Overview

- Where We Were – MRT Progress to Date
  - Total Medicaid Spending Over Time (SFY 03-13)
  - Quality Impact of MRT
- Where We Are – Current State of Medicaid
- Where We Are Going – Future State of the Medicaid Program
Where We Were

*MRT Progress to Date*
Where We Were

- In 2010 Medicaid reform was not on the agenda.
- Program was stuck in neutral, reform derailed by a harsh political climate and a deep recession.
- In 2011, Governor Cuomo changed the game by creating the Medicaid Redesign Team (MRT).
- The MRT developed a multi-year action plan – we are still implementing that plan today.
Major MRT Reforms Implemented

- **Cost Control**: Reduced Medicaid’s annual spending growth rate from 13% to less than 1%.

- **Global Spending Cap**: Introduced fiscal discipline to an out of control government program; focus on transparency with monthly report on spending.

- **Care Management for All**: Expanded existing and created new models of improved primary/coordinated care that will both improve outcomes and lower costs, moving Medicaid members from fee-for-service to managed care.

- **PCMH and Health Homes**: Investments in high-quality primary care and care coordination through major MRT reforms such as Patient Centered Medical Homes and the creation of Health Homes.
At its core, MRT was about trying to ensure that the Medicaid program was financially sustainable.

After years of out of control cost growth the state budget was no longer able to afford Medicaid driven budget problems.

MRT and its approach to cost containment was to launch many initiatives simultaneously with the goal being to both generate immediate cost savings while also launching multiple systemic reforms designed to generate future cost savings.

To date, the MRT fiscal impact has been staggering – billions of dollars have been saved.
Total Medicaid Spending Over Time
(SFY 03-13)
NYS Statewide Total Medicaid Spending (CY2003-2013)

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>2003</th>
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</thead>
<tbody>
<tr>
<td># of Recipients</td>
<td>4,267,573</td>
<td>4,594,667</td>
<td>4,733,617</td>
<td>4,730,167</td>
<td>4,622,782</td>
<td>4,657,242</td>
<td>4,911,408</td>
<td>5,212,444</td>
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<td>Cost per Recipient</td>
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<td>$9,257</td>
<td>$8,884</td>
<td>$8,504</td>
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*Projected Spending Absent MRT Initiatives was derived by using the average annual growth rate between 2003 and 2010 of 4.28%. Excluded from the 2013 total Medicaid spending estimate is approximately $5 billion in "off-line spending (DSH, etc.)
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NYS Statewide Total Medicaid Spending for All Categories of Service Under the Global Spending Cap (CY2003-2013)

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<td>4,910,528</td>
<td>$8,520</td>
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<td>5,211,559</td>
<td>$8,386</td>
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Quality Impact of MRT
New York has a well-established system to monitor quality of care for Medicaid managed care enrollees. Over time, measures have evolved from preventive care to measures of chronic care and outcomes.

Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.

The rates of performance have:

- *improved over time*;
- *met or exceeded national benchmarks*; and
- *seen a reduction in the gap in performance between Medicaid and commercial managed care.*
State of Quality: Medicaid

New York State Medicaid meets or exceeds the national average on most HEDIS measures

(HEDIS) Healthcare Effectiveness Data and Information Set

Data compiled from the 2011 NYSDOH Managed Care Plan Performance Report.
State of Quality: Medicaid

Most Medicaid readmissions for patients with mental health and substance abuse (MH/SA) conditions are for medical reasons.

All Readmissions* ($814M)

- Patients without MH/SA ($149M)
- Patients with MH/SA ($665M) 82%

Readmissions for Patients with MH/SA Conditions ($665M)

- MH/SA medical readmission ($395M) 59%
- MH/SA readmission ($270M)

*Readmissions within 30 day from original admission date
New York stayed about the same overall, with a rank of 19 compared to a rank of 18 in 2009.

The ranking for Access and Availability improved from a ranking of 22\textsuperscript{nd} in 2009 to 17\textsuperscript{th} in 2014.

For Avoidable Hospital Use and Cost, New York improved slightly from a rank of 36\textsuperscript{th} to a rank of 34\textsuperscript{th} in 2014.
Commonwealth State Scorecard
Results 2014 (continued)

- New York does well compared to other states in measures of Equity, or the measure of performance of vulnerable groups. New York currently ranks 7th in Equity, up from 12th in 2009.

- New York has shown improvement in improving health by reducing mortality, persons who smoke and persons who are obese. New York ranks 12th in the nation on Healthy Lives, up from 21st in 2009.
Overall, Managed Long-Term Care plans (MLTCs) are continuing to provide high-quality services to consumers in the areas of effectiveness of care and stability or improvement in managing activities of daily living.

Among the findings:

- The report shows that 88 percent of enrollees had no reported falls in the past six months.
- 81 percent of enrollees' ambulation was stable or improved over a six- or twelve-month follow-up period.
- 77 percent of enrollees were stable or showed improvement in the ability to manage their oral medication over the follow-up period.
- 84 percent of enrollees rated their MLTC good or excellent.
Where We Are

Current State of Medicaid
Big Reforms Ahead:
Agenda for the Next Six Months

- Nursing Home benefit being carved into managed care: August 2014
- FIDA – Fully Integrated Duals Advantage Program:
  - NYC/Nassau County: Voluntary enrollment begins on January 1, 2015 with passive in April 2015.
Big Reforms Ahead: Agenda for the Next Six Months

- HARP/Behavioral Health Carve-In
  - January 1, 2015—BH Adults transition in NYC
  - July 1, 2015—BH Adults transition Rest of State
  - January 1, 2016—BH Children transition Statewide
# Current Status of Medicaid Global Spending Cap

## Medicaid Spending – FY 2015

<table>
<thead>
<tr>
<th>Category of Service</th>
<th>Estimated</th>
<th>Actual</th>
<th>Variance Over / (Under)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Managed Care</td>
<td>$1,016</td>
<td>$999</td>
<td>($17)</td>
</tr>
<tr>
<td>Mainstream Managed Care</td>
<td>$750</td>
<td>$732</td>
<td>($18)</td>
</tr>
<tr>
<td>Long Term Managed Care</td>
<td>$266</td>
<td>$267</td>
<td>$1</td>
</tr>
<tr>
<td>Family Health Plus</td>
<td>$59</td>
<td>$62</td>
<td>$3</td>
</tr>
<tr>
<td>Total Fee For Service</td>
<td>$686</td>
<td>$677</td>
<td>($9)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$278</td>
<td>$276</td>
<td>($2)</td>
</tr>
<tr>
<td>Outpatient/Emergency Room</td>
<td>$36</td>
<td>$43</td>
<td>$7</td>
</tr>
<tr>
<td>Clinic</td>
<td>$56</td>
<td>$60</td>
<td>$4</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>$320</td>
<td>$307</td>
<td>($13)</td>
</tr>
<tr>
<td>Other Long Term Care</td>
<td>$73</td>
<td>$71</td>
<td>($2)</td>
</tr>
<tr>
<td>Non-Institutional</td>
<td>($77)</td>
<td>($80)</td>
<td>($3)</td>
</tr>
<tr>
<td>Medicaid Administration Costs</td>
<td>$38</td>
<td>$33</td>
<td>($5)</td>
</tr>
<tr>
<td>OHIP Budget / State Operations</td>
<td>$18</td>
<td>$7</td>
<td>($11)</td>
</tr>
<tr>
<td>Medicaid Audits</td>
<td>($35)</td>
<td>($32)</td>
<td>$4</td>
</tr>
<tr>
<td>All Other</td>
<td>$315</td>
<td>$344</td>
<td>$29</td>
</tr>
<tr>
<td>Local Funding Offset</td>
<td>($709)</td>
<td>($709)</td>
<td>$0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$1,388</td>
<td>$1,381</td>
<td>($7)</td>
</tr>
</tbody>
</table>

- Total State Medicaid expenditures under the Medicaid Global Spending Cap for FY 2015 through April are $7 million or 0.5 percent under projections. Spending for FY 2015 resulted in total expenditures of $1.38 billion compared to the projection of $1.39 billion.
Global Cap Risk Factors

- ACA enrollment – We are now serving more people than ever before: 6,269,841 (for Calendar Year 2013).

- $300 million contribution to the financial plan (tax cut) and $445 million transfer to the Mental Hygiene Stabilization Fund.

- Full implementation of Wage Parity in NYC for SFY14-15 is $420 million. The distribution is as follows:
  - MLTC Risk Rates - $225M; MLTC Mandatory Rates - $75M; Fee-For-Service - $50M; Quality Incentive Vital Access Provider Pool (QIVAPP) - $70M

- Complex year with lots of “puts and takes.” Need to monitor very closely.
Where We Are Going

Integrated Delivery and Meaningful Accountability
Health Care Delivery – Current State

- Silos
- Provider Centered
- Un-coordinated
- Limited Health Information Sharing
- Little meaningful accountability for results
- Under-investment in primary and preventative care
- System fails those most in need the most often
- Health care infrastructure doesn’t match community need
Health Care Delivery – Future State

- Focus on Results
- Payments are based on providing value to patients
- Providers from across the spectrum work together as a team
- Health care infrastructure is re-balanced, meets community need
- Integrated
- Patient Centered
- Care Is Coordinated
- Care is Accountable
Why Do We Have This System?

- The health care delivery system we have is a direct result of how we purchase and regulated health care services.
- Historically, we have rewarded institutional care and under-valued primary/preventative care.
- Reimbursement decisions were made to protect and retain providers and not ensure patient-centered care.
- Both the reimbursement and regulatory systems were “input focused” not “outcome focused” – less than $300 million out of the $50 billion plus Medicaid budget was based on performance.
DSRIP: Seed Capital for the New Delivery System: Performing Provider Systems

- DSRIP is not an ends but a means.
- Historic opportunity to build the delivery system of the future.
- We can’t see DSRIP as a means for preserving the present or returning to the past. It must be about building the future.
- What is the future? It’s up to each community to define its exact future. DSRIP is a tool for building that future.
- That said DSRIP is seed money with strings. Performing Provider Systems will need to perform and failure will have real consequences.
DSRIP: How Does It Fit Into Broader Medicaid Redesign

- DSRIP is the culmination of the MRT action plan.
- Redesign, without the waiver, had its limits.
- Care Management for All and the Global Spending Cap changed the program’s trajectory by improving outcomes and controlling costs but it did not address the underlying challenges facing health care delivery for Medicaid members.
- DSRIP creates the opportunity to fundamentally restructure delivery to achieve the system we need while also ensuring its long term sustainability.
**Five Years in the Future**

**How The Pieces Fit Together: MCO, PPS & HH**

- **MCO***
  - Insurance Risk Management
  - Payment Reform
  - Hold PPS/Other Providers Accountable
  - Data Analysis
  - Member Communication
  - Out of PPS Network Payments
  - Manage Pharmacy Benefit
  - Enrollment Assistance
  - Utilization Management for Non-PPS Providers
  - DISCO and Possibly FIDA/MLTCP Maintains Care Coordination

- **Other Providers**
- **PPSs**

- **HH #1**

- **HH #2**

- **Other PPS Providers**

- **ROLE:**
  - Care Management for Health Home Eligibles
  - Participation in Alternative Payment Systems

*Mainstream, MLTC, FIDA, HARP & DISCO*
Achieving the Future State: Much Work to Be Done

- Communities across the state need to come together to form sustainable Performing Provider Systems (PPSs) committed to improving patient care and achieving true integration.

- Medicaid Managed Care needs to be redesigned with more focus applied to meaningful payment reform and increased expectation around improved patient outcomes in ways aligned with DSRIP goals.

- Integrated care will likely mean some consolidation. Consolidation should lead to great financial sustainability but it can’t mean a loss of cultural competence.

- Other “heavy lift” reforms – FIDA and HARP as two examples – must be successfully implemented because they are essential building blocks for the future state.
We Are All In This Together!

**DSRIP e-mail:**
dsrip@health.state.ny.us

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