study the drivers of Medicaid spending or the role of advocacy groups and politics in Medicaid decision-making, although it touches on all of these issues. Rather, it describes how and by whom Medicaid policy decisions are developed and implemented. Of necessity, it does not provide an exhaustive survey of every aspect of Medicaid administration in New York. Instead, it focuses on the big picture—the principal organizational units and high-level administrative decisions that affect the operation of the program. Finally, the report does not make recommendations for change in the administration of New York’s Medicaid program. It describes the existing administrative structure and identifies selected features of the structure that have worked well to facilitate the development and implementation of sound policies—as well as those features that have fallen short.

This report was developed with the help of dozens of current and former State agency staff members, as well as stakeholders representing different components of the Medicaid program, who agreed to be interviewed about their work with the program. It examines the administration of the program in four parts. First, it provides background information about the Medicaid program generally. Second, it describes Medicaid in New York, identifies the various entities involved, and summarizes the diverse roles they play in administering the program. Third, it describes in greater detail the specific responsibilities delegated to the

agencies primarily engaged in the administration of the program, and how they carry out those responsibilities. And fourth, it examines the implications of these administrative structures for selected aspects of the State's Medicaid program.

The administration of New York's Medicaid program rests primarily with the State Department of Health (DOH), which is designated as "the single state agency," responsible under federal law for supervising the program. The Department serves as the State's liaison to the federal government on Medicaid issues, works to ensure compliance with federal requirements, implements eligibility and benefits policies, oversees the Medicaid claims system, and establishes rates of payment for certain providers. Among the people interviewed for this report, there was almost universal agreement that the assignment of primary responsibility to the Department of Health has promoted the perception of Medicaid as a health care rather than a poverty program, and has heightened the importance of health care quality and access in the program.

Within DOH, the Office of Medicaid Management is principally responsible for administering the Medicaid program, overseeing eligibility policy, benefits, systems, federal relations, practitioner fees, and pharmaceutical reimbursement. Almost every office or division within the Department, however, handles some aspects of the Medicaid program. Most notably, the Office of Health Systems Management is responsible for establishing rates of payment for institutional and long-term care providers licensed by DOH; the Office of Managed Care is responsible for managed care programs; the AIDS Institute takes the lead on HIV/AIDS-related programs and services; and the Center for Community Health oversees the family planning benefit program, Medicaid-reimbursable services under the Early Intervention program, the breast and cervical cancer Medicaid expansion, and the public health aspects of the Medicaid program.

While DOH is the single state agency, with legal responsibility for federal compliance and spending, it controls only a portion of the Medicaid program. More than a dozen State entities, 57 counties and the City of New York, and private contractors all play roles in the administration of Medicaid. Substantial responsibility for special populations, discrete programs, and functions such as program development, client enrollment, and oversight is distributed among a variety of State agencies, as well as local governments. Specifically, the Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS) each administer sizeable programs funded primarily with Medicaid dollars.

Collectively known as the Department of Mental Hygiene or DMH agencies, OMRDD, OMH, and OASAS have a narrower focus than DOH. Their mission is to meet the needs of their discrete constituencies. The delegation of substantial administrative responsibility to agencies with targeted missions and specialized expertise has facilitated the development and funding of a broad array of programs for traditionally underserved groups, such as people with mental retardation and developmental disabilities, mental illness, and chemical

dependence. Further, the agencies' ability to identify State- and locally funded programs that can be matched with federal Medicaid dollars has strengthened the delivery systems they oversee and their position in negotiations with the Division of the Budget and Governor's staff.

While the allocation of responsibilities within DOH and between DOH and the DMH agencies has enhanced the development of specialized programs for certain stakeholders, it also impedes the development of a comprehensive approach to Medicaid. The distribution of authority among the agencies and within different units of DOH makes the establishment of program-wide priorities, coordination, and oversight difficult at best. The State's Medicaid director, while charged with overseeing the program in its entirety, does not have the organizational stature to fulfill this role. The director is one of many deputy commissioners, sitting two levels below the Commissioner of Health on the organizational chart.

As a result, coordination, program-wide direction, and oversight have fallen to the Division of the Budget (DOB) and the Governor's staff. Both entities have been hampered in fulfilling this role by their limited mandate and authority, limited resources, and distance from the operational aspects of the programs funded by Medicaid. In DOB's case, the ability to assume responsibility for program-wide priorities is further limited by the fiscal lens through which it views the program.

Under the current administrative structure, no single entity or person has both the authority and the mandate to establish program-wide priorities; analyze Medicaid services, spending, and revenue across all agencies; resolve differences among agencies; and determine whether the program is maximizing the value of the State's health care dollars and fulfilling its goals. In particular, this impedes the development of policies to address the complex needs of beneficiaries requiring multiple services supervised by different agencies; it also complicates efforts to align licensure and rate-setting policies with desired public health, access, and quality goals. While the dispersal of responsibility and the specialized expertise that it cultivates has strengthened the State's Medicaid program in many respects, it has also created a program that operates without an overarching set of principles and priorities to guide policy development and implementation.

The Medicaid Program

Understanding the administration of Medicaid begins at the federal level. The nation's largest health insurance program, Medicaid provides health insurance coverage to over 53 million Americans, surpassing even the Medicare program in enrollment.² Medicaid has filled the gap created by the contraction of employer-sponsored health coverage. It is the insurer not just of women and children in poverty, but also of the working poor, impoverished elderly, and low-income people with disabilities. It is the health insurer of last resort for the nation's most medically vulnerable.

The Medicaid program is a federal-state partnership. Federal rules mandate the overall parameters of the program, including a set of benefits that must be offered and optional benefits that may be.³ In order to participate, a state must submit a "state plan" for Medicaid that meets stringent standards, some of which may be waived with the approval of the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, which administers Medicaid at the federal level.⁴

Under federal law, there are three major waiver categories: (1) research and demonstration waivers under section 1115 of the Social Security Act, which generally require a study of policy innovations; (2) freedom of choice waivers under section 1915(b) of the Social Security Act, which allow states to restrict beneficiaries' choice of Medicaid providers, generally through the implementation of a managed care system; and (3) home and community-based services waivers under section 1915(c) of the Social Security Act, which give states flexibility in benefits and eligibility in order to provide comprehensive long-term care services in the community. All waivers must be budget neutral—they may not cost the federal government more than the cost of operating the program in the absence of a waiver.

States that agree to comply with the complex array of federal rules and requirements and receive federal approval of their plans are entitled to a federal contribution to their Medicaid programs. With the exception of a few program elements that are reimbursed at higher rates, the federal matching rate can range from 50 percent of total expenses to 83 percent, under a formula incorporated into Title XIX of the Social Security Act, based on the relative wealth of each state versus the national average. New York's overall federal matching rate is 50 percent; the state with the highest matching rate, Mississippi, receives 76 percent.⁵

Federal rules do not prescribe a specific administrative structure for state Medicaid programs, and the approaches adopted by the states vary widely. Federal law does, however, impose certain general requirements. Most notably, every state that opts to participate in the Medicaid program must designate a "single state agency" to "administer or supervise the administration" of the state Medicaid plan. Additional administrative requirements include the single state agency's determination of eligibility, and the operation of a Medicaid fraud control unit separate from the single state agency.⁶ In New York State, the single state agency is the State Department of Health.

Overview of Medicaid in New York State

New York's Medicaid program provides health insurance coverage for over 4 million low-income people (including Family Health Plus beneficiaries) at an aggregate cost estimated to reach \$46 billion in State fiscal year 2006-07.⁷ In addition to the State and federal government, New York's counties share in the cost of the Medicaid program. In 2004, the State was responsible for about 32 percent of the total Medicaid bill. Local governments covered about 17 percent of the cost (of which 70 percent was paid by New York City), and the federal government provided the remaining 51 percent.⁸ The relative percentages of the State and local shares will change, with the State share increasing, due to the cap on local government contributions that became effective in January 2006.⁹

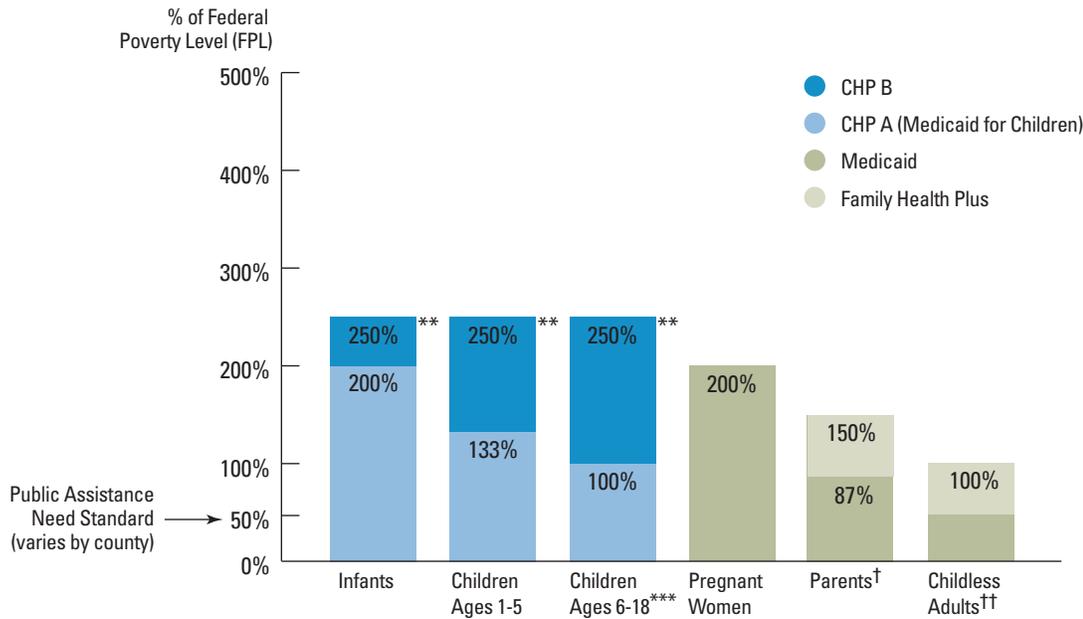
Low-income New Yorkers qualify for Medicaid under several different eligibility categories with different income and asset limits (see Figure 1). Consistent with federal law, the most generous coverage in terms of income limits is available to children and pregnant women. Medically needy adults, the elderly, people with disabilities, and parents of minor children are eligible for coverage at lower income levels. And single adults and childless couples under age 65 are subject to the most stringent income limits. New York's Medicaid expansion, known as Family Health Plus (FHP), provides a somewhat more limited managed care benefit package to adults with slightly higher income than allowed by standard Medicaid.

In New York, as elsewhere, Medicaid provides health insurance to people who would otherwise have limited or no access to coverage or health care. Compared with the general population, a disproportionate number of New York's Medicaid beneficiaries have disabilities and chronic conditions.¹⁰ Twenty-four percent are aged or severely disabled, and they constitute only a fraction of Medicaid beneficiaries with chronic or disabling conditions.¹¹ The diverse and intensive needs of the population served by Medicaid contribute to both the cost of the program and its administrative complexity.

Medicaid benefits in New York are delivered in accordance with the State's Medicaid plan and through 10 different federal waivers. The State administers two demonstration waivers under section 1115 of the Social Security Act (the Partnership Plan and the Federal-State Health Reform Partnership, or F-SHRP). Both authorize mandatory enrollment in managed care plans for most Medicaid beneficiaries. F-SHRP also entails investments in restructuring the State's health care delivery system to reduce excess hospital inpatient capacity and emphasize care in community-based settings. In addition, New York administers eight waivers under section 1915(c) that allow the State to provide long-term care services in the community to individuals who would otherwise be served in institutional settings (see Figure 2).

Numerous agencies, offices, and organizations—federal, state, and local, and nongovernmental—are responsible for deciding who should be eligible for Medicaid in New York, how eligibility should be determined, what benefits should be covered, what waivers to seek and who should qualify for them, what providers should participate, how health care

Figure 1. New York State Eligibility Rules for Medicaid, Child Health Plus, and Family Health Plus, 2006*



CHP B is New York State's S-CHIP program and is not funded by Medicaid.

* Medicaid and Child Health Plus A eligibility are expressed in net income, while Child Health Plus B and Family Health Plus (FHP) eligibility are expressed in gross income, as written in HCRA 2000 and Medicaid law. The 2006 Federal Poverty Level (FPL) is \$9,800 for an individual and \$16,600 for a family of three.

** Children with gross family income above 160% FPL are charged an income-related premium. Premiums for children with gross family income of 160%-222% FPL are \$9/month/child up to \$27; for children with gross family income of 223%-250% FPL premiums are \$15/month/child up to \$45.

*** Through March 2005, the Child Health Plus A eligibility level for children ages 6-18 was 133% FPL. Effective April 2005, the Child Health Plus A eligibility level for children ages 6-18 was lowered to 100% FPL, at which time children in that age range with gross family income of 100%-133% FPL who were enrolled in Child Health Plus A were shifted into Child Health Plus B.

† "Parent" is defined as a parent of a child under 21 years who lives in the household. Medicaid eligibility includes disabled adults and 19- and 20-year-olds with net income up to 87% FPL. FHP eligibility includes 19- and 20-year-olds living with their parents, where gross family income is up to 150% FPL.

†† "Childless adult" is defined as a non-disabled adult age 21 years or over who does not have a child living in the household. FHP eligibility includes 19- and 20-year-olds not living with their parents, with gross income up to 100% FPL. Income levels for Medicaid eligibility vary by county.

Note: Low-income, uninsured women who are diagnosed with breast or cervical cancer through screenings in New York's Healthy Women Partnerships program are eligible for Medicaid coverage. Women must have income levels below 250% FPL to qualify for the screenings. Women and men of childbearing age with income up to 200% FPL are eligible for Medicaid Family Planning Services. As of July 2003, disabled workers aged 16-64 with net income of up to 250% FPL and non-exempt resources of up to \$10,000 are eligible for Medicaid coverage through the Medicaid Buy-In for Working People with Disabilities program (MBIWPD); enrollees with incomes above 150% FPL will eventually be subject to an income-related premium.

Source: United Hospital Fund

services should be reimbursed, how to improve quality and accessibility of services, and how to ensure compliance with a myriad of federal and State rules. In New York, those entities, and their Medicaid-related responsibilities, are:

The Governor. The Governor sets broad policy directions for the Medicaid program. These directions are translated by his staff, the Division of the Budget, and relevant agencies into budget initiatives and programmatic legislation. The Governor's staff is responsible for coordinating the development of concrete initiatives arising from the Governor's policy agenda, overseeing implementation of these initiatives, coordinating the activities of the multiple agencies involved in Medicaid, and navigating conflicts among agencies.

The Legislature. The Legislature enacts legislation that sets forth the broad parameters for the program, such as eligibility thresholds, managed care enrollment requirements, and covered benefits. It appropriates the funds necessary to operate the program and adopts and amends rate-setting methodologies for certain types of providers. It also responds through legislation and public hearings to discrete, high-profile issues that arise in connection with the operation of the program.

Division of the Budget (DOB). The Division of the Budget is responsible for developing the entire \$46 billion Medicaid budget and, indeed, the total State budget, which reached \$114 billion on an all-funds basis in 2006-07.¹² It approves all Medicaid rates, all programmatic initiatives that have a fiscal impact, and the hiring of additional personnel by the agencies.

Department of Health (DOH). As the single state agency, DOH is held responsible by the federal government for overseeing the entire Medicaid program. It is projected that approximately \$36.4 billion (including State, federal, and local shares) will be spent through the components of the Medicaid program that are in the DOH budget this fiscal year.¹³ This represents roughly three-quarters of the Department's all-funds budget.

As discussed more fully below, DOH oversees the implementation of Medicaid eligibility policies, operation of the Medicaid claims payment system, Medicaid benefits related to physical health, the Medicaid pharmacy benefit, and the Medicaid managed care program. In addition, it is responsible for licensing, regulating, and setting Medicaid rates for providers, such as hospitals, diagnostic and treatment centers, nursing homes, long-term care providers, and managed care plans.

Office of the Medicaid Inspector General (OMIG). The Office of the Medicaid Inspector General was created in 2005 to prevent, detect, and combat fraud, waste, and abuse in the Medicaid program. OMIG is intended to consolidate these responsibilities in an independent office separate from the entities responsible for program development, licensure, and reimbursement. It is unique in that it resides within DOH while its director, the Medicaid Inspector General, reports directly to the Governor. OMIG's State Fiscal Year (SFY) 2006-07 budget is approximately \$95 million.

Figure 2. New York State Waivers

Waiver	Description
OMRDD Waiver for Adults and Children with Developmental Disabilities	Administered by DOH and OMRDD for adults and children who are developmentally disabled and who require intermediate care facility level of care.
OMH Waiver for Children with Serious Emotional Disturbances	Administered by DOH and OMH for children who are seriously emotionally disturbed and who require psychiatric hospital level of care. (Available in selected counties in NYS)
Care at Home I and II	Administered by DOH for children under age 18 who are physically disabled and who have had a 30-day inpatient stay but who are not eligible for Medicaid due to parental income and resources.
Care at Home III, IV, VI	Administered by DOH and OMRDD for children under the age of 18 who are developmentally disabled, have complex health care needs, and require intermediate care facility level of care but who are not eligible for Medicaid due to parental income and resources.
Long Term Home Health Care Program	Administered by DOH for persons who are elderly or disabled and who require nursing home level of care.
Traumatic Brain Injury	Administered by DOH for persons age 18 and over who have experienced a traumatic brain injury and who require nursing facility level of care.
Partnership Plan	Administered by DOH, this waiver mandates enrollment of Medicaid beneficiaries into managed care plans, with some exemptions and exclusions. An amendment to this plan created the Family Health Plus program for low-income, uninsured adults.
Federal-State Health Reform Partnership (F-SHRP)	Administered by DOH, this five-year waiver is intended to restructure the State's health care delivery system, improve the quality of care, and result in long-term savings for both the State and federal government, and is subject to special terms and conditions.
Nursing Home Transition and Diversion Waiver (Approval pending with CMS)	This waiver program will be administered by DOH for individuals 18 and over with disabilities who require the level of care provided at a nursing facility but can be treated in a community-based setting.

[Office of Mental Retardation and Developmental Disabilities \(OMRDD\)](#). OMRDD develops, operates, licenses, and regulates Medicaid-funded programs serving beneficiaries with mental retardation or developmental disabilities. An estimated \$6.8 billion in Medicaid funds will be spent this fiscal year on programs and services budgeted in OMRDD.¹⁴ OMRDD programs currently serve approximately 140,000 people, of whom about 90,000 are Medicaid beneficiaries.¹⁵

The Office administers a diverse array of Medicaid-funded programs and services, including four home and community-based waivers for children and adults who require the level of care offered by an intermediate care facility; clinics that provide habilitative, clinical, medical, and dental care; day treatment programs; developmental centers; community intermediate care facilities; community residences and family care programs with residential habilitation; day habilitation; individual residential alternatives; and Medicaid Service Coordination. Some of the services provided under its new Options for People Through Services program are also funded by Medicaid.

Office of Mental Health (OMH). OMH develops, operates, licenses, and regulates Medicaid-funded programs serving beneficiaries with mental illness. Approximately \$2.2 billion in Medicaid funds is projected to be spent this fiscal year on OMH-budgeted programs and services.¹⁶ Approximately 600,000 clients are served by the Office, about two-thirds of them Medicaid beneficiaries.¹⁷

OMH administers more than a dozen programs and services that are partially or fully funded by Medicaid, including a home and community-based waiver for children with serious emotional disturbances; inpatient psychiatric treatment; residential treatment facilities; family-based treatment; mental health clinics; continuing day treatment; Intensive Psychiatric Rehabilitative Treatment; Assertive Community Treatment; partial hospitalization; comprehensive psychiatric emergency programs; case management; the Medication Grant Program; community residences; the Prepaid Mental Health Plan; and the new Personalized Recovery-Oriented Services program.

Office of Alcoholism and Substance Abuse Services (OASAS). OASAS develops, operates, licenses, and regulates Medicaid-funded programs serving beneficiaries with alcoholism or substance abuse problems. Approximately \$150 million in Medicaid funds are projected to be spent this year on programs and services budgeted in the Office.¹⁸ Of the more than 250,000 people who receive services through OASAS programs in a given year, approximately 55 percent are enrolled in Medicaid.¹⁹

OASAS oversees a spectrum of inpatient, outpatient, and residential services that receive Medicaid reimbursement. These include medically managed withdrawal, medically supervised withdrawal, outpatient clinics, outpatient rehabilitation programs, and inpatient rehabilitation. In addition, certain residential programs may be available through Medicaid managed care at the option of the client's managed care plan.²⁰

Office of Children and Family Services (OCFS). OCFS touches on Medicaid through its licensure and rate-setting function for foster care agencies that opt to receive a per diem Medicaid rate. It also works to ensure that all eligible children in foster care have access to medically necessary services through Medicaid. OCFS recently participated in the development

of a home and community-based waiver application that proposes to provide enhanced services to children in foster care with severe disabilities.²¹ Approximately \$130 million is expected to be spent on Medicaid payments to foster care agencies in this fiscal year.²²

Education Department. The Education Department, together with OMIG, is involved in the administration of School Supportive Health Services funded by Medicaid. An estimated \$750 million in Medicaid funds is expected to be spent on these services in this fiscal year.²³

State Office for the Aging (SOFA). While it does not currently administer any Medicaid-funded programs, SOFA is taking the lead in the development of a point-of-entry system for long-term care services that will be heavily involved in assessments and referrals to Medicaid-funded programs. Its long-term care ombudsman program already oversees activities in Medicaid-funded facilities and programs. And the State's long-term care restructuring effort and new F-SHRP waiver include plans to draw down federal matching funds based on State spending for the SOFA-regulated Expanded In-Home Services for the Elderly and Community Services for the Elderly programs.²⁴

Office of Temporary and Disability Assistance (OTDA). OTDA administers the fair hearing system through which beneficiaries can appeal adverse eligibility and benefits decisions by local social services districts, the State, and, in some cases, managed care plans. OTDA is also responsible for managing the Welfare Management System, the eligibility processing system for Medicaid and many public assistance programs.

Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD). The Commission conducts quality of care audits of providers—including Medicaid providers—of services for people with disabilities.

Office of the State Comptroller. The State Comptroller audits Medicaid-funded programs, approves all Medicaid payments, and signs off on all State contracts, including those with entities, such as health plans, participating in the Medicaid program.

Office of the New York State Attorney General—Medicaid Fraud Control Unit. The Medicaid Fraud Control Unit of the State Attorney General's Office is charged with investigating and prosecuting Medicaid fraud and, if the case is primarily related to Medicaid, fraud in other federal health care programs. In addition, the Unit is charged with reviewing and prosecuting or referring complaints of patient abuse or neglect by Medicaid providers.²⁵

United States Attorney's Offices. Federal prosecutors also have authority to investigate and prosecute fraud in the Medicaid program and other federal health care programs.

Counties and district attorneys are increasingly entering the field of Medicaid fraud detection, investigation, and prosecution.

Local Departments of Social Services. Located in each of New York's 57 counties and New York City, these agencies process applications for coverage, contract with certain types of providers (e.g., transportation providers, personal care agencies), and authorize the provision

of certain services (e.g., personal care). In New York City, the Department of Health and Mental Hygiene also contracts with Medicaid managed care plans to manage and arrange for services to beneficiaries.

Local mental hygiene agencies. These county agencies work with the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and its Developmental Disabilities Services Offices, and the Office of Alcoholism and Substance Abuse Services to develop local plans for the delivery of services in their communities. They are also integral to the process of licensing new mental health facilities.

Private contractors have been delegated a variety of administrative functions, most notably one contractor's operation of the Medicaid payment processing system, known as eMedNY. Another contractor provides managed care enrollment assistance and processing in New York City and other counties, and others are heavily involved in quality reviews and efforts to combat fraud, waste, and abuse.

The Multiple Roles of the State and Local Governments in Administering the Medicaid Program

The administrative complexity of the Medicaid program stems from several sources, including the interplay of multiple state and federal laws, the involvement of multiple agencies and bureaus at all levels of government, and the special needs of the populations served. This complexity is compounded by the many roles the State, each of the 57 counties, and New York City play in the program's administration:

Benefits Manager. Like the human resources department of a large employer, the State's first obligation is to determine who is eligible for coverage and what benefits they will receive. Federal laws and rules establish mandatory and optional eligibility categories and require states to cover certain benefits, but each state has the latitude to fix its own rules within that framework. In New York, that process starts with the Legislature. Financial eligibility standards and basic requirements for proving initial and ongoing eligibility are set forth in legislation.²⁶ The Legislature also defines the broad parameters of the benefits package.²⁷ The Department of Health provides additional detail, designing application forms and determining what income and assets to count, how to count them, and what specific documents must be produced by applicants initially and at renewal. The 57 county departments of social services and the New York City Human Resources Administration are authorized by DOH to make actual determinations of initial and ongoing eligibility. DOH has delegated similar responsibilities to OMH and OMRDD with respect to individuals served by those agencies who are "state charges" under state law. In addition to developing policies governing eligibility, DOH and the DMH agencies also determine the contours of certain benefits covered by Medicaid. For example, DOH determines which dental procedures are covered and how often a beneficiary is entitled to a new pair of glasses.

Payor/Purchaser. Multiple state agencies and in some instances local social services districts serve as payors and purchasers of the services required by enrollees, not unlike traditional health insurers. The Department of Health enrolls providers in the Medicaid program; several bureaus within DOH, as well as OMRDD, OMH, and OASAS, set provider rates and fees. DOH oversees the Medicaid claims processing system and makes payments where appropriate. Outside of New York City, DOH also contracts with health plans for the delivery of a specific package of benefits to Medicaid managed care enrollees; the New York City Department of Health and Mental Hygiene contracts with plans operating in New York City.

Provider. The State itself provides services through its operation of State psychiatric facilities, addiction treatment centers, and developmental centers, and through community-based programs for people served by OMRDD, OMH, and OASAS. The State also acts as provider in its operation of State veterans homes and the Helen Hayes Hospital.

Regulator. Not only does the State determine eligibility for coverage, arrange for benefits, pay for them, and provide them, but it also regulates providers of those benefits. It determines whether and where there is a need for additional health care providers, licenses them, calculates the rates that Medicaid will pay them, and conducts quality reviews and financial audits of their services and operations.

Auditor/Investigator/Prosecutor. Through the Office of the Medicaid Inspector General, the New York State Comptroller, the New York State Attorney General, the DMH agencies, and DOH, the State conducts audits, investigations, and criminal prosecutions to ensure that Medicaid providers, plans, and beneficiaries comply with Medicaid rules.

The State Agencies with Primary Responsibility for New York’s Medicaid Program

This section discusses the administration of the Medicaid program in the five State agencies with the greatest responsibility for the program—DOH, the DMH agencies (OMRDD, OMH, OASAS) and DOB—as well as the Governor’s staff. It examines the range of roles these agencies assume and the administrative structures that affect their ability to effectively and efficiently fulfill them.

The Department of Health: The Single State Agency

Designated the “single state agency” responsible for the administration of Medicaid, the State Department of Health actually shares administrative responsibility with several other State agencies, local governments, and private contractors. While DOH is just one of several entities involved in the administration of Medicaid, Medicaid is also just one of several programs administered by DOH. The Department has a broad mission to promote the public health, the advancement of science, and the delivery of quality health care.²⁸ It has a

vast portfolio that encompasses such diverse areas as vital statistics, health care facility licensure and surveillance, nutrition and communicable disease control policies, health and environmental research, funeral direction, safe drinking water and environmental hazards, and summer camp regulation (see Figures 3 and 4).²⁹

Nevertheless, Medicaid is a dominant force within the Department, occupying a significant share of the Department's staff, budget, and attention. As the single state agency, DOH is the central resource for all other agencies on federal Medicaid requirements, serves as the liaison between the State and the federal government, oversees the local social services districts, controls the Medicaid billing and information systems, implements eligibility policies and supervises eligibility determinations, sets many of the rates and fees paid to Medicaid providers, and handles a host of other functions related to specific services, providers, and populations. In its capacity as single state agency, DOH is held accountable for compliance with federal requirements and for rising Medicaid spending.

The Department of Health assumed the role of single state agency, in 1996, from what was then the Department of Social Services (DSS). According to everyone interviewed for this report, this shift represented a major cultural change in the thinking about Medicaid. As many of those interviewed noted, it was a positive move that infused the Medicaid program with a public health mission and recast it as a health insurance program rather than a poverty program. Some of those interviewed, however, maintained that the shift narrowed the focus of Medicaid's administrators to DOH's traditional constituents—large institutional health care providers such as hospitals and nursing homes—at the expense of other stakeholders, such as ambulatory care providers, Medicaid beneficiaries, and people with disabilities.

Since the transition from DSS to the Department of Health, large numbers of mid-level and senior Medicaid staff have left the program. According to those interviewed for this report, many of the senior staff had joined the Medicaid program at its inception, dedicated the next 25 to 30 years to it, and then reached retirement age *en masse* in the last five to ten years. Others who were interviewed pointed to retirement incentives that have encouraged administrators with less tenure to retire. Because the retirees have not been replaced, both the personnel and the expertise that reside within the Department have been seriously depleted.

Medicaid-related functions are handled in almost every Office and Division of the Department. The following organizational units within DOH are most actively involved in the administration of Medicaid:

Office of Medicaid Management. OMM is headed by the Medicaid Director—a deputy commissioner within the Department, two rungs below the Commissioner on the agency ladder. With about 400 staff members, OMM serves a variety of functions, fulfilling the roles of benefits manager, payor/purchaser, and regulator (see Figures 5-7). According to one

Figure 3. New York State Department of Health

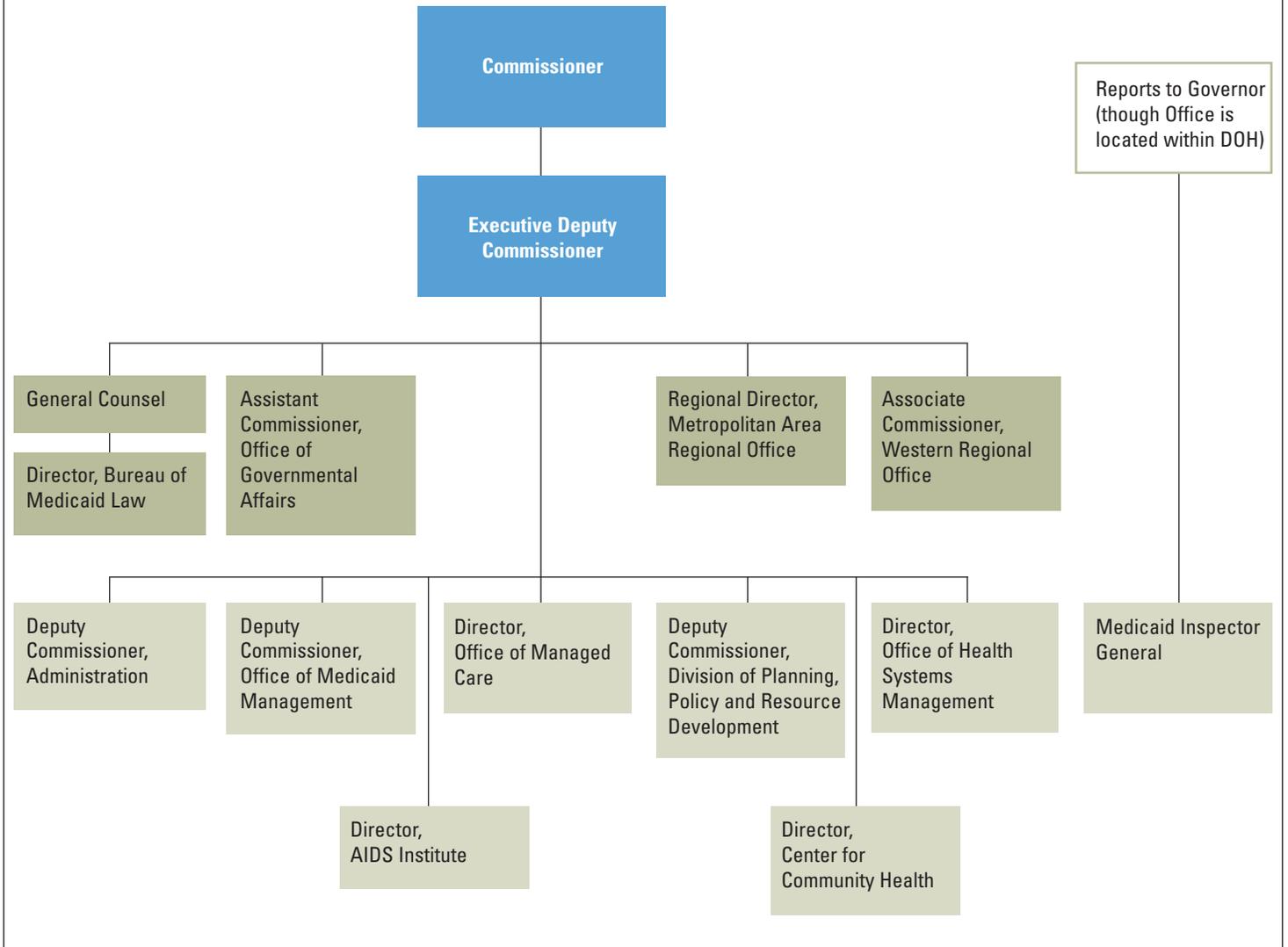
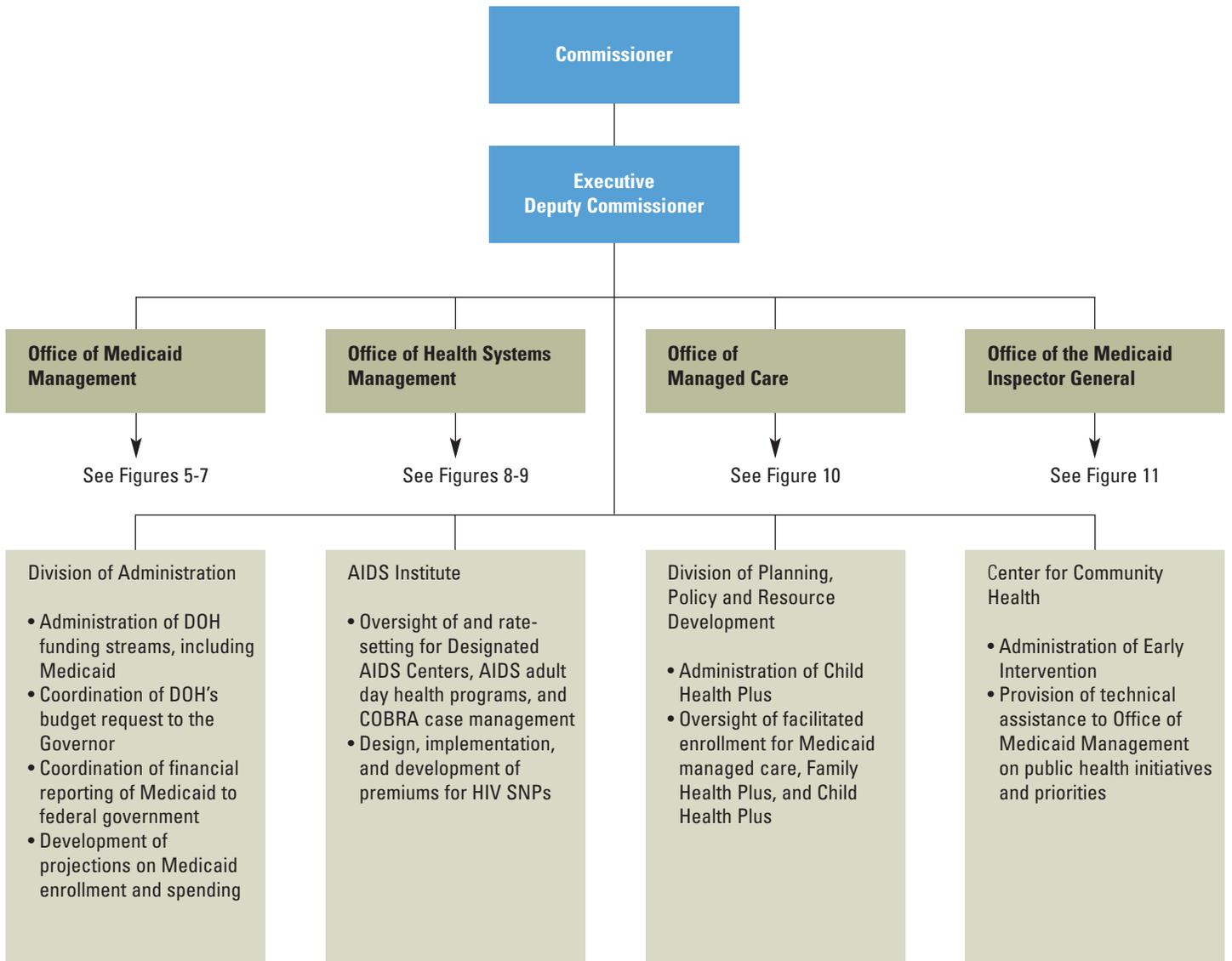


Figure 4. New York State Department of Health*

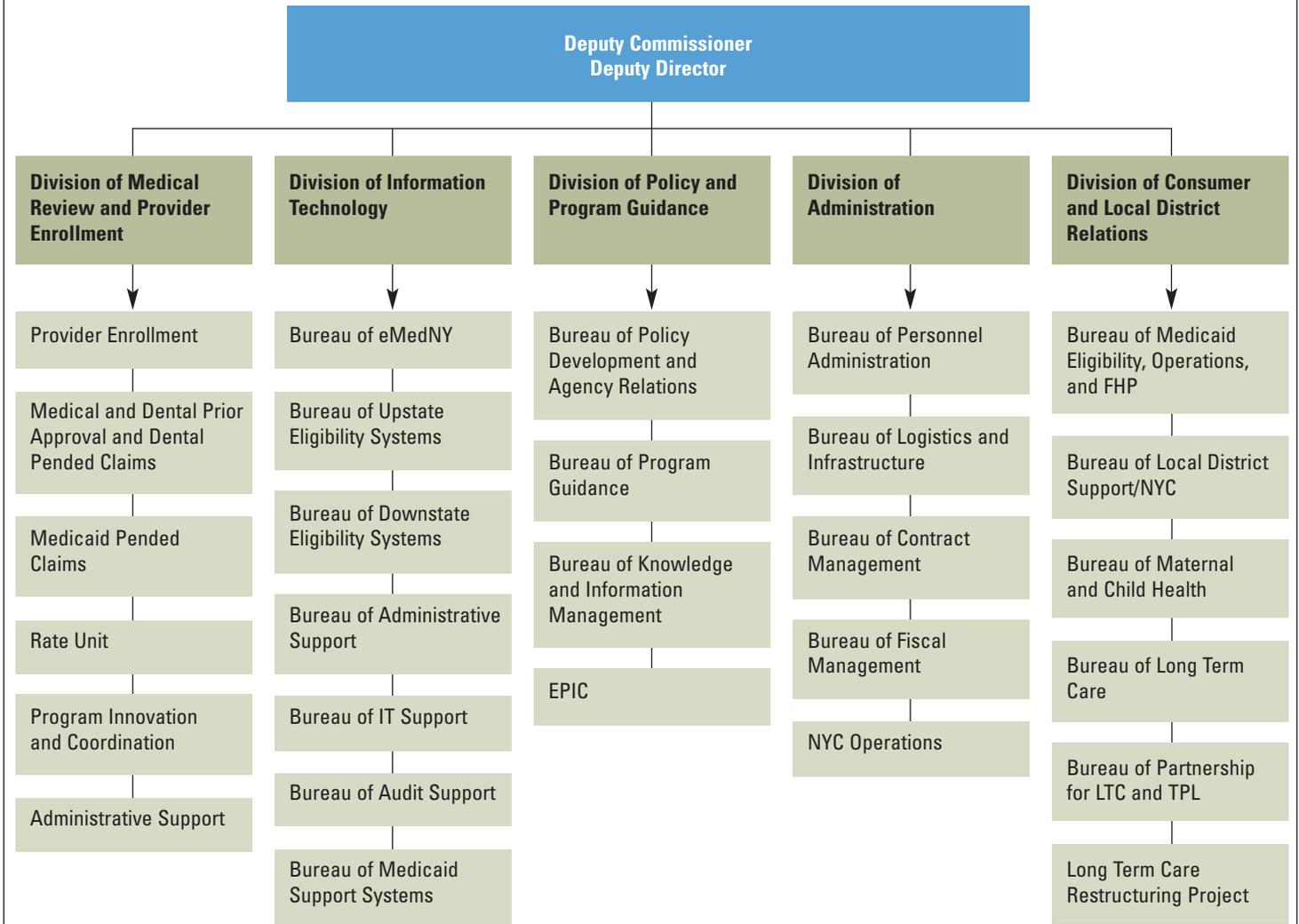


*The responsibilities listed per Division highlight those that are most directly related to Medicaid. Each has significant responsibilities that go beyond Medicaid.

OMM official interviewed for this paper, the Office has daily management responsibility and complete control “from soup to nuts” over about 40 percent of the program.

As a benefits manager, OMM develops and implements eligibility policy for the entire Medicaid program, within the framework adopted by the federal government and the State Legislature. This involves a host of policy decisions and administrative actions, including determining what income and assets are counted, which members of a household are counted, what other demographic or clinical criteria must be satisfied to qualify for each category of eligibility, what documents must be provided to verify eligibility, and how eligibility information

Figure 5. Office of Medicaid Management*

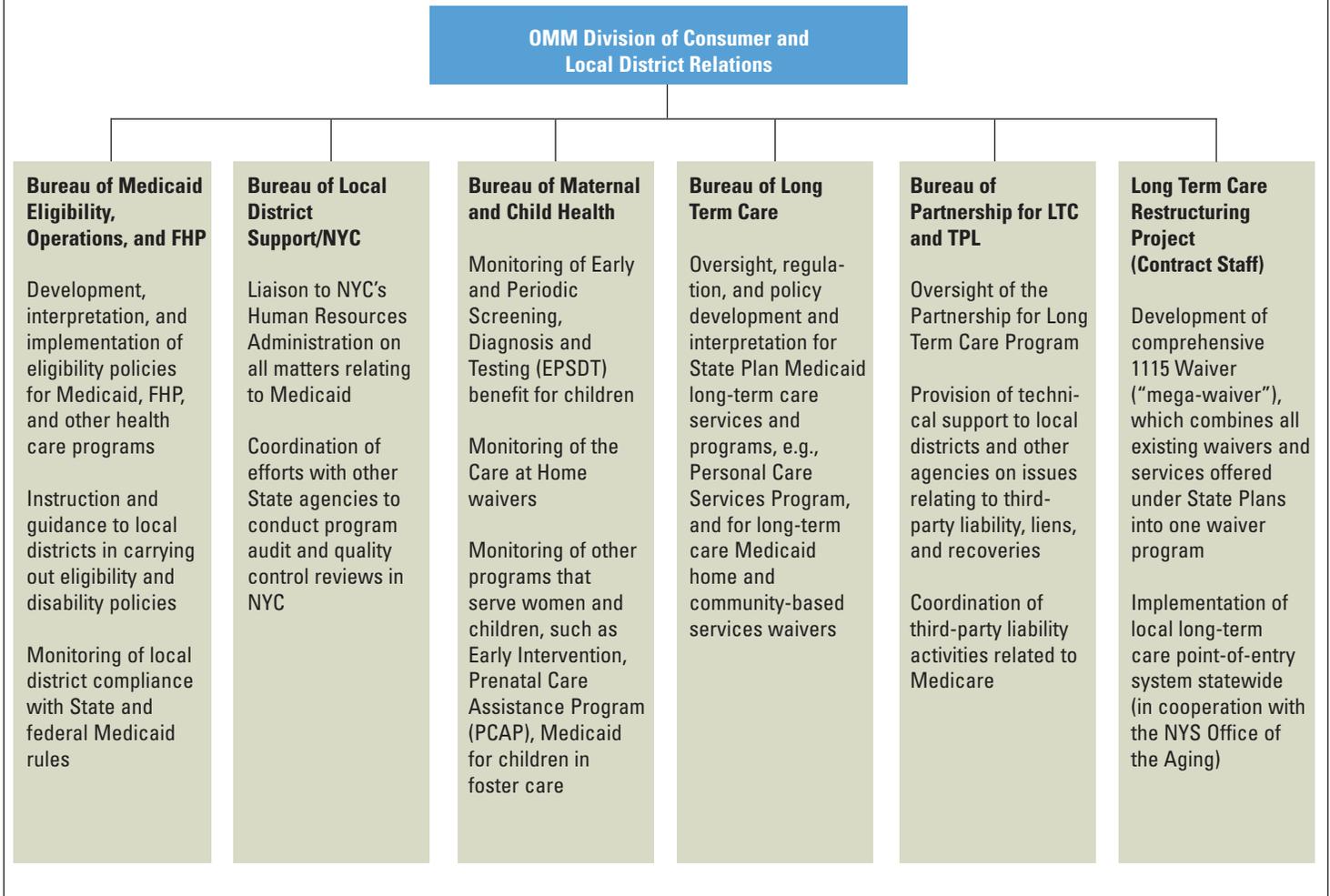


* All Divisions are currently run by a director and assistant director, with the exception of the Division of Consumer and Local District Relations, which is run by two co-directors.

should be gathered in an application or renewal form. In addition, OMM trains and oversees all 58 local social services districts (in the 57 counties plus New York City) that are empowered to process applications for Medicaid and make eligibility decisions.

These activities have enormous implications not only for Medicaid applicants and beneficiaries but also for the health care delivery system as a whole. They affect the number of uninsured New Yorkers requiring free or discounted care at the State’s hospitals, community health centers, and other provider sites, and thus affect the financial stability of the system. They are also important for ensuring compliance with federal and state program requirements.

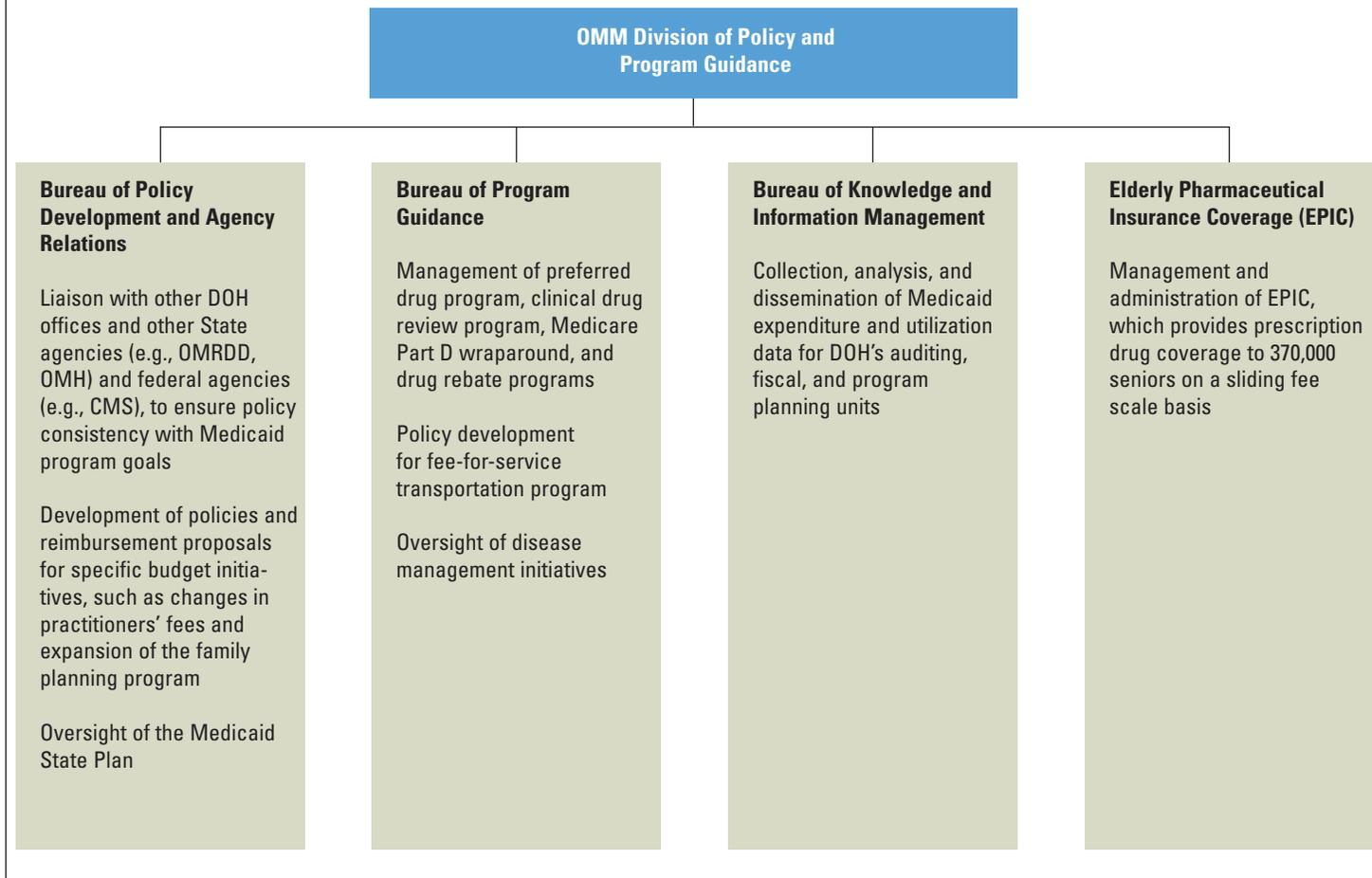
Figure 6. Office of Medicaid Management: Division of Consumer and Local District Relations



Along with managing eligibility for benefits, OMM oversees the delivery of certain benefits, by determining their scope and by screening the practitioners and suppliers who seek to offer them. For example, OMM:

- Determines what dental services and durable medical equipment may be reimbursed by Medicaid, and approves dentists, physicians, and durable medical equipment suppliers to participate in the program;
- Administers the program's pharmacy benefit, including the enrollment of pharmacies in the program and the operation of the new preferred drug and clinical drug review programs, which require prior approval for certain prescription drugs;³⁰ and
- Oversees the local social services districts' administration of personal care and transportation benefits.

Figure 7. Office of Medicaid Management: Division of Policy and Program Guidance



As a purchaser of health care, OMM determines what the program will pay for certain benefits. Specifically, OMM sets:

- Fees for physicians and dentists;
- Prices for durable medical equipment; and,
- Within the guidelines set forth in legislation, reimbursement for prescription drugs.

OMM also develops and implements the information and decision support systems needed to determine eligibility, maintain beneficiary records, and make appropriate payments to enrolled providers for medically necessary services. It coordinates with the Office of Temporary and Disability Assistance to develop and manage the Welfare Management System that processes all eligibility data. It also oversees, with the private contractor that serves as the State's fiscal agent, the Medicaid claims processing system known as eMedNY. This system processes about 1 million claims daily and handles not only claim review and payment but also prior approvals, eligibility inquiries, recoveries of overpayments, and data warehousing activities.

Finally, OMM is responsible for relations with, and reports to, the federal government on oversight of several waivers, including the Care at Home waivers for children with physical disabilities, the Long-Term Home Health Care Program, the pending Nursing Home Transition and Diversion Waiver, and the proposed “mega-waiver” for long-term care restructuring. While OMM oversees all waiver applications and state plan amendments, it does not take the lead on the 1115 waivers, which are handled by the Office of Managed Care, or on state plan amendments related to rate-based reimbursement, which are handled by the Office of Health Systems Management. OMM is also responsible for overseeing and coordinating programs, including waiver programs, developed by the DMH agencies.

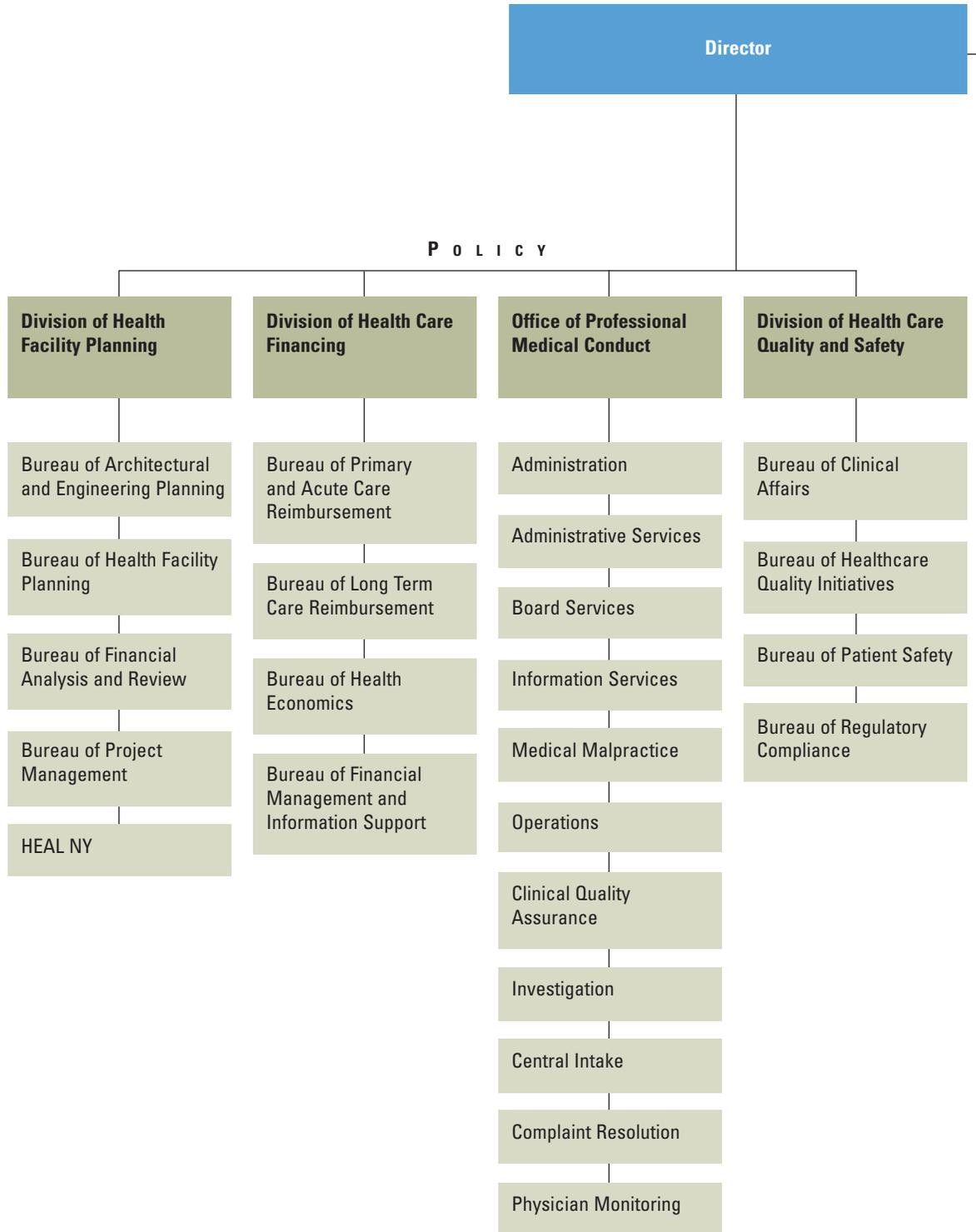
Office of Health Systems Management. The Office of Health Systems Management (OHSM) is the organizational unit with primary responsibility for licensing and regulating institutional health care providers and home care agencies and establishing their rates. While its regulatory activities have a significant impact on the nature and quality of the delivery system serving the Medicaid program, they extend well beyond Medicaid to the health care delivery system as a whole. With 1,000 employees working in nine divisions (see Figures 8 and 9), OHSM is responsible for:

- Developing Medicaid rates for hospitals, nursing homes, clinics, diagnostic and treatment centers (D&TCs), certified home health agencies, personal care, private duty nursing, hospice, and foster care agencies;³¹
- Preparing state plan amendments related to rate changes and shepherding them through CMS for approval;
- Approving, through the certificate of need process, the establishment, merger, and capital projects of institutional health care facilities and long-term care providers, including hospitals, nursing homes, D&TCs, certified home health agencies, licensed home care services agencies, and hospice programs;
- Collecting and distributing funds through pools established under the Health Care Reform Act;
- Setting standards for institutional health care providers and home care agencies licensed under the Public Health Law, conducting surveillance to ensure compliance with those standards, and handling complaints concerning institutional health care providers and home care agencies;
- Investigating and prosecuting physician misconduct.

Office of Managed Care. With about 2.5 million Medicaid and Family Health Plus beneficiaries enrolled in managed care plans, the Office of Managed Care (OMC) plays a significant role as both a purchaser of health insurance for these beneficiaries and a regulator of the health plans that serve them. In this regard, OMC is unique among managed care units within Medicaid agencies nationally. It not only administers a Medicaid managed care program but also regulates both the health plans serving public health insurance beneficiaries and the commercial health maintenance organizations (HMOs) serving the employer-based and individual markets. With a staff of 144 in 10 bureaus and other units (see Figure 10), OMC's responsibilities include:

- Negotiating the terms and conditions of the State's Partnership Plan 1115 waiver, which mandates enrollment in managed care plans for most Medicaid beneficiaries;
- Negotiating the terms and conditions of the recently approved F-SHRP 1115 waiver, which provides federal financial participation in the costs of restructuring and rebalancing the delivery system, along with the mandatory enrollment of special populations in managed care plans;
- Developing and implementing managed care policy for the Medicaid program, including contracting with health plans to provide coverage under the Medicaid managed care, FHP, and managed long-term care programs, and developing premiums for these programs;³²
- Serving as a liaison with local governments on Medicaid managed care issues such as mandatory enrollment; and
- Certification, surveillance, and regulation of HMOs, pre-paid health services plans, and managed long-term care plans, under Article 44 of the Public Health Law.

Figure 8. Office of Health Systems Management



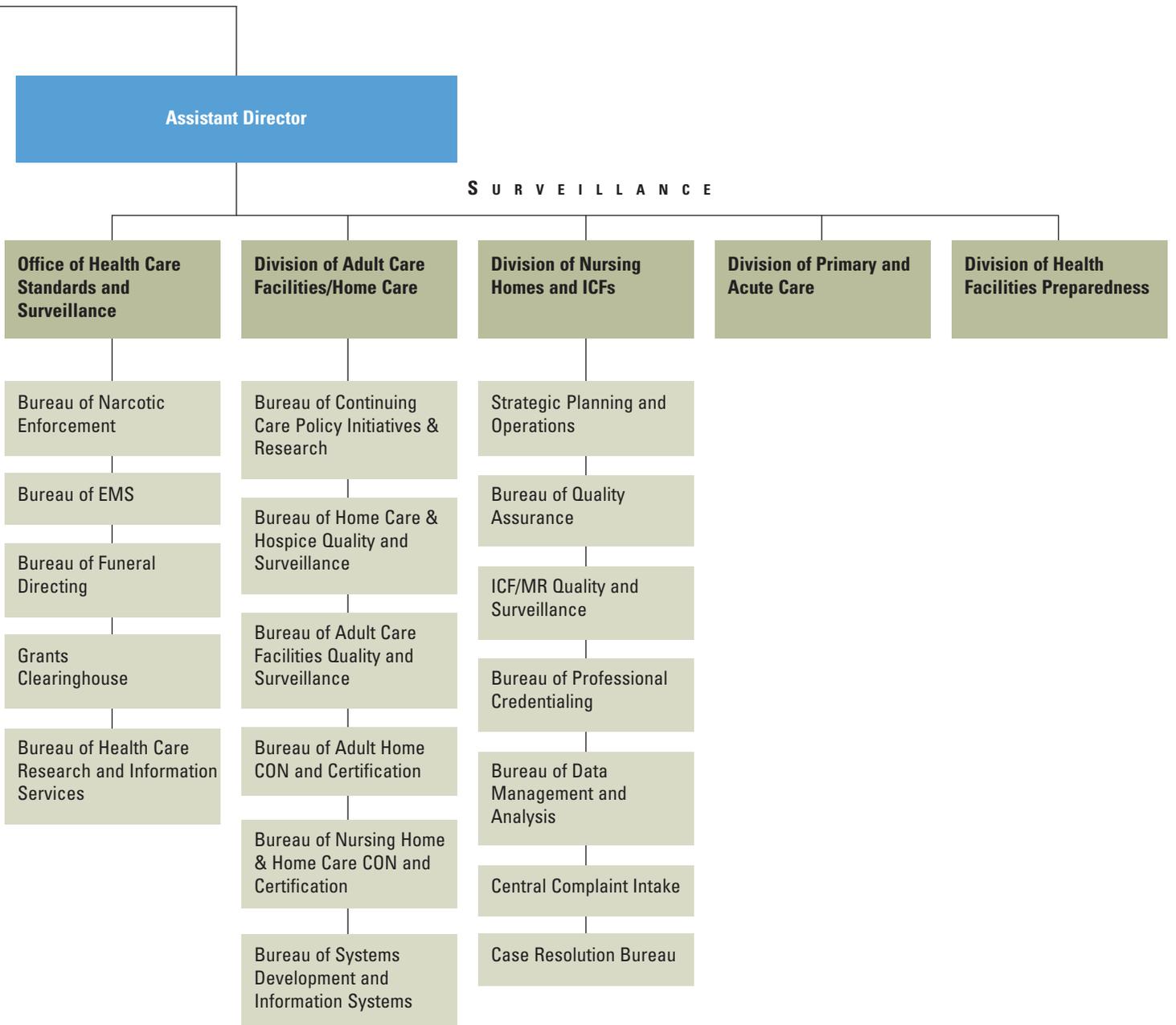
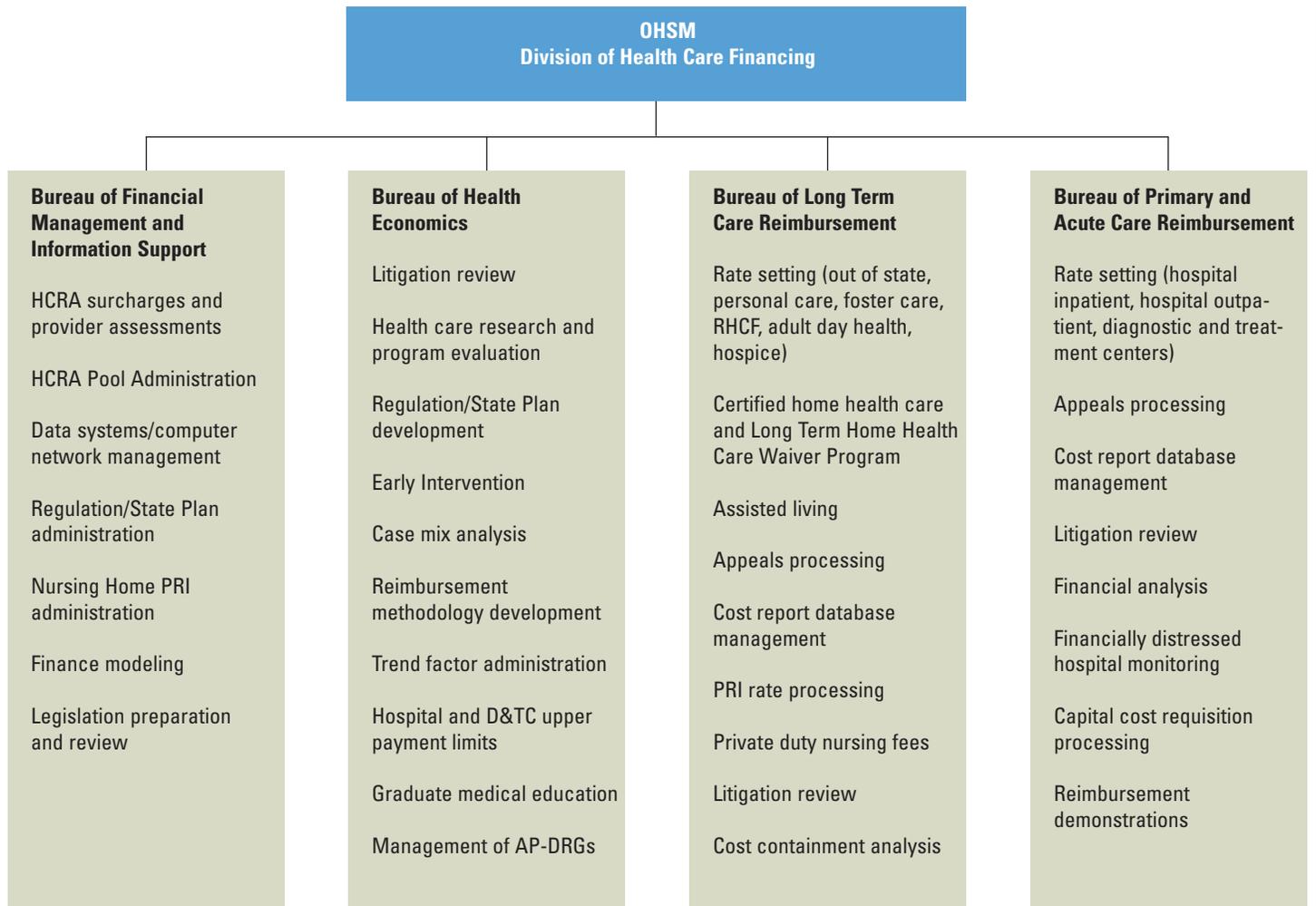


Figure 9. Office of Health Systems Management: Division of Health Care Financing*

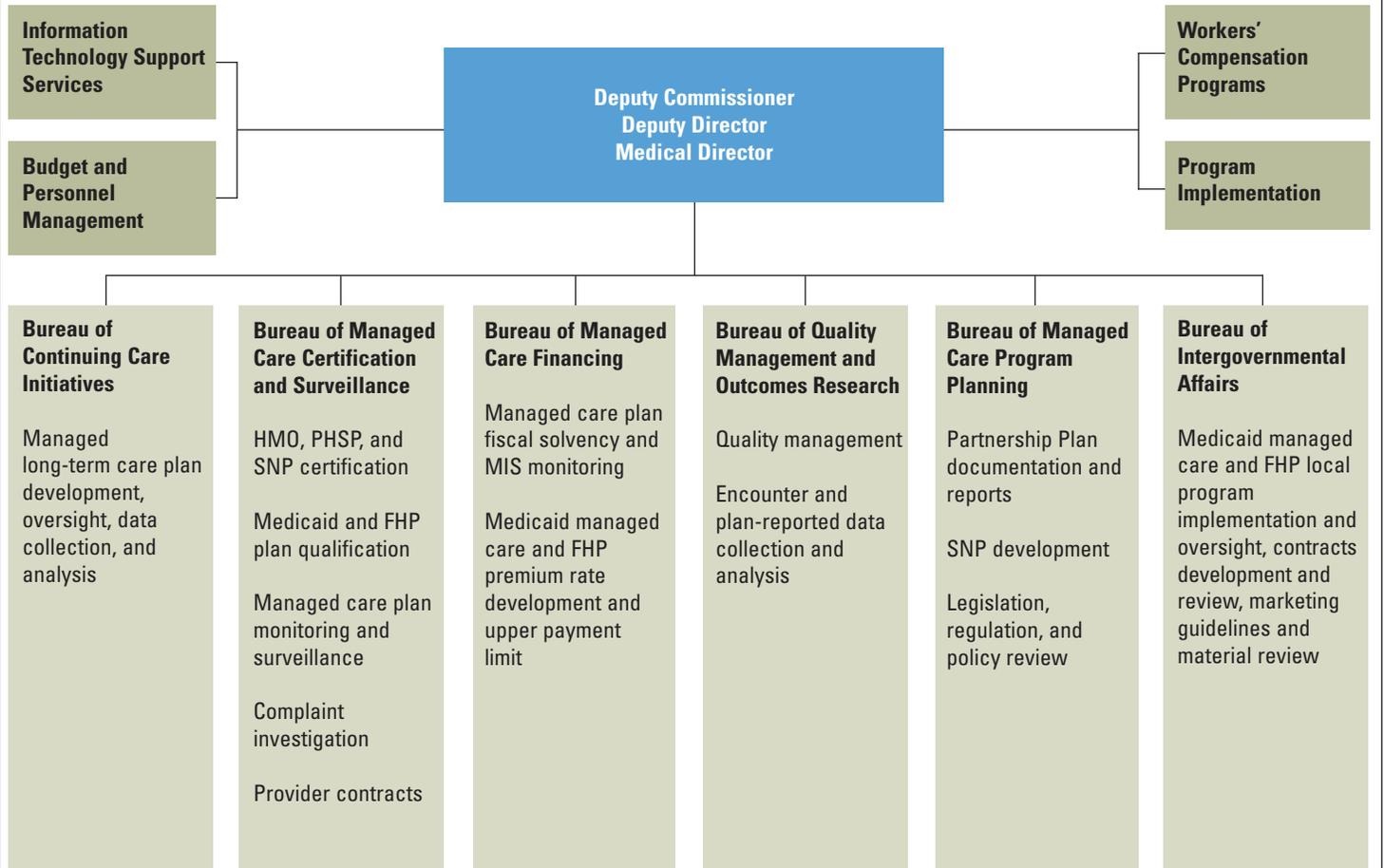


*The Bureaus of Financial Management and Information Support and Long Term Care Reimbursement are currently run by directors, while the Bureaus of Health Economics and Primary and Acute Care Reimbursement are run by assistant directors. The responsibilities listed per Bureau highlight those that are most directly related to Medicaid. Each has significant responsibilities that go beyond Medicaid.

Office of the Medicaid Inspector General. The position of Medicaid Inspector General was created by executive order in February 2005, and the Office of the Medicaid Inspector General (OMIG) was created six months later, to serve as an “independent fraud-fighting entity within the Department of Health.”³³ The Governor’s order positioned the Inspector General as “a single point of leadership of and responsibility for such activities.” The Office was subsequently established by statute to “consolidate staff and other Medicaid fraud detection, prevention and recovery functions” and to grant OMIG additional powers.

Under the legislation, OMIG is housed within the Department of Health, but retains its independence. The Medicaid Inspector General is appointed by the Governor, subject to confirmation by the Senate, and reports directly to the Governor. In addition, OMIG’s budget

Figure 10. Office of Managed Care*



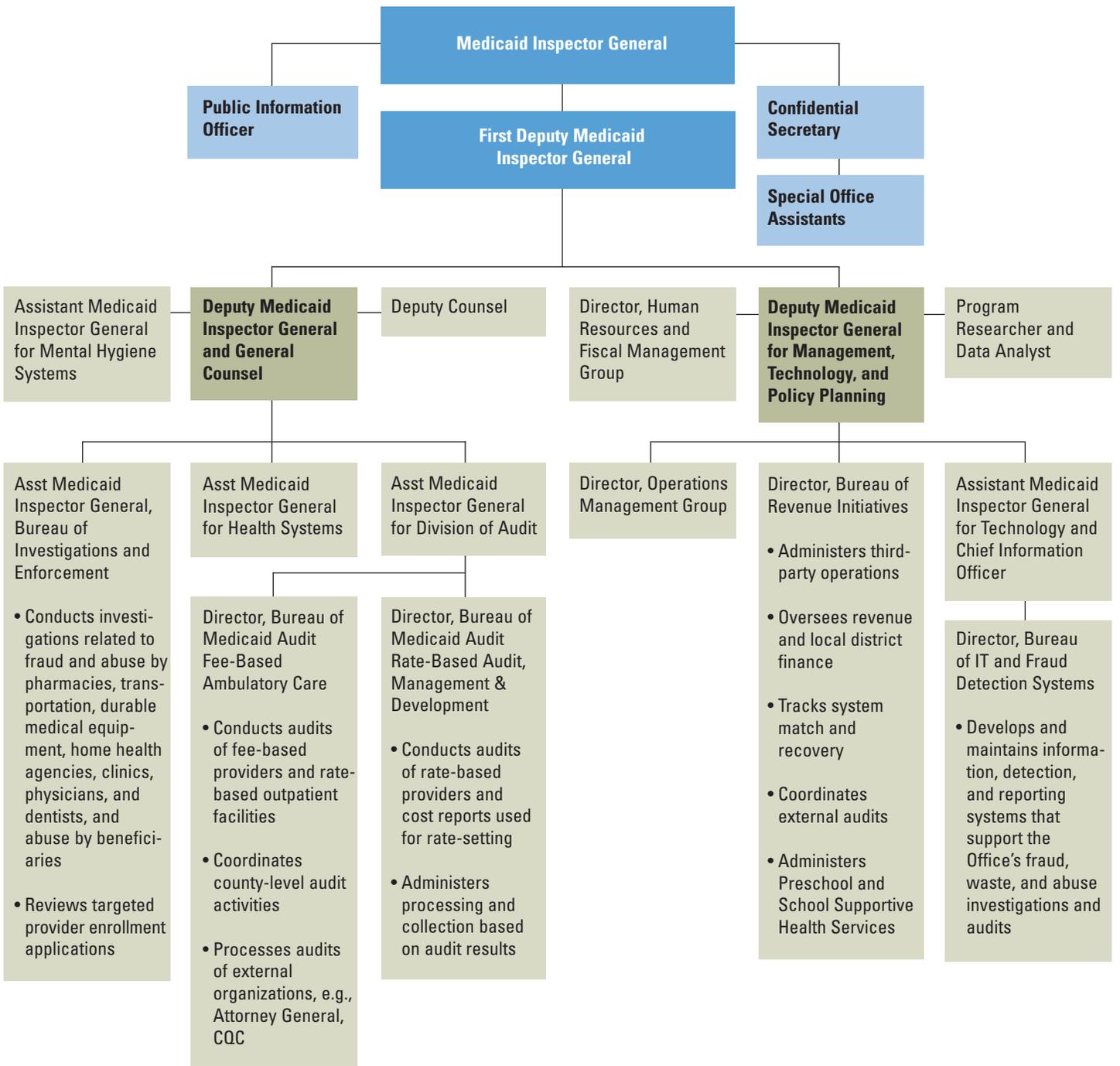
* All Bureaus are currently run by a director. The Bureaus of Managed Care Certification and Surveillance, Quality Management and Outcomes Research, and Managed Care Program Planning have assistant directors; the Bureau of Managed Care Financing has two assistant directors.

is separate from the Department's, and its authorizing legislation explicitly precludes any role for the Commissioner in the development of the Office's budget.³⁴

The State has dedicated considerable resources to OMIG. It has a staff of over 350 state employees and over 100 contract workers (see Figure 11). Their responsibilities include the coordination of fraud and abuse activities among all of the agencies involved in the Medicaid program, as well as federal, state, and local prosecutors and auditors. OMIG is charged with pursuing civil and administrative enforcement actions, but must refer any matter involving suspected criminal activities to the Medicaid Fraud Control Unit. OMIG is also directed to implement policies related to the prevention of fraud and abuse and to collaborate with relevant agencies to utilize information systems to facilitate this effort.

The role of OMIG in recovering improper Medicaid payments or overpayments has heightened importance in the context of the recently approved F-SHRP waiver. Under the

Figure 11. Office of the Medicaid Inspector General



waiver, the State must submit a plan detailing OMIG staffing and new budget proposals to further enhance OMIG's resources. In addition, if the State fails to meet specified monetary targets for fraud and abuse recoveries, it will have to return up to \$500 million in federal funds. Notably, fraud avoidance does not appear to count toward these targets.³⁵

In addition to its fraud prevention and detection responsibilities, OMIG has also assumed the duties formerly performed by the Office of Medicaid Management with respect to the School Supportive Health Services program. Currently, OMIG works with the Education Department to oversee Medicaid reimbursement for certain special education services (i.e., speech therapy, occupational therapy, physical therapy, special transportation, psychological counseling, and service coordination) provided to eligible pre-school and school-age children with disabilities. Under the program, local school districts and county governments are enrolled as Medicaid providers and bill Medicaid for these services. OMIG and the Education Department jointly train school districts on Medicaid policy and billing procedures. The Education Department also administers the payment of the non-federal share of the Medicaid reimbursement. The training and policy implementation functions currently handled by OMIG will be transferred back to OMM shortly. OMIG will continue to review claims submitted by school districts and develop corrective action plans where errors are identified.

Although OMIG does not have programmatic responsibility for Medicaid-funded programs (aside from School Supportive Health, which is about to be shifted to OMM), its efforts to combat fraud and abuse may have a significant impact on program development, quality, and access to services, as well as on Medicaid spending and program integrity. Among the many challenges facing the Office is striking the appropriate balance between fighting fraud and abuse and programmatic considerations. It is too soon to tell how these challenges will be addressed.

AIDS Institute. The AIDS Institute takes the lead in developing and implementing policies designed to prevent the transmission of HIV, promote early diagnosis of HIV infection, and ensure access to high-quality treatment and supportive services for New Yorkers with HIV or AIDS. It oversees a continuum of medical and non-medical services and programs dedicated to addressing all aspects of the epidemic. Its Medicaid-related responsibilities include certifying providers and recommending rates for the HIV Primary Care Medicaid Program, the Community Follow-Up (COBRA) Case Management Program, Designated AIDS Centers, AIDS home care services, and AIDS adult day programs. In addition, the AIDS Institute works with OMC to certify and develop capitation rates for the HIV Special Needs Plans operating in the Medicaid managed care program.

Center for Community Health. The Center for Community Health (CCH) is the public health arm of DOH. With a staff of over 1,000, it works to reduce the incidence of disease, improve access to high-quality treatment, and address public health issues such as adolescent pregnancy and nutrition. CCH's most significant impact on the Medicaid program is through its administration of the Early Intervention (EI) program, which provides services to children with disabilities, up to age 3. Medicaid pays for almost all EI services provided to Medicaid-eligible children, spending over \$250 million annually on these services.³⁶ CCH also provides clinical and public health expertise to OMM in support of initiatives such as the family planning benefit waiver and outreach to Medicaid providers on best practices for the treatment of chronic disease.

Division of Administration. The Division of Administration supports the Medicaid program in the areas of budgeting, financial reporting, and processing fund transfers. It oversees development of the DOH budget request and any responses to legislative budget proposals; calculates each county's share of Medicaid costs and monitors payment of local shares; oversees all expenditure reports to the federal government; serves as a liaison to federal auditors; and works with the State Comptroller to ensure proper payment of the weekly Medicaid payment cycle.

The delegation of Medicaid responsibilities to specialized units within DOH is a two-edged sword. It deepens staff expertise in various program areas and, in some cases, encourages staff to take a proactive approach to policy development on behalf of their constituents. The AIDS Institute, for instance, has actively sought to strengthen the delivery system, services, and supports for people with HIV and AIDS.

On the other hand, the specialization and dispersion of responsibilities within DOH can hinder formulation of coherent policies. For example, there are three offices and six bureaus or divisions charged with overseeing long-term care in DOH—the Bureau of Long Term Care and the Long Term Care Restructuring Project in OMM, the Bureau of Continuing Care Initiatives in OMC, and the Bureau of Long Term Care Reimbursement, the Division of Adult Care Facilities and Home Care, and the Division of Nursing Homes and ICFs in OHSM. Each has a significant impact on the delivery of long-term care services funded by Medicaid. In order to formulate rational long-term care policy, each should be consulted—a process that is inevitably cumbersome.

Despite the wide distribution of Medicaid responsibilities, staff members noted, coordination within the Department is achievable because there is regular contact, on both an ad hoc and a structured basis, among the various offices on policy issues of mutual concern. Still, some former staff members indicated, the distribution of Medicaid responsibilities to different

offices does make coordination more challenging because priorities and perspectives can vary significantly from office to office.

A number of individuals interviewed indicated that the demands of responding to new federal initiatives, such as Medicare Part D and the Health Insurance Portability and Accountability Act (HIPAA),³⁷ along with growing pressure to reduce Medicaid spending, have absorbed much of the Department's attention and staff resources in recent years. They maintain that this situation, combined with an exodus of experienced staff, has worked to diminish affirmative policy development on the part of the Department. They note an emphasis on federal compliance and cost containment at the expense of innovation that would expand access to services and community supports.

The Department of Mental Hygiene Agencies: Using Medicaid to Serve People with Special Needs

Although established under the Mental Hygiene Law as a State agency, the Department of Mental Hygiene (DMH) does not have its own staff or engage in any activities independent of the three "autonomous offices" it comprises: the Office of Mental Retardation and Developmental Disabilities (OMRDD), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS). DMH is led by an interagency coordinating council consisting of the commissioners of OMRDD, OMH, and OASAS.³⁸

The DMH agencies operate sizeable programs funded by Medicaid, in accordance with memoranda of understanding between DOH as the single state agency and each of the DMH agencies. Collectively, approximately \$9 billion in Medicaid funds is appropriated to support programs budgeted in these agencies. The DMH agencies design Medicaid-funded treatment, habilitation, and rehabilitation programs serving the diverse behavioral and disability-related needs of people with mental illness, mental retardation or developmental disabilities, or chemical dependency. They license providers to meet these needs, set reimbursement rates, determine what Medicaid services will be provided under their auspices, and determine clinical qualifications for the Medicaid-funded services they oversee (see Figure 12). Notably, their clients generally access physical health care through providers overseen by DOH.³⁹

Figure 12. Medicaid-Funded Services Overseen by DMH Agencies

Office of Alcoholism and Substance Abuse Services

Medically Managed Withdrawal
 Medically Supervised Withdrawal – Inpatient
 Medically Supervised Withdrawal – Outpatient
 Outpatient Clinic – Medically Supervised
 Outpatient Rehabilitation
 Methadone Treatment
 Inpatient Rehabilitation
 Managed Addiction Treatment Services (MATS)

Intensive residential, community residential, and supportive living services may be reimbursed by Medicaid managed care plans, but are not reimbursed in the fee-for-service program.

Office of Mental Retardation and Developmental Disabilities

Article 16 Clinics
 Care at Home Waivers III, IV, and V
 Community Intermediate Care Facilities
 Community Residence/Home and Community-Based Services Waiver (HCBS) Residential Habilitation Day Treatment
 Developmental Center
 Family Care/HCBS Waiver Residential Habilitation
 HCBS Waiver Day Habilitation, Supported Employment, and Pre-Vocational Services
 HCBS Waiver Environmental Modifications and Adaptive Technologies
 HCBS Waiver Family Education and Training
 HCBS Waiver Hourly Respite

Office of Mental Health

HCBS Waiver for Children with Serious Emotional Disturbance
 Family-Based Treatment
 Intensive Case Management, Supportive Case Management, Blended Case Management
 Article 31 Clinic Treatment
 Continuing Day Treatment
 Children’s Day Treatment
 Intensive Psychiatric Rehabilitation Treatment
 Assertive Community Treatment
 Partial Hospitalization
 Community Psychiatric Emergency Programs
 Inpatient Psychiatric Services*
 Residential Treatment Facilities
 Personalized Recovery-Oriented Services (PROS)
 Prepaid Mental Health Program

Other Medicaid funding streams that support multiple OMH programs as supplemental payments are:
 Comprehensive Outpatient Program (COPS)
 Non-COPS (for outpatient programs that are not designated as COPS programs)
 Disproportionate Share Hospital Payments
 Community Support Program

*Because of the federal “institution for mental disease” exclusion, these services are only reimbursed by Medicaid if provided in a facility with fewer than 16 psychiatric beds, or to a child under age 21, or to an adult age 65 or older.

Over the last two decades, the DMH agencies have dramatically expanded the role of Medicaid in their agency budgets and programs. This expansion has been driven by a number of factors, including the deinstitutionalization movement, which has been supported in part by the availability of Medicaid dollars for community-based residential services, rehabilitation, habilitation, and case management. Using Medicaid, the DMH agencies have been able to create extensive systems of community-based services for their Medicaid-eligible clients. In some cases, they have enhanced or modified existing programs to meet Medicaid requirements and partially replaced State and local funding with federal Medicaid funds. In addition, they have created new programs funded by Medicaid.

The ability of the DMH agencies to use Medicaid to fund their programs has created new capacity and services for their clients while minimizing the impact on the State and local budgets. Agency staff interviewed for this paper noted, however, that there are pros and cons, for both the agencies and their constituents, associated with Medicaid participation.

Medicaid funds are not easy money—they come with multiple strings attached. The complex rules and requirements of Medicaid have determined the contours of the agencies' programs, the services that are available, the providers that may offer them, and the administrative resources that must be devoted to them.

Following are brief descriptions of the administrative responsibilities of each of the agencies, with an emphasis on the Medicaid-funded programs and services they supervise.

Office of Mental Retardation and Developmental Disabilities. Over the past 30 years, OMRDD has reconfigured its programs to emphasize community-based services and community integration over institutional care. By statute, it is charged with “developing a comprehensive, integrated system of services which has as its primary purposes the promotion and attainment of independence, inclusion, individuality and productivity for persons with mental retardation and developmental disabilities; to serve the full range of needs of persons with mental retardation and developmental disabilities by expanding the number and types of community-based services and developing new methods of service delivery.”⁴⁰

The agency's staff emphasizes a participatory and inclusive approach to carrying out its mandate. It oversees an extensive system of services and supports with input from dozens of advisory groups representing providers, clients, and their families. Its programs and services range from habilitation, family support, employment, and clinic services to intermediate care facilities and developmental centers. Its NYS-CARES program provides out-of-home residential opportunities for individuals with developmental disabilities.

OMRDD has been able to pursue its statutory charge primarily through the use of Medicaid. A majority of its clients are eligible for Medicaid, and, notably, its facilities are not subject to the federal “institution for mental disease” exclusion that limits Medicaid funding for the other DMH agencies, as discussed below.⁴¹ Accordingly, it has developed innovative programs and services that use Medicaid and draw down federal funds.

The agency's most significant Medicaid-funded program is its home and community-based waiver, which serves 55,000 individuals who would qualify for institutional care. In addition to this waiver, OMRDD administers three different Care at Home waivers for 600 children with developmental disabilities and complex needs. Through the waivers, OMRDD is able to secure Medicaid funding of non-medical services such as habilitation, pre-vocational training, family education, and environmental modifications. The agency recently expanded the opportunities available to its clients through the creation of the Options for People Through Services (OPTS) program, which uses an organized health care delivery system model to provide person-centered services that promote community integration.

OMRDD serves as a provider of services through its operation of the developmental centers and certain day habilitation and residential habilitation programs. OMRDD is also the sole Medicaid provider under the OPTS program. It subcontracts with other providers to furnish the approved OPTS services.

Office of Mental Health. OMH is directed by statute to “work with local governments, voluntary agencies and all providers and consumers of mental health services” to develop an “effective, integrated, comprehensive system for the delivery of all services to the mentally ill.”⁴² OMH seeks to fulfill this mandate through its development and oversight of mental health programs that provide access to treatment and community supports, while promoting recovery, for adults with serious mental illnesses and children with serious emotional disturbances. Like OMRDD, OMH has, in the last 30 years, transformed New York’s public mental health system from one that provided predominantly institutional care into one in which institutional care is delivered only when community-based services would be inappropriate. Today, state psychiatric centers serve approximately 5,000 inpatients, compared with 23,000 in 1981.⁴³ Relying heavily on Medicaid dollars and the reinvestment of savings derived from the closure of State psychiatric facilities, OMH has built an extensive community-based system of medical and non-medical services and housing options for people with mental illness.⁴⁴

The programs administered by OMH fall into four categories: (1) community support services that help adults with serious mental illness to live independently in the community, and children with serious emotional disturbances to remain with their families (e.g., sheltered workshops, psychosocial clubs, family support services); (2) outpatient services that provide treatment and rehabilitation (e.g., partial hospitalization, continuing day treatment, Assertive Community Treatment, Intensive and Supportive Case Management, and the Prepaid Mental Health Plan); (3) inpatient services that provide acute stabilization, treatment, and rehabilitation on a 24-hour basis; and (4) emergency services providing rapid psychiatric stabilization for people who present a danger to themselves or others. OMH also oversees a variety of community residences and supported housing options for people with serious mental illnesses.

While many of these programs are supported at least in part by Medicaid, some are funded entirely by State and local dollars and/or federal grants. In addition to Medicaid eligibility rules and restrictions on the types of services that Medicaid will cover, OMH is affected by the federal “institution for mental diseases,” or IMD, exclusion. Under this rule, federal funds may not be used to pay for any services (including physical health care services) provided to residents of IMDs who are between the ages of 21 and 64.⁴⁵ Because of that exclusion, OMH’s State-operated psychiatric centers, for example, are funded mainly with

State dollars.⁴⁶ In order to fulfill its statutory mission and meet the diverse needs of its clients, OMH must find ways to finance programs using a combination of Medicaid and non-Medicaid funds.

To the extent possible within these limitations, OMH has used Medicaid to secure federal support for its programs and services. For example, by engaging clients in community-based programs that can be paid for with a combination of State and federal Medicaid dollars, OMH not only promotes better outcomes for clients but also avoids placements in IMDs that must be funded almost entirely by the State. Most recently, OMH has created the Personalized Recovery-Oriented Services (PROS) program, under the rehabilitation option, to provide persons with serious mental illness with an individualized and coordinated array of treatment, rehabilitation, and support services. In addition, OMH administers a home and community-based waiver for children with serious emotional disturbances who require an institutional level of care. Under the waiver, children and their families may receive case management, respite care, and other services that would not otherwise be available under the State's Medicaid plan.

OMH directly provides services, as well as regulating providers. It operates 16 psychiatric centers for adults and six for children, three forensic facilities, and two research institutes. It also operates outpatient and community support services, most notably the Prepaid Mental Health Plan, which uses a managed care approach to delivering an array of services.

Office of Alcoholism and Substance Abuse Services. OASAS is charged with developing “comprehensive plans, programs, and services in the areas of research, prevention, care, treatment, rehabilitation, education, and training of persons who abuse or are dependent on alcohol and/or substances and their families.”⁴⁷ Consistent with that mandate, the agency has sought to expand access to chemical dependence treatment and rehabilitation services.

OASAS licenses and oversees a spectrum of chemical dependence services, from detoxification to inpatient and outpatient rehabilitation to community residences and supportive living arrangements. About 25 percent of OASAS's treatment programs are dually licensed by DOH and OASAS.⁴⁸ For example, hospital-based detoxification, inpatient rehabilitation, and methadone maintenance services are licensed by both agencies. Similarly, outpatient chemical dependence treatment programs (representing the largest treatment category in the OASAS system) are often provided by hospital outpatient departments and by D&TCs licensed by DOH. Over 70 percent of Medicaid-eligible clients in the OASAS system are treated in outpatient settings.

The agency has recently received federal approval to offer a new Medicaid-reimbursed service category—residential rehabilitation services for adolescents. Services provided to eligible adolescents will be reimbursed by Medicaid. In addition, OASAS has implemented the Managed Addiction Treatment Services (MATS) program—a Medicaid-funded program that offers case management services to high-cost Medicaid beneficiaries—as part of an effort to ensure access to necessary medical and non-medical services, while reducing excessive and inappropriate utilization.

Like the other DMH agencies, OASAS directly provides services, as well as licensing and regulating chemical dependence providers. It operates 13 addiction treatment centers throughout New York State that provide inpatient chemical dependence services, including specialized services for deaf and hard of hearing clients, Native Americans, women with children, Spanish-speaking clients, and lesbian, gay, bisexual, or transgender clients.

Most OASAS programs are funded, at least in part, by Medicaid. In comparison with the other two DMH agencies, however, Medicaid plays a more limited role in OASAS programs. This is primarily because a smaller, fluctuating percentage of OASAS clients are eligible for Medicaid than in the other two agencies. In addition, residents of large inpatient programs licensed by OASAS are subject to the federal IMD exclusion. Further, Medicaid will not pay for inpatient rehabilitation outside of a hospital setting, or for certain non-medical services, including those that are employment-related, certain residential costs, and educational services. As a result of these restrictions, OASAS must strike the right balance between Medicaid and non-Medicaid funding streams in order to serve its clients.

The administrative approach to Medicaid presented by the three DMH agencies is different from that of the Department of Health. Where DOH views Medicaid as a distinct program, the DMH agencies view it as an important source of revenue for a variety of programs, but not as a program itself. Accordingly, there are no Medicaid program bureaus in the DMH agencies (see Figures 13-15). Medicaid responsibilities are woven into the day-to-day activities of managing the agencies' programs and finances, and within each agency there is an organizational unit that is responsible for overseeing Medicaid spending. Further, the DMH agencies consider Medicaid a revenue source, whereas DOH is more likely to view Medicaid as a cost center. The difference in perspective from that of DOH is derived from the combined effect of three characteristics that the DMH agencies share:

Figure 13. Office of Mental Retardation and Developmental Disabilities

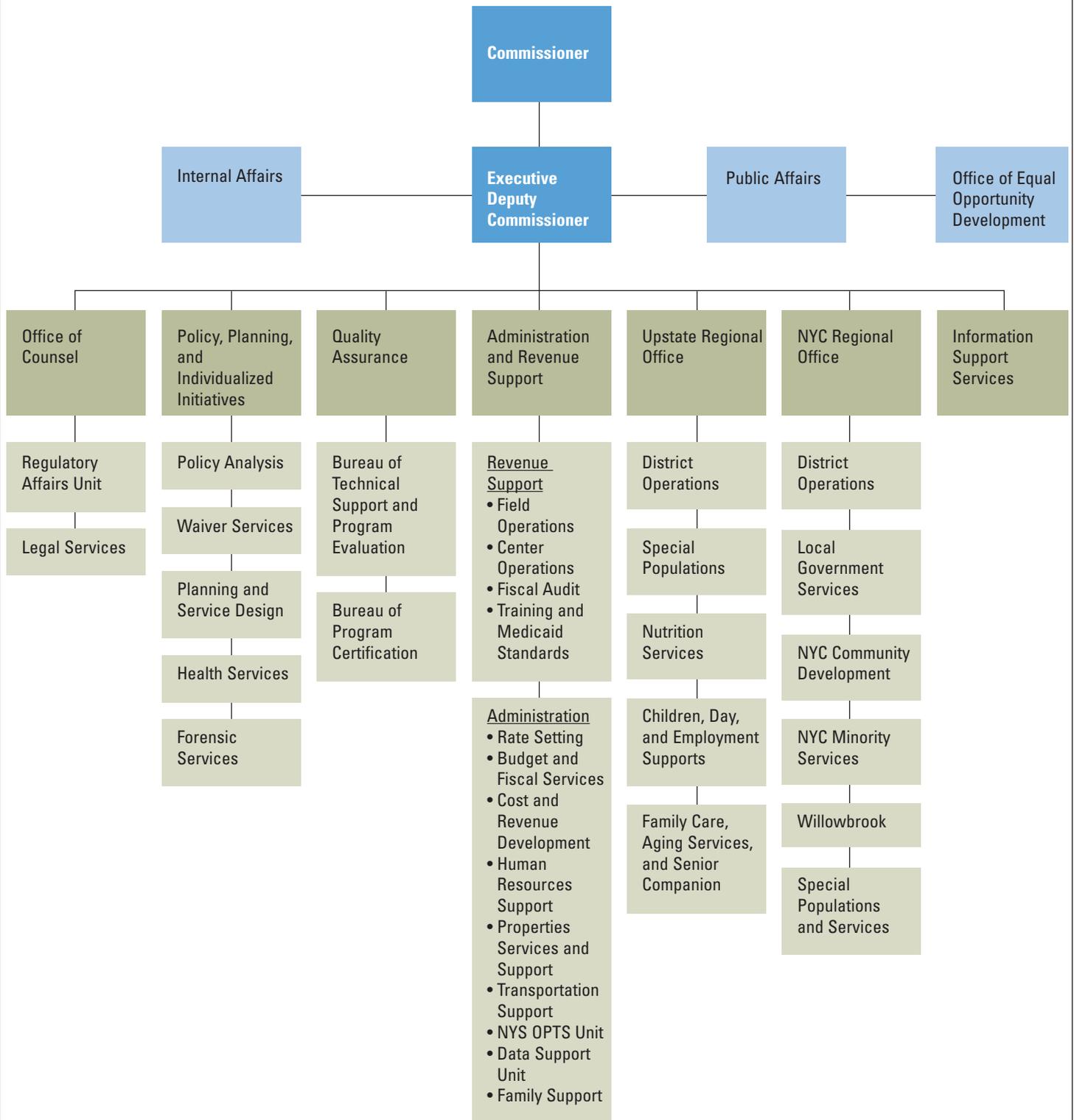


Figure 14. Office of Mental Health

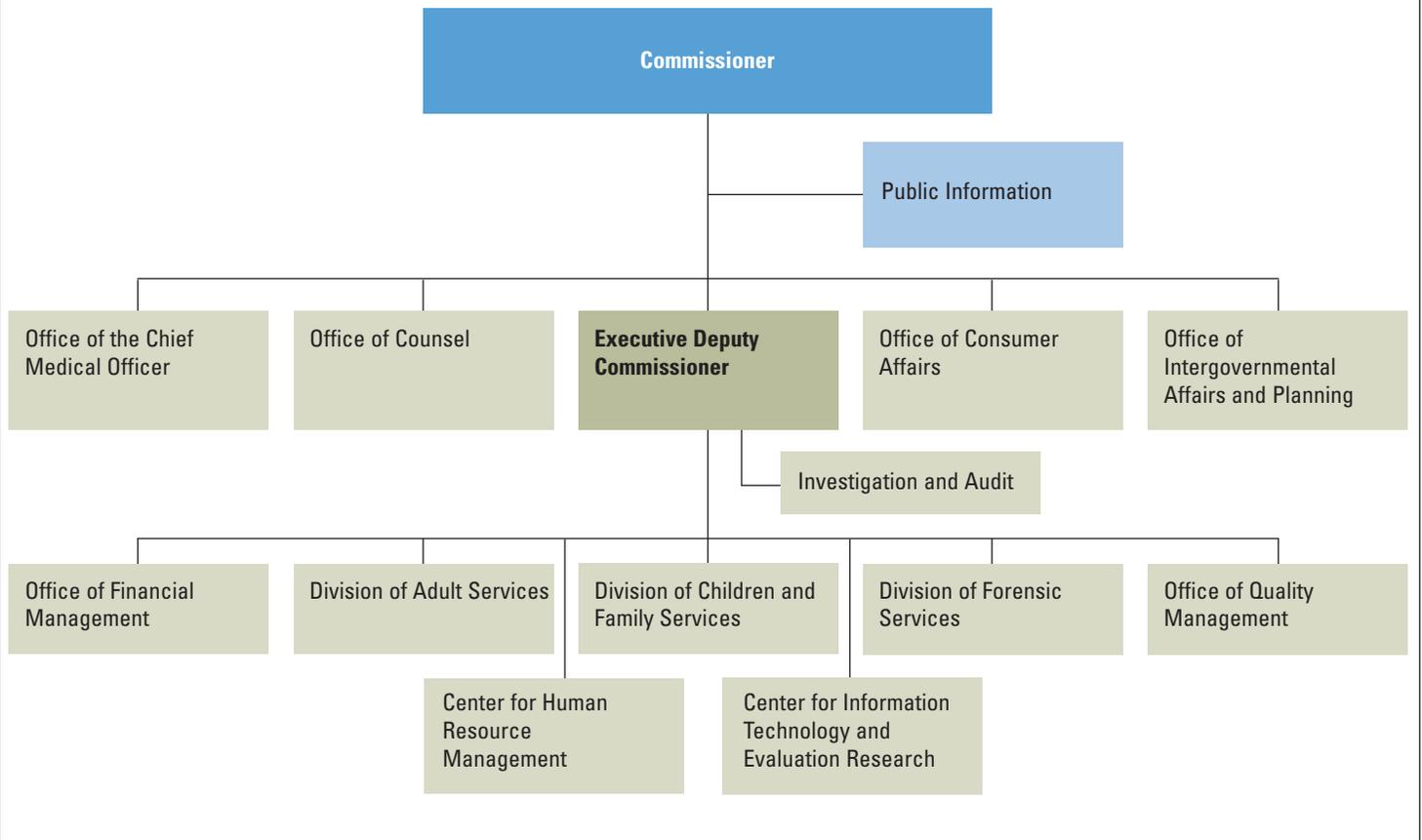
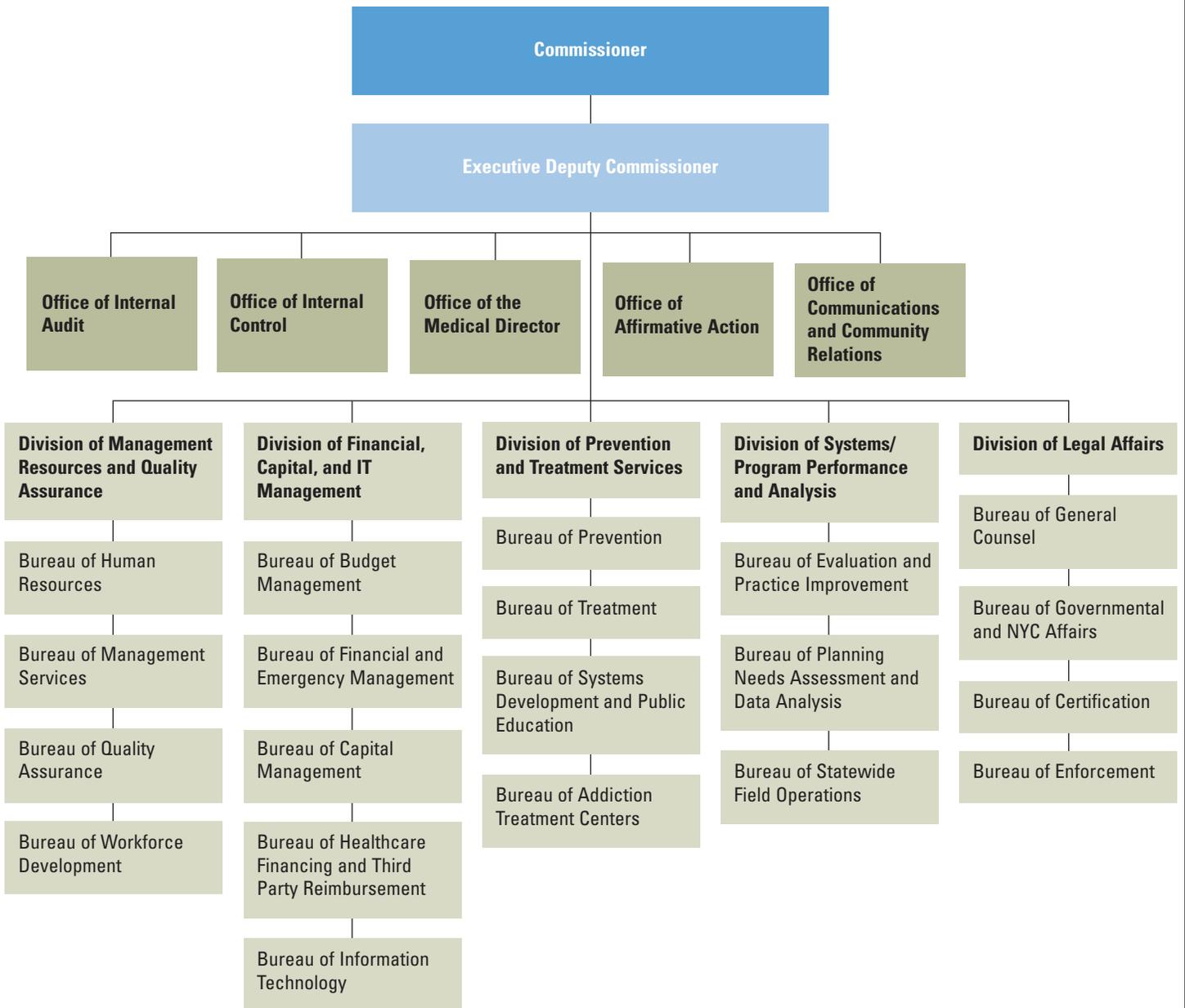


Figure 15. Office of Alcoholism and Substance Abuse Services



Targeted Mission and Constituency. The DMH agencies are driven by their missions and by statutory and constitutional mandates⁴⁹ to develop the programs and make available the services necessary to address the diverse disability-related needs of discrete constituencies. Their mandates extend beyond medical needs to an array of supportive services intended to promote community integration, rehabilitation, and/or recovery. While DOH attends to a broad array of stakeholders and medical services, the DMH agencies focus primarily on expanding and adjusting their delivery systems to better meet the disability-related needs of their constituents.

Provider Orientation. The DMH agencies cannot carry out their mandates without a financially viable, high-quality delivery system. These agencies point out that the providers that serve their clients are not as influential in the State budget process as other Medicaid providers, such as hospitals and nursing homes. As a result, the DMH agencies advocate for their providers, as well as their consumers, in State budget and policy discussions.

Further, to a much greater extent than DOH, the DMH agencies themselves serve as providers of Medicaid-funded services. OMRDD directly operates approximately 10 percent of the programs supervised by the agency. More than 10 percent of the clients served by OMH-licensed programs receive services through a state-operated program.⁵⁰ And OASAS's addiction treatment centers serve about 3 percent of the total population receiving treatment for chemical dependency in a given year.⁵¹ At the same time, the DMH agencies must balance their roles as advocates and providers against their regulatory and fiscal responsibilities.

Budgetary Incentives. The DMH agencies' ability to develop Medicaid-funded programs (with a 50 percent federal contribution) has also bolstered their view of Medicaid as a source of revenue. This perspective is reinforced in OMH by its ability to save State dollars, and foster community integration, by engaging clients in Medicaid-funded community services, as opposed to State-funded psychiatric centers that are subject to the IMD exclusion. Using Medicaid as a funding stream, the DMH agencies have been able to develop an extensive range of services for their clients within available resources and budgetary constraints.

The location of Medicaid appropriations within the State budget also affects the DMH agencies' approach to Medicaid program development and administration. Currently, the State share of Medicaid for most OMH and OASAS programs is appropriated in the DOH budget, while the State share for most OMRDD programs is appropriated in the OMRDD budget. The federal share for all of the DMH programs is appropriated in the DOH budget. The DMH agencies have expressed varying views concerning the agency in which the State share of Medicaid should be appropriated for DMH programs. Some staff believe that aligning

the appropriations with the respective DMH agencies would bring greater financial control and accountability to the DMH agencies. Others prefer to leave Medicaid funds in DOH, which can more readily address cash flow issues due to its larger budget.

This combination of mission and provider orientation, along with budgetary flexibility, has promoted and strengthened the DMH agencies' delivery systems and expanded access to services and supports for the Medicaid beneficiaries they serve. Some observers have also noted that investments in services for DMH clients may come at the expense of other services and populations, and that in the absence of a comprehensive approach to Medicaid policy-making, competing priorities are not effectively weighed. In any event, the ability of the DMH agencies to find creative and legitimate ways to use federal Medicaid dollars has strengthened their ability to advance their objectives with the Governor and the State's Division of the Budget.

The Governor's Staff and the Division of the Budget

With Medicaid responsibilities divided among multiple agencies, the role of establishing and ensuring the implementation of program-wide priorities rests with the Governor's staff and the Division of the Budget. In theory, the Governor's staff is in a position to transcend individual agency or office agendas, examining the Medicaid program as a whole, identifying policy goals, and ensuring that agency activities advance those goals. The effectiveness of the Governor's staff in fulfilling this role is in part determined by the mandate and authority it is given by the Governor. Further, because the Governor's staff is relatively small in relation to the broad portfolio it handles, staff members' experience and expertise and the priority assigned to Medicaid issues are also critical factors. Due to their distance from program operations, staff members must rely heavily on the information and options presented by agency staff and DOB. If they are unable to enlist the active support of the commissioners and agency staff, their job is extraordinarily challenging.

With a mandate to oversee the budgets of all of the entities involved in Medicaid, plus a larger staff than that of the Governor's Office, and the power of the purse, the Division of the Budget is positioned to examine the program as a whole and influence its varied elements. As a result of its power to approve all rates, State Plan Amendments, and the hiring of agency personnel, DOB has leverage over the agencies to take the steps necessary to achieve the goals it identifies. DOB's focus, expertise, and mission, however, relate to the fiscal aspects of Medicaid. Like the Governor's staff, it does not have the same level of programmatic expertise as the agencies charged with directly administering Medicaid-funded programs. It cannot single-handedly develop Medicaid policies nor operationalize them.

DOB's ability to address the financing of Medicaid in a comprehensive way was strengthened four years ago when its unit responsible for mental hygiene programs was merged with the unit responsible for DOH. Compared with the shift of Medicaid single state agency responsibility from DSS to DOH, this change received little notice. But its impact may have been just as significant. The merger of the two units created a unit chief position with a bird's-eye view of the financing of practically all the components of the Medicaid program. As a result, costs and savings can be shared across the Medicaid program as a whole, rather than within limited agency budgets, to promote initiatives advanced by the Governor, the agencies, and/or DOB. In addition, programmatic initiatives can be vetted by an interdisciplinary team. Nevertheless, DOB's perspective and approach are necessarily colored by the fiscal lens through which it views the program.

Implications of the Administrative Structure

The administrative structure of New York's Medicaid program informs, influences, and at times determines the distribution of resources within the program, the availability of services, and the types of providers that offer them. This section examines the impact of the administrative structure on three functional areas: licensure, establishment of payment rates, and program development. We look at licensure and rate-setting together because of the common issues and themes they raise.

Licensure and Rate-Setting

Licensure and rate-setting functions are among the most powerful tools available to the State in shaping the Medicaid program. They influence the availability of services, the quality of services, and where and how those services are provided. Where rates or fees for a particular class of providers are adequate, the number of providers in that class tends to expand. Recently enacted pay-for-performance initiatives, for instance, recognize the power of enhanced payments to change provider behavior or further expand services. Inadequate rates and fees, by contrast, drive providers from the system, deter the addition of new ones, and diminish the ability of remaining providers to offer high-quality care.

Similarly, when a particular type of license is hard to get, existing service providers may be unable to meet demand, and different types of providers requiring different licensure may take up the slack. When licenses are readily available, excess capacity may stimulate excess utilization. Ultimately, in establishing payment rates and granting licenses, Medicaid administrators have to strike an appropriate balance among the goals of access, quality, and cost.

Administrative responsibility for licensing Medicaid providers and establishing provider rates of payment rests with multiple entities at different levels of government. As a general matter, rate-setting and licensure policies are established within the silos that define the Medicaid program. These policies are typically made without a comprehensive assessment of the ripple effects they may cause in other sectors or their implications for the program as a whole. An exhaustive discussion of the laws and regulations governing the licensure and reimbursement of Medicaid providers is beyond the scope of this paper. Instead, we discuss the division of responsibilities for these functions within and among governmental entities, with a focus on the ambulatory care sector, to illustrate the implications of diffuse responsibility in the absence of a “big picture” approach to Medicaid policy-making.

At the federal level, Congress enacts laws and CMS promulgates regulations that set general parameters for Medicaid rates and for conditions of participation in the Medicaid program.⁵² For example, federal law includes a provision requiring payments that “are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [State Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area.”⁵³

In New York, federal requirements governing licensure and reimbursement are applied by several different State agencies, several different organizational units of DOH, and, in some cases, the Legislature or local governments. The availability of licenses depends on a number of factors, including community need, character and competence of the applicant, and the financial feasibility of the applicant’s proposal. As a practical matter, the availability of a particular license also depends in part on the agency responsible for issuing the license and the extent to which fiscal issues factor into licensing. Rate-setting methodologies also vary widely, and payment amounts for similar services often differ significantly by license.

The Department of Health is responsible for licensing the institutional or corporate health care providers and plans delineated in the Public Health Law (e.g., general hospitals, nursing homes, D&TCs, HMOs, home care agencies, and hospice programs), whereas the State Education Department licenses individual practitioners. DOH sets Medicaid rates for the facilities it licenses, as well as fees for individual practitioners and suppliers (e.g., physicians, dentists, private duty nurses, pharmacies, and durable medical equipment providers).

Three different DOH units are primarily responsible for setting rates and fees paid to Medicaid providers and health plans: the Office of Medicaid Management (practitioners, pharmaceuticals, and durable medical equipment), the Office of Health Systems Management (institutional and home care providers), and the Office of Managed Care (managed care plans).⁵⁴ Regulations governing rate-setting methodologies for institutional and home care providers must also be approved by the State Hospital Review and Planning Council, a statutorily mandated advisory council to DOH.⁵⁵ Additionally, DOB approves all rates, fees, and premiums.

Along with DOH and DOB, the Legislature is involved in setting and adjusting rates for certain types of providers, whose rate-setting methodologies have been enacted in statute (e.g., hospitals, nursing homes, hospital outpatient clinics, D&TCs, and pharmacies);⁵⁶ it also occasionally steps in, when pressed to do so by stakeholders or budgetary concerns, to mandate enhanced or reduced reimbursement for other types of providers.⁵⁷ By contrast, the Legislature has had limited involvement in establishing the premium methodology for health plans participating in the Medicaid managed care, Family Health Plus, and managed long-term care programs.⁵⁸ Accordingly, premiums have been left almost entirely to the discretion of the Office of Managed Care, subject to the approval of DOB.⁵⁹

This distribution of authority within DOH and between the Legislature and DOH can have incongruous results, particularly in the ambulatory care sector. For example, hospital clinics, D&TCs, and physicians can provide similar services and receive vastly different reimbursement. By statute, the rate for hospital clinic visits has been frozen for more than a decade at \$67.50 plus capital expenses.⁶⁰ D&TC rates have also been frozen by statute since 1992, but these rates are based on costs and vary by individual D&TC.⁶¹ Newer D&TCs are reimbursed at higher rates than D&TCs established prior to the freeze because their rates are based on projected current-year costs, rather than 1992 costs. Overall, D&TC rates tend to be higher than hospital outpatient clinic rates, averaging \$100 to \$190 per visit, including capital costs, while hospital clinic rates average \$70 to \$90 per visit, including capital costs. Physician fees have not changed appreciably since they were first established, early in the history of the Medicaid program, although office visit fees were increased to \$30 per visit in 2000 pursuant to legislation, and certain discrete rates have been raised to address specific areas of concern.⁶² Despite the statutorily mandated fee increase, physician fees remain far lower than rates for hospital clinic and D&TC visits.

The disparities in rates paid to D&TCs and hospital clinics versus physician fees are based, at least in part, on differences in their services and cost structures.⁶³ However, the disparities in reimbursement among the three settings drive capacity and utilization in arbitrary ways. It is widely acknowledged that depressed physician fees have led to low physician participation

and under-utilization of physician services in New York's Medicaid program, compared with other states.⁶⁴ Below-market physician fees have also prompted physicians to attempt to convert their practices into D&TCs. At the same time, the below-cost cap on hospital clinic rates has caused a growing number of hospitals to convert their clinics into D&TCs, causing an increase in Medicaid fee-for-service reimbursement generally without a meaningful change in the service model.⁶⁵ In short, by changing the corporate structure of its clinics and securing a D&TC license, a hospital can increase its Medicaid per-visit reimbursement by 20 or 30 percent or even more.

Like the allocation of rate- and fee-setting responsibilities among different offices within DOH, the separation of rate-setting authority between the DMH agencies and DOH has had a pronounced impact on the ambulatory care services available to Medicaid beneficiaries and the settings in which they may be accessed. The DMH agencies license or certify and set rates or fees for facilities and programs that principally address the behavioral health or disability-related needs of their clients. For example, OMRDD licenses and sets rates for its developmental centers, intermediate care facilities, waiver services, and Article 16 clinics that provide medical and rehabilitative services to people with developmental disabilities. OMH licenses and sets rates for a variety of providers and programs, including psychiatric centers, waiver services, community residences, and services provided in clinics and other programs licensed under Article 31 of the Mental Hygiene Law. OASAS licenses and sets fees (nominally in consultation with DOH) for the chemical dependency outpatient programs, and rates for non-hospital inpatient rehabilitation, non-hospital detoxification services, and OASAS addiction treatment centers.

Many of the services DMH clinics provide may be offered in D&TCs or hospital outpatient clinics. Specifically, D&TCs and outpatient clinics that receive DOH approval may provide some psychiatry, psychology, and social work services. Likewise, with DOH approval, D&TCs may offer rehabilitative services, along with physical health services, to people with disabilities. A session with a psychiatrist could be reimbursed at \$85 (i.e., \$67.50 plus capital costs) in a New York City hospital outpatient clinic, \$130 in a D&TC, and \$72 in a clinic licensed by OMH under Article 31.⁶⁶ While there are differences in the variety and intensity of services offered under the respective licenses, and there may be differences in the cost structure of the different types of facilities, the bottom line is that similar services are reimbursed at different rates depending on the provider's license, without a clear and compelling programmatic or fiscal rationale.⁶⁷

This disparate reimbursement for clinics with OMH licenses, combined with restrictions on the establishment of new clinics under Article 31 of the Mental Hygiene Law, has driven providers increasingly to offer mental health services under a DOH license rather than an OMH license. In the early 1990s, in connection with a restructuring of OMH provider rates, OMH and DOB imposed a “Medicaid neutrality” condition on the licensure of new providers, to curb any further increase in Medicaid spending under the OMH budget. The Medicaid neutrality policy requires applicants for a license under Article 31 of the Mental Hygiene Law to demonstrate that they have a source—other than the State—that will underwrite the State share of Medicaid reimbursement claimed by the proposed facility.⁶⁸

This policy has effectively blocked the establishment of any new Article 31 facilities. At the same time, demand for mental health services has grown and applications to add mental health services to the operating certificates of DOH-licensed clinics have skyrocketed. The DOH approval process, unlike the OMH process, does not require a demonstration of Medicaid neutrality. While OMH curbed its own growth in spending, DOH has seen its Medicaid spending increase as a result of OMH’s policy. Further, because DOH-licensed clinics almost always have considerably higher reimbursement rates than OMH clinics, the Medicaid neutrality policy may have triggered higher Medicaid spending overall, rather than reining it in. The Medicaid neutrality policy also has clinical implications, resulting in an increase in the number of mental health services providers regulated by DOH rather than OMH. According to DOH staff, the provision of these services should be overseen by an agency with mental health expertise.

The division of labor between DOH and the DMH agencies can also place a stumbling block in the way of dual licensure by DOH and a DMH agency. Applications to establish a clinic or D&TC licensed by both DOH and a DMH agency, or to add an additional clinic to an existing license, must be approved by both licensing agencies. An application may be in limbo indefinitely because both agencies do not agree on the public need for the services.

The rate-setting process for dually licensed facilities is even more convoluted. A D&TC licensed by DOH and OMH is generally reimbursed for all mental health services at the lower OMH rates.⁶⁹ By contrast, a D&TC providing limited mental health services and licensed by DOH alone will be reimbursed at the higher DOH rates. Clinics licensed by both DOH and OASAS are paid at DOH rates, which for D&TCs are generally higher than OASAS fees and for hospital outpatient departments are sometimes lower than OASAS fees.

The affected agencies have established an interagency provider council to resolve some of these issues. To date, it has focused on the appropriate licensure and reimbursement of clinics that principally serve people with developmental disabilities. However, this and other issues have yet to be resolved.

This discussion is not intended to suggest that rates of payment and licensure policies for all ambulatory care services should be the same, nor that they should be established by a single agency, but rather that these policies and their implications should be examined in a comprehensive, system-wide fashion. Rate-setting and licensure could be used more effectively to improve quality and access in the Medicaid program and to encourage provider activities that advance important public health goals. These functions could promote utilization in higher-quality or more cost-effective settings. Instead, the administrative structure supporting the State's licensure and rate-setting activities appears to have had the opposite effect, with differentials in rates and licensure activities driving utilization, quality, and costs in an apparently arbitrary manner.

Program Development

The various offices within DOH, the DMH agencies, the Governor's Office, DOB, the Legislature, and, on occasion, other State agencies all play a role in the design and implementation of new programs within Medicaid, including expansions of coverage, new models of service delivery, and initiatives designed to improve outcomes while containing costs. In some cases, close communication and mutual interests have propelled implementation of new initiatives. In others, divergent priorities have stalled the development of new programs that cut across agency portfolios. In still others, the Legislature has pushed new initiatives through legislation or blocked agency proposals that require legislation.

Within DOH, the specialized offices have worked jointly with OMM to design and implement successful programs. For example, after the enactment of legislation creating the Family Health Plus program, the Office of Medicaid Management took the lead in designing the program but worked closely with the Office of Managed Care on managed care issues, and with the Division of Planning, Policy and Resource Development on incorporating facilitated enrollment of beneficiaries into the program. Once the program was established, the Office of Managed Care assumed the lead programmatic role, overseeing managed care plan contracts and consulting with OMM on eligibility and with the Division of Planning on enrollment issues. Similarly, the Center for Community Health has worked collaboratively with OMM on an expansion of coverage for women diagnosed with breast or cervical cancer and on the State's family planning benefit waiver.

The DMH agencies have actively worked to develop new Medicaid-reimbursed models of care that address the disability-related needs of their clients, and DOH has provided support for these efforts. OMRDD, for example, has developed the Options for People Through Services program, which provides individualized services to maximize independence and community integration. OMH has developed Personalized Recovery-Oriented Services to promote recovery by integrating treatment, support, and rehabilitation. And OASAS has developed a new chemical dependency treatment model for adolescents. All of these programs are supported at least in part by Medicaid funds. In every case, the DMH agencies consulted with DOH on federal requirements related to program design, and DOH helped shepherd the program through the federal approval process.

Interagency collaboration has not been as fruitful, however, in addressing issues that require more than one agency to actively and jointly develop and institute policy changes. Specifically, the State has been working for several years to address the diverse needs of high-cost Medicaid beneficiaries, especially those who receive care through multiple systems. Analysis of Medicaid data reveals that 24 percent of New York's Medicaid beneficiaries are generating 78 percent of the program's cost;⁷⁰ many of that 24 percent are recipients of long-term care provided by DOH-licensed entities and clients of the AIDS Institute, OASAS, OMH, and/or OMRDD. Many of these clients tend to use services in a number of systems, regulated by different agencies. A high-cost beneficiary might, for example, have co-occurring mental illness, chemical dependency, and a chronic physical condition, such as diabetes or HIV, and in any given year might use services licensed and reimbursed by OMH and OASAS, as well as by DOH (e.g., acute general hospital, emergency care, and pharmaceuticals).

OMM brought this cost and utilization data to the attention of the DMH agencies, DOB, and the Governor's staff. The Governor's staff convened interagency meetings and asked the agencies to peel back the layers of data with the goal of developing initiatives to coordinate services, reduce excessive hospitalizations, and promote better health outcomes. This exercise became known as "the Onion Analysis." To date, the agencies have responded with discrete actions, generally within the confines of their own portfolios. No agency or individual is accountable for the full range of services used by high-cost beneficiaries, the associated expenditures, and the health outcomes that result.⁷¹

Another example of the effect of distributing authority among several agencies without effective coordination can be seen in the evolution of the mandatory Medicaid managed care program. Until recently, all seriously and persistently mentally ill (SPMI) beneficiaries have been exempt from mandatory enrollment in Medicaid managed care plans. When the Governor's office, in consultation with DOH, decided to expand mandatory managed care enrollment to Supplemental Security Income (SSI) beneficiaries with serious mental illness, decisions had to be made about the scope of their benefit package. Under the voluntary managed care program, behavioral health services were carved out of the benefit package for enrollees receiving SSI. Through negotiations between DOH and OMH, a decision was

made to continue the carve-out for the SSI population and maintain behavioral health services as fee-for-service benefits. In addition, the agencies agreed to exempt SPMI beneficiaries who are *not* receiving SSI from mandatory enrollment. One rationale offered for the exemption was to avoid disruption of established relationships with behavioral health providers. However, if SPMI beneficiaries who are not receiving SSI voluntarily enroll in managed care, they will access their behavioral health care through their managed care plan's benefit package regardless of their established relationships. The decision to require some, but not all, SPMI beneficiaries to enroll in managed care plans, and to include behavioral health services in the managed care benefit package for some of these beneficiaries but not others, was, according to some of those interviewed, a compromise between the two agencies.

While DOH and the DMH agencies have a programmatic interest in developing models that link the delivery of physical and behavioral health services, none has the expertise or authority to do so single-handedly. Similarly, the Governor's staff and DOB are motivated to address these issues, but have not been able to develop or implement a comprehensive solution.

Along with the agencies, the Legislature plays an important role in program development, both by pushing the agencies to implement new programs and by rejecting or shaping agency initiatives that require legislation. Responding to stakeholder advocacy, it has enacted legislation requiring programmatic changes that were not initially advanced by the Executive Branch. For example, the Legislature directed implementation of the Nursing Home Transition and Diversion Waiver to encourage the delivery of DOH-supervised long-term care services in the most integrated setting. In addition, the Legislature enacted legislation to create a Medicaid buy-in program for workers with disabilities, and to promote streamlining of the Medicaid application and renewal process. On the other hand, the Legislature has also responded to stakeholders by blocking certain agency proposals to restructure the delivery of Medicaid-funded services or reduce provider reimbursement.

As described above, the allocation of responsibilities among several offices within DOH and among several agencies and the Legislature has both encouraged innovative program development and hindered the formulation of coherent policies that take into account program-wide implications. In an effort to encourage interagency coordination on Medicaid issues, legislation was enacted as part of the 2006-07 State budget that requires quarterly meetings of the commissioners of all State agencies primarily involved in the administration of Medicaid-funded programs, and representatives of local social services districts.⁷² Through these meetings, the agencies are directed to identify collective priorities for the Medicaid program and ways to contain costs and improve the quality of services.⁷³ It is too soon to measure the impact of this legislation.

Conclusions

The administration of New York's Medicaid program is undertaken by dedicated public servants doing their utmost to ensure access to health care services for people who would otherwise have little or no access to them, and to sustain a viable delivery system to serve both those in the program and the general public. The perspectives and expertise of these public servants are inevitably determined by the missions and cultures of the agencies that employ them. In New York, administrative responsibilities are dispersed among multiple agencies, organizational units within agencies, and the Legislature, where multiple missions abound.

While DOH is the designated single state agency, and is accountable to the federal government and the general public for the operation of the Medicaid program, it has complete control over only a portion of the program. For good reasons, administrative responsibilities have been dispersed among agencies and within DOH. The allocation of significant responsibility to the DMH agencies has enhanced the services and strengthened the delivery systems available to discrete populations. But it has also presented challenges for establishing and implementing program-wide priorities, coordinating agency activities, and resolving interagency disputes.

An administrative structure that facilitates a more coherent and integrated approach to the program and the needs of its beneficiaries would improve individual health outcomes, the public health, the financial stability of the State's delivery system, and the value derived from New York's Medicaid dollars. The challenge is to develop and implement a comprehensive vision for Medicaid in New York State without stifling the creativity, advocacy, and expertise of the specialized agencies.

Notes

- 1 Unless the context indicates otherwise, references to “Medicaid” throughout this report are intended to include New York’s Family Health Plus program, as well as the standard Medicaid program. New York State Department of Health. *Monthly Medicaid Eligibility Reports*, January–May 2006. Accessible online at http://www.health.state.ny.us/nysdoh/medstat/el2006/mo_06_el.htm
- 2 Centers for Medicare & Medicaid Services. *Medicare State Enrollment Report 2005*. Accessible online at <http://www.cms.hhs.gov/MedicareEnRpts/Downloads/05All.pdf>
- 3 42 U.S.C. §1396a(a)(10), 1396d(a), 42 C.F.R. §§440.210–44.225.
- 4 42 U.S.C. 1396a.
- 5 Kaiser Family Foundation. *State Medicaid Fact Sheets: State Lows and Highs*. Accessible online at <http://www.kff.org/mfs/hl.jsp>
- 6 42 U.S.C. §§1396a(a)(5), 1396a(a)(33), 1396a(a)(61), 1396b(q)(6).
- 7 New York State Department of Health. May 2006. *Number of Medicaid Eligibles by Category of Eligibility by Social Services District*. Accessible online at http://www.health.state.ny.us/nysdoh/medstat/el2006/2006-05_eligibles.htm; New York State Division of the Budget. *2006-07 Enacted Budget Report*. Accessible online at http://www.budget.state.ny.us/pubs/enacted/2006-07_Enacted_Budget.pdf
- 8 Birnbaum M. 2005. *Medicaid in New York: A Primer*. New York: United Hospital Fund.
- 9 Legislation enacted in 2005 capped the local share of Medicaid based on each county’s calendar year 2005 Medicaid expenditures, increased annually thereafter by a statutory trend factor. In 2008 and beyond, counties have the option of contributing a fixed percentage of their local sales taxes rather than paying the cap amount. See Bachrach D and MS Burghardt. 2006. *Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation*. New York: United Hospital Fund.
- 10 According to a survey by the Centers for Disease Control and Prevention, 17 percent of adults in New York report having a condition that interferes with daily activities or requires the use of equipment. National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention. 2005. *Behavioral Risk Factor Surveillance System, 2005*, as cited in *Kaiser State Health Facts*. Accessible online at <http://apps.nccd.cdc.gov/brfss/list.asp?cat=DL&yr=2005&qkey=4000&state=All>
- 11 Birnbaum M. 2005. *Medicaid in New York: A Primer*, 6. Nationally, more than half of non-elderly adult Medicaid beneficiaries have a chronic condition, and over one-fourth have two or more chronic conditions. In comparison, less than one-third of persons with employer-provided coverage have a chronic condition, and only 10 percent have two or more chronic conditions. Cunningham P. April 2002. *Affording Prescription Drugs: Not Just a Problem for the Elderly*. *Center for Studying Health System Change Research Report No. 5*.
- 12 New York State Division of the Budget. July 31, 2006. *New York State 2006-07 Financial Plan First Quarterly Update, 2-3*.
- 13 New York State Division of the Budget. All figures in this section include State, federal, and local shares.
- 14 New York State Division of the Budget. The state share of these dollars (approximately \$3 billion) is appropriated in the OMRDD budget, while the federal share is appropriated in the DOH budget. The local share of Medicaid, although reflected in the \$6.8 billion spending estimate, is not appropriated in the State budget.
- 15 New York State Office of Mental Retardation and Developmental Disabilities. January 2006. *Fiscal Year 2006-07 Budget Briefing Booklet*.
- 16 New York State Division of the Budget. The state share, approximately \$980 million, is appropriated in the OMH budget, and the federal share is appropriated in the DOH budget.
- 17 New York State Office of Mental Health. *2005-2009 Statewide Comprehensive Plan for Mental Health Services*, 13.
- 18 New York State Division of the Budget. The state share, estimated at \$50 million, is appropriated in the OASAS budget, while the federal share is appropriated in DOH.

- 19 New York State Office of Alcoholism and Substance Abuse Services, Division of Financial, Capital and Information Technology Management. *Percent of Medicaid Persons in Treatment by County of Residence and Statewide, FFY 2003-04 and 2004-05.*
- 20 New York State Office of Alcoholism and Substance Abuse Services. 2006. *Sources of Payment for OASAS Services.* Accessible online at <http://www.oasas.state.ny.us/admin/hcf/sourcechart.cfm>
- 21 Home and Community-Based Services Waiver "Bridges to Health" (B2H). Accessible online at <http://www.ocfs.state.ny.us/main/b2h>
- 22 New York State Division of the Budget.
- 23 New York State Division of the Budget.
- 24 Centers for Medicare & Medicaid Services. Sept. 29, 2006. *Special Terms and Conditions, Federal State Health Reform Partnership, Medicaid Section 1115 Demonstration.*
- 25 42 U.S.C. §1396b(q).
- 26 N.Y. Social Services Law §§366, 366-a.
- 27 N.Y. Social Services Law §365-a.
- 28 New York State Department of Health. 2003. *Strategic Priorities of the New York State Department of Health: Message from the Commissioner.* Accessible online at http://www.health.state.ny.us/commissioner/strategic_plan.htm
- 29 The organizational charts in these and subsequent figures are current as of October 2006.
- 30 Although not a Medicaid benefit, EPIC—the Elderly Pharmaceutical Insurance Coverage program—is also administered by OMM. The Department determined that because EPIC is similar to Medicaid’s pharmacy benefit, there are efficiencies to be gained in administering EPIC through OMM.
- 31 The hospital rates developed by OHSM also apply to payors of No Fault and Workers Compensation insurance benefits.
- 32 Although contracting authority for the Medicaid managed care program was shifted from counties to the State in 2005, New York City has retained this authority.
- 33 Executive Order No. 140-1. February 2, 2006. *Establishing the Office of Medicaid Inspector General*; see also Executive Order No. 140. August 5, 2005. *Establishing the Position of Medicaid Inspector General.*
- 34 2006 Laws of NY, Ch. 442.
- 35 Centers for Medicare & Medicaid Services. September 29, 2006. *Special Terms and Conditions, Federal-State Health Reform Partnership, Medicaid Section 1115 Demonstration.*
- 36 New York State Division of the Budget.
- 37 Medicare Part D is the prescription drug benefit program that commenced on January 1, 2006. HIPAA has required the implementation of new billing procedures and privacy rules that affect the State’s Medicaid claims system, State agencies, and Medicaid providers.
- 38 N.Y. Mental Hygiene Law §5.05.
- 39 The DMH agencies oversee physical health care services when they are provided to residents of State-operated inpatient programs and intermediate care facilities and when they are provided by certain clinics licensed under Article 16 of the Mental Hygiene Law.
- 40 N.Y. Mental Hygiene Law §13.01.
- 41 “An institution for the mentally retarded is not an institution for mental disease.” 42 C.F.R. §435.1009. See discussion at note 45.
- 42 N.Y. Mental Hygiene Law §701.

- 43 New York State Division of the Budget. *2006-07 Executive Budget—Agency Presentations, Office of Mental Health*, 148; Weddle B. 1998. *Mental Health in New York State, 1945-1998*. New York State Archives; see also *Overview of Mental Health in New York and the Nation*. New York State Archives. Accessible online at http://www.archives.nysed.gov/altformats/GuidesHistRecs/mh_timeline.pdf
- 44 New York State Office of Mental Health. January 2001. *Progress Report on New York's Public Mental Health System*, 5.
- 45 An IMD is a facility with more than 16 beds that is “primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.” 42 U.S.C. §1396d(a)(1); 42 C.F.R. §435.1008; Tremblay M and E Boyce. 2006. The Medicaid Institutions for Mental Disease Exclusion: Impact on New York State and Options for Reform. *Journal of Governmental Finance and Public Policy* July:58-59. Accessible online at <http://www.budget.state.ny.us/pubs/supporting/finPubPolicyJournal.pdf>
- 46 State psychiatric centers receive a portion of New York's Medicaid disproportionate share payment—federal funding that supports facilities serving a disproportionate share of “low-income people with special needs.” 42 U.S.C. §1396a(a)(13).
- 47 N.Y. Mental Hygiene Law §19.07.
- 48 New York State Office of Alcoholism and Substance Abuse Services. 2004. *Fast Facts. . . About the Addiction Treatment and Prevention System*.
- 49 New York State Constitution Article XVII, §4.
- 50 New York State Office of Mental Health. January 2001. *Progress Report on New York's Public Mental Health System*, 4.
- 51 Office of Alcoholism and Substance Abuse Services. *OASAS Overview*. Accessible online at <http://www.oasas.state.ny.us/pio/oasas.cfm>; OASAS Division of Financial, Capital and Information Technology Management. *Percent of Medicaid Persons in Treatment by County of Residence and Statewide, FFY 2004/05*.
- 52 See, e.g., 42 C.F.R. Parts 442, 482, 483, 484.
- 53 42 U.S.C. 1396a(a)(29).
- 54 The AIDS Institute also plays a major role in setting rates for HIV Special Needs Plans, AIDS adult day health programs, and specialized HIV/AIDS programs in hospitals and clinics.
- 55 N.Y. Public Health Law §2803.
- 56 A diagnostic and treatment center is an ambulatory care facility that is not part of an inpatient hospital facility. 10 N.Y.C.R.R. §751.1. For statutory rate methodologies and fees, see, for example, N.Y. Public Health Law §§2807, 2807-c, 2808; N.Y. Social Services Law §367-a.
- 57 See, for example, N.Y. Social Services Law §§367-q (increasing rates of payment for personal care providers), 367-T (increasing fees for emergency physician services), and N.Y. Public Health Law §3614(8) (increasing rates of payment for home health agencies).
- 58 An exception to this general approach occurred in 1997 when low premiums triggered the exodus of several managed care plans from the newly mandatory Medicaid managed care program. The Legislature appropriated funds for an increase in managed care premiums and enacted legislation prescribing a formula for allocating the funds. See N.Y. Social Services Law §364-j(21); 1996 Laws of N.Y. Ch. 433, §54.
- 59 Under federal regulations, Medicaid managed care premiums must be actuarially sound. 42 C.F.R. §438.6(c)(2). Under State law, DOH must consult with the State Insurance Department with respect to the establishment of managed long-term care premiums. N.Y. Public Health Law §4403-f(8).
- 60 N.Y. Public Health Law §2807(1)(g).
- 61 1995 Laws of N.Y. Ch. 81, §4. Federally qualified health centers, which are licensed as D&TCs in New York, are reimbursed at rates set in accordance with a federally mandated methodology. 42 U.S.C. 1396a(bb).
- 62 eMedNY. April 1, 2006. *New York State Medicaid Program Physician Fee Schedule*, 22-23, 56-57.

- 63 There are programmatic justifications for paying higher rates to D&TCs and hospital outpatient clinics than physicians. D&TCs and clinics generally provide enabling services such as interpreters and social work, have higher capital and overhead costs, and are subject to more stringent regulations than physician practices.
- 64 Rosenbaum S, P Shin, R Perez Trevino Whittington. June 2006. *Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative*, 19-20; New York State Governor's Health Care Reform Working Group. November 17, 2004. *Final Report*. Accessible online at http://www.health.state.ny.us/health_care/medicaid/related/health_care_reform/pdf/final_report.pdf
- 65 The significance of disparities in fee-for-service rates is mitigated to some extent by growing enrollment in Medicaid managed care plans.
- 66 14 NYCRR §588.13(a). Article 31 clinic rates vary based on location and the type and duration of the service. Certain OMH outpatient programs are eligible for a Comprehensive Outpatient Program supplement (COPS), which provides additional Medicaid reimbursement for a limited number of clinics that meet certain standards. 14 NYCRR Parts 588, 592. Others are eligible for a non-COPS Medicaid supplement. 14 NYCRR §588.13(g).
- 67 Oversight by different agencies has also resulted in disparate policies governing the services that are reimbursed. For example, Article 31 clinics, but not Article 28 D&TCs or outpatient clinics, may bill for mental health services provided by social workers. The one exception to this is federally qualified health centers, which are entitled to reimbursement for social work services under federal law.
- 68 14 NYCRR §551.13(b)(3).
- 69 Federally qualified health centers represent one exception to this rule. If they are licensed by both DOH and OMH, they are reimbursed at the rate set by DOH based on the federally mandated methodology.
- 70 New York State Office of Alcoholism and Substance Abuse Services. 2006. *State Concerns: DOH Medicaid Data 'Onion' Report*. This phenomenon is not limited to New York. Nationwide, elderly and disabled beneficiaries make up 26 percent of Medicaid enrollment and drive 64 percent of Medicaid spending. U.S. Department of Health and Human Services. *CMS Financial Report: Fiscal Year 2005*, 6.
- 71 One example of a joint agency effort to address this issue is an RFI recently released by OASAS and OMH concerning the management of co-occurring disorders. See, for example, New York State Office of Alcoholism and Substance Abuse Services. August 1, 2006. *Request for Information Re: Co-Occurring Coordinated Care Plan*.
- 72 2006 Laws of N.Y. Ch.57, §68-c; N.Y. Social Service Law §363-c.
- 73 2006 Laws of N.Y. Ch.57, §68-c; N.Y. Social Service Law §363-c.