New York State Medicaid: Achievements and Challenges Is this the model for the nation?

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United Hospital Fund

VISION

Quality health care and better health for every New Yorker

MISSION

United Hospital Fund works to build a more effective health care system for every New Yorker. An independent, nonprofit organization, we analyze public policy to inform decision-makers, find common ground among diverse stakeholders, and develop and support innovative programs that improve the quality, accessibility, affordability, and experience of patient care.

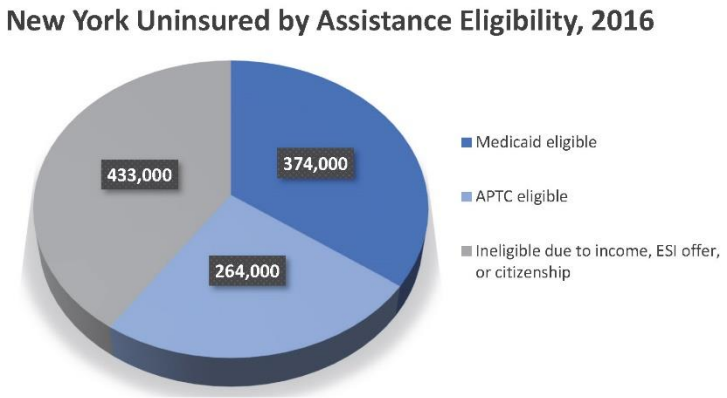
UHF's Unique Role in New York

- 140-year record of success stimulating innovation and improvement in how health care is organized, paid for, and used.
- Trusted independent source of information and analysis, tackling persistent and complex problems that require systemic solutions.
- Known for convening diverse stakeholders, finding common ground, and developing productive partnerships.
- Facilitated the creation of vital organizations at critical moments: from GNYHA, Empire BC/BS, NY Blood Center to the Primary Care Development Corporation, New York eHealth Collaborative, and National Quality Forum.
- Current staff of 42, with deep policy and program expertise across the continuum of health care.

Critical Challenges For New York Health Care

COVERAGE

Over 1 million New Yorkers remain uninsured

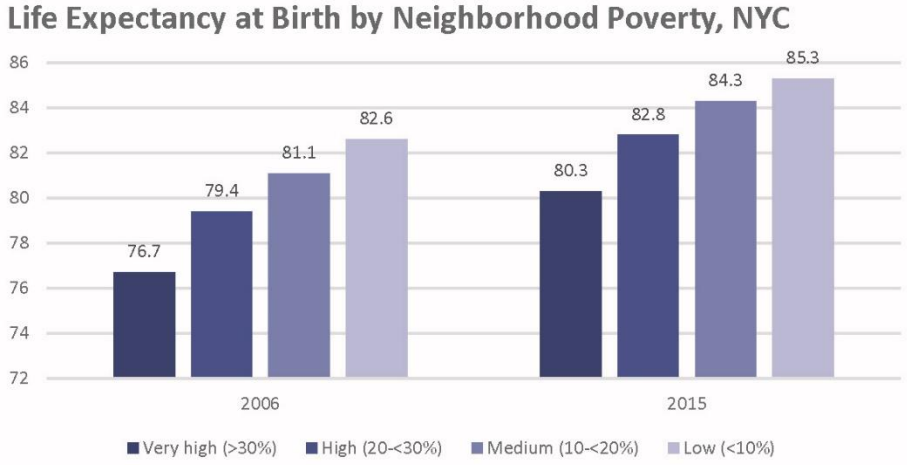


QUALITY

Uneven quality and patient experiences throughout the health system

HEALTH OUTCOMES

Wide disparities in health outcomes by neighborhood



UHF Programs in Coverage and Access

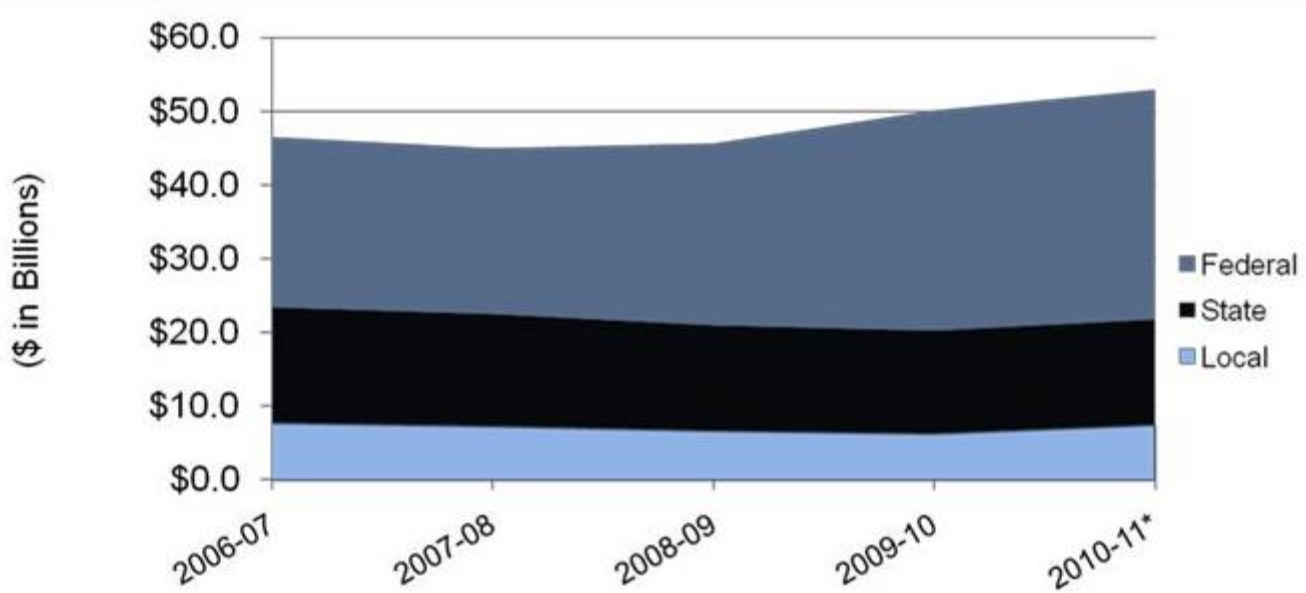
- **Medicaid Institute**
  - Protecting the health of low-income New Yorkers by supporting a strong Medicaid program in a changing health care payment and federal policy reform environment
    - Partnering on state efforts to redesign delivery systems and foster value-based payment
    - Identifying opportunities for improved health by focusing on related social needs
- **Health Insurance Project**
  - Promoting and protecting strong health insurance markets to foster affordable, effective health coverage for New Yorkers
    - Analyzing market trends and recommending policy changes
    - Assessing barriers to and opportunities for lower-income populations to get covered

Overview

- New York Medicaid Basics
- ‘Innovative’ Reforms
- Ongoing and Emerging Challenges
- New York in the National Context
- Crystal Ball

New York Medicaid Circa 2011

- $52.9 billion total spend
- Large numbers of enrollees and services outside managed care (only 3.4 million MMC enrollees)
- Limited cost containment options for state
  - Reduce enrollment
  - Eliminate services
  - Reduce provider payments



Beneficiaries	4,692,645	4,600,593	4,691,405	4,977,870	5,204,401
Cost/Beneficiary**	$8,749	$9,220	$9,466	$9,481	$9,158

New York Medicaid Today By the Numbers

- Second largest number of enrollees in the country (California)
- Historically the most robust program in terms of services provided and populations enrolled
- Among the highest spending states per enrollee

Total Beneficiaries October 2018	**6,041,819**
Managed Care	**4,678,688**
Fee-For Service	**1,363,131**
Adults Age 21-64	**3,069,226**
Dual-Eligibles	**901,505**
Total Expenditures (Estimated SFY 20)	**~$73 Billion**

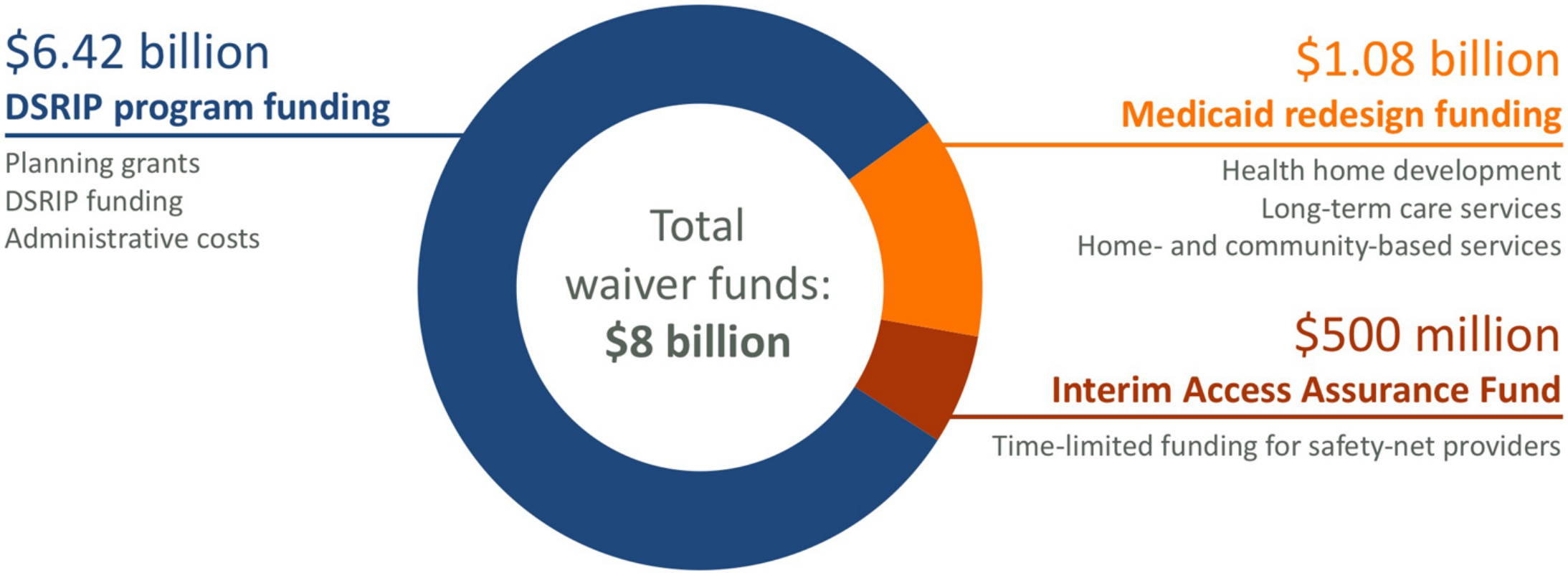
What Did NY Do? – Medicaid Redesign Team & Waiver

- Original Spring 2011 MRT Action-Plan was merely a framework
- 10 workgroups created detailed recommendations (July –November 2011) which were turned into hundreds of projects across multiple phases
- New projects have been added in the budget process each year and framed as MRT initiatives, despite the MRT proper not meeting after 2011
- Big initiatives (some requiring waivers/SPAs, others administrative)

Global Cap	MLTC	FIDA	BH Managed Care Transition
BIP	MFP	CFCO	Supportive Housing
Essential Plan	Basic Benefit Design		Care Management for All

Exhibit 1

Distribution of New York's 1115 Waiver Funds



Note: The federal Centers for Medicare and Medicaid Services and the state allocated an additional $1.83 billion to DSRIP, bringing total DSRIP funds to $8.25 billion. The state also is funding a $1.5 billion Capital Restructuring Financing Program for DSRIP.

Sources: Centers for Medicare and Medicaid Services, New York Partnership Plan Special Terms and Conditions, March 31, 2016; New York State Department of Health, Final DSRIP Valuation Overview, June 2015; and New York State Department of Health, Capital Restructuring Financing Program, April 2015.

Source: The Commonwealth Fund

Delivery System Reform Incentive Payment (DSRIP)

- What was it sold as?
  - Vehicle for reforming delivery system to deliver on MRT goals and move to VBP
  - Method for capturing re-investment of federal dollars from “savings” generated by other MRT initiatives
- What is it really?
  - Attempt to truly transform the way health care is delivered and paid for?
  - Set of specific projects that hold promise for reducing costs and/or transforming care delivery?
  - Complicated pay-for-performance program?
  - Promise to providers to recoup initial 2% across the board cuts?
  - Vehicle for freeing up other state dollars via designated state health programs?

How's DSRIP Going?...Depends on Who You Ask

- On track to reach 25% "avoidable hospitalizations" reduction
  - Major projects focus on patient centered medical home adoption and behavioral health integration
  - State created a series of side projects to help providers do quality improvement sprints to reduce avoidable hospitalizations
- 5th and Final Year Underway - $3.38 billion distributed to date
  - Lots of promising 'project' results – e.g., substantial PCMH growth
  - Some participants are truly transforming care delivery
  - Plans and community-based organizations still feel left out

What's Happening Now - Value-Based Payment

- Waiver required state to achieve robust VBP goals
- VBP Workgroup and Subcommittees (and KPMG) created Roadmap, including a subcommittee focused on social determinants and social services
- VBP Roadmap/goals in reality?
  - Path to financial sustainability for DSRIP participants/projects?
  - Heavily camouflaged 'stick' to get MCOs to meet waiver goals?
  - Overly complicated attempt to encourage Accountable Care Organizations?
  - Vehicle for health care to address social needs and pay for social services?

NYS Recognition of Social Determinants and Social Services

- New York DSRIP encourages providers to work with social-service CBOs on specific projects, especially population health improvements
- New York using Medicaid and other funding sources to provide supportive housing (though Medicaid can't pay for rent)
- VBP Roadmap requires MCOs/providers in shared-risk to contract with at least one CBO on at least one social need
  - De minimis requirement?
  - Examples to date focus on discrete projects to limit high hospital utilization?
- New Bureau of Social Determinant of Health in Medicaid

Challenges Piling Up

- Care management for all (aka managed care for most) still not totally implemented with cascading delays (school-based health services, children's behavioral health, individuals with developmental disabilities, etc.)
- DSRIP legal entities are not "providers" so they can't enter VBP contracts with MCOs - Must change structure to an Accountable Care Organization or Independent Practice Association to VBP contract
- VBP progress at 62% of managed care spend
- DSRIP portion of waiver expires in March 2020

What's Next in NY?

- What happens to unspent DSRIP funds?
- State working on concept for DSRIP renewal.
  - CMS Interested?
- Never-ending reform marathon
- $1-2 billion Medicaid budget deficit in FY20-21 (MRT 2.0)

Is NY Approach a Model for Other States?

- Managed care alone does not transform the payment or delivery system – It just changes who pays the bills and holds the risk
- Managed care implementation itself is difficult, moving MCO provider networks to value-based payment takes even more time
- Medicaid cost savings maybe unrealistic for some populations, e.g., children, dual-eligibles, individuals with disabilities
- Zero-sum game (beyond DSRIP) – Reforms require honesty about winners and losers

HHS/CMS/CMCS Administration

- Target on high-cost states like New York – Seema Verma
  - *"We need to ask serious questions about a system that…allows one state to spend nearly $45 thousand per person to care for the same category of enrollee that it costs another state less than $9 thousand."*
  - State scorecard to demonstrate whether *"the $558 billion spent on Medicaid is producing positive results"*
- Encouraging states to develop waivers including "community engagement" (aka work requirements) and block grants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What's Next

- Transition to robust VBP in New York (and elsewhere) will take a while
  - Smaller providers will struggle to participate
  - Many vulnerable populations will be left out
  - Slow transition to shared risk arrangements and CBO inclusion
- State strategies (e.g., block grants, work requirements) that undermine core purpose of Medicaid as a coverage program will wind up in the courts
- States will continue to innovate (e.g., North Carolina, Minnesota, Oregon, Washington) trying to improve care and reduce costs with different payment and delivery system models.
- Social determinants and coordination with social service CBOs will remain the buzz. On the ground successes will be highlighted, failures to launch, not so much.

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