



240 West 35th Street ■ Suite 302 ■ New York, New York 10001

Public Comment Submitted to the Medicaid Redesign Team II

March 2, 2020

Andrew S. Rein, President, Citizens Budget Commission

Thank you for the opportunity to comment. I am Andrew Rein, President of the Citizens Budget Commission. CBC is nonprofit, nonpartisan think tank dedicated to achieving constructive change in the finances and services of New York City and New York State government.

CBC has supported reconvening a Medicaid Redesign Team (MRT) since October 2019, shortly after it was revealed that Medicaid costs were significantly higher than budgeted and on an unsustainable trajectory. We support the MRT's goal, and recognize identifying \$2.5 billion in State-share Medicaid savings—an almost 10 percent reduction in the Medicaid budget—is ambitious and will be challenging to implement fully within one fiscal year. We recommend the Governor and Legislature also identify other savings options since Medicaid reductions need not fill the entire Medicaid-related gap in the short run if other options would minimize negative impacts on New Yorkers.

While the State was largely successful in restraining Medicaid spending growth from 2011 to 2017, significant and accelerating growth has returned. Reconvening the MRT within the fiscal year 2021 budget process presents an opportunity to improve Medicaid's fiscal management, including changes to the Medicaid Global Cap (the Cap), and to restructure the program to target resources to New Yorkers most in need. In order to promote these goals, CBC offers these recommendations to the MRT and hopes they also guide State leaders when adopting the fiscal year 2021 budget:

Improve the Medicaid Global Cap

1. Make the Global Cap global by including all spending. All Medicaid costs should be accounted for and managed within the Cap. Since its introduction in 2011, the Medicaid Global Cap was focused on limiting growth of State-share Medicaid spending overseen by the Department of Health. It has not included Medicaid spending by other State agencies, and over time billions of dollars have been exempted from the Cap (including the cost of the local takeover, minimum wage increases, and the Essential Plan), limiting its utility as a fiscal management tool.¹ Furthermore, some programs and costs have been shifted into and out of spending subject to the Cap, resulting in adherence to the Cap through accounting manipulation rather than true spending restraint.

Although some spending items outside the Cap are the result of broad policy choices (such as minimum wage increases), these are State obligations that should be sustainably funded and managed under a reasonable cap.

2. Make the Global Cap a cap by following accounting principles. Medicaid spending for purposes of the Cap should be accounted for on a modified accrual basis in accordance with generally accepted accounting principles (GAAP).² The State “adhered” to the Cap in fiscal year 2019 by deferring \$1.7 billion of payments for three days into the next fiscal year. This “adherence” was possible because the State budgets, and generally reports, on a cash rather than GAAP basis. Cash-based accounting also obscured the fact that spending was rising beyond what was budgeted at an unsustainable rate, demonstrating that the Cap is such in name only. Spending under modified accrual accounting would be recorded when services are rendered rather than when funds are disbursed, precluding the use of payment deferrals to adhere to the Cap.
3. Choose the right cap. Indexing Medicaid spending to the rolling average of medical inflation is a sound strategy and metric for growth. The State should consider two refinements. First, to provide appropriate discipline for specific portions of the Medicaid program, components of the program could be indexed to related components of medical inflation. Because long-term and personal care services are the components driving the greatest spending growth, they can be managed relative to indexed growth on disaggregated inflation measures for nursing homes, home care, or other components reported by the Bureau of Labor Statistics. Second, the Cap could be adjusted for enrollment changes; the Cap could be lowered when enrollment declines or raised to accommodate external shocks (such as enrollment growth due to economic recession or a public health emergency) under strict rules, assuming resources are available to fund temporarily higher spending. Focusing on cost per enrollee, particularly specific categories of enrollees, could also be an effective tool for promoting cost-effective strategies of care management.
4. Adhere to and improve the law requiring Medicaid spending transparency. Significant obfuscation in reporting of Medicaid expenses preceded the March 2019 payment deferral and January 2020 convening of the MRT. State law requires monthly updates in a “timely manner,” yet other than in June 2019, the State did not publish monthly Cap updates from December 2018 through January 2020.³ These reporting gaps prevented the public from seeing how the program was growing, in total or by specific component, which enabled the State’s delay in acknowledging and addressing the Medicaid spending gap. These reports should be published monthly and the requirements for their contents enhanced. The State should again publish the Medicaid Statistical Reports that were discontinued after 2014.⁴ Data also should be added to monthly reports that present:
 - Costs associated with local, state, and federal funds;
 - Costs by State agency;
 - Aggregate costs and utilization by category of service;
 - Unit costs by category of service (per claim and per unique beneficiary for fee-for-service claims and managed care encounters);
 - Unit costs for any claim type that has an annual cost of \$100 million or more (per claim and per unique beneficiary for fee-for-service claims and managed care encounters);
 - Costs of supplemental payment programs;

- Administrative costs (State workforce costs and contracted costs);
- Costs of approved managed care rate components (medical services, administration, quality pools, minimum wage, and others); and
- Enrollment by type (youth, adult, aged, disabled, and others) and average cost per enrollee by type.

The Department of Health should be at the forefront of transparency, but other State officials also have the capacity to report publicly on the Medicaid program. The Office of the State Comptroller recently added new exhibits to monthly cash reports to summarize Medicaid spending. The Legislature has access to Medicaid data; the 2014 amendment to the Global Cap statute guarantees the Legislature access to data and data training from the Department of Health.⁵ The Legislature should be fully utilizing its access to track the program and to be a partner in transparency. Public stakeholders also should have access to cross-tabular, longitudinal spending, and utilization data disaggregated on the basis of geography, demographics, and other categories. Public data should be as detailed as possible without compromising enrollee privacy.

Constrain Costs

- 1) *Focus on areas with high growth rates or extraordinary spending levels.* Priority should be placed on savings in areas with large and rapid spending growth. Several initiatives have already been identified for “course correction” by the MRT. These include:
 - a) *Long-term care:* Long-term care represents an increasing share of the Medicaid budget each year, now consuming nearly half of the Medicaid budget.⁶ Enrollment, price, and utilization of long-term care and personal care services are high and will continue to grow. Daily nursing home costs in New York are approximately 50 percent higher than the national average, and increased minimum wage levels will continue to drive higher spending in home and community-based services.⁷ Long-term care costs also are exceptionally high in New York due to eligibility rules that allow many non-indigent residents to qualify for the relatively generous benefits. One such provision is so-called “spousal refusal;” its repeal has been proposed in each Executive Budget since fiscal year 2011 and would yield growing savings in long-term care, but it has been repeatedly rejected by the Legislature.⁸ In addition, there should be a focus on improving efficiency in ways that minimize service reductions, including savings from care redesign and labor productivity from work rule and benefit changes.⁹
 - b) *Health homes:* After health homes launched in 2011, the cost for this care coordination model rose to \$500 million in the first five years and continues to grow. The program has not been comprehensively evaluated, despite its rapid cost growth. The differing benefits to subpopulations enrolled in the program are unknown and should be examined to identify potential savings.
 - c) *Consumer Directed Personal Assistance Program (CDPAP):* The Executive Budget Briefing Book identified rising costs in the CDPAP as one of the drivers of growth in Medicaid.¹⁰ The Empire Center has noted that New York’s personal care spending per capita was more than six times greater than the national average in 2016, and per-capita costs have doubled since then.¹¹ A prompt retrospective evaluation should assess whether these costs are appropriate, if high CDPAP

costs are being offset by lower costs elsewhere in Medicaid, and what program eligibility or other service-level parameters should change.

- 2) *Target supplemental payments based on need.* Medicaid payments vary among providers. This is especially true among hospitals; certain “safety net” hospitals are heavily reliant on below-cost reimbursements from Medicaid. The State fully leverages available federal funding for supplemental payments to cover portions of financial losses associated with serving Medicaid patients, but the State’s allocations of supplemental payments are not sufficiently sensitive to the financial condition of hospitals. Supplemental payments should be better targeted to hospitals in order to promote equity and reduce total costs. ¹²
- 3) *Avoid misguided actions.* The MRT should avoid shortsighted cuts to programs that reduce long-term costs and improve quality of care, such as incentive programs that have a proven positive impact on quality and cost reduction. In addition, the budget should not supplant program spending with capital grants or off-budget shifts as an accounting maneuver to avoid budgetary spending limits.

Do Not Raise Health Care Taxes

The current budget gap is a spending growth, not a revenue shortfall, problem. The State should not raise health care taxes. These taxes are passed on to New Yorkers as higher health insurance premiums. Healthcare taxes already raise billions of dollars, increasing health insurance premiums paid by the average commercially insured family in New York \$1,000 per year. ¹³

CBC supports the MRT and looks forward to sensible recommendations from your work. In recent years CBC has urged better accounting in Medicaid, convened stakeholders to discuss emerging issues you now are considering, and highlighted inequities in Medicaid payments. ¹⁴ We urge you to identify sound savings strategies, and to recommend a better Medicaid budgeting framework to avoid the financial management issues of the recent past.

Even after the MRT’s recommendations, the State’s health system will continue to face challenges of fiscal sustainability, quality, and access. The lessons from the past are clear: despite the accomplishments of the first MRT and the federal five-year Delivery System Reform Incentive Payment (DSRIP) program, Medicaid costs are not on a permanently sustainable path and the health system remains in many ways largely untransformed. The State should not waste this opportunity to create a path to fiscal sustainability and health quality. Once the State has addressed the current Medicaid deficits, it should set up an accountable structure that develops a long-term strategy to improve both the state’s Medicaid program and health delivery system overall.

Thank you. I welcome the opportunity to answer your questions.

¹ See Sections 91 and 92 of Part H of Chapter 59 of the Laws of 2012 as amended by Section 1 of Part D of Chapter 57 of the Laws of 2019.

² The State should adhere to GAAP budgeting principles overall and the deferral of Medicaid spending highlights the weakness of budgeting on a cash basis. See: Robert J. Freeman and Craig D. Shoulders, *Modified Accrual: Decision-Useful & Accountability-Centered* (Government Finance Review, August 2010), www.gfoa.org/sites/default/files/GFR_AUG_10_18.pdf.

³ See Sections 91 and 92 of Part H of Chapter 59 of the Laws of 2012 as amended by Section 33-a of Part C of Chapter 60 of the Laws of 2014; and New York State Department of Health, “Monthly and Regional Global Cap Updates” (January 2020), www.health.ny.gov/health_care/medicaid/regulations/global_cap/.

⁴ New York State Department of Health, “Medicaid Statistics” (November 2013), www.health.ny.gov/health_care/medicaid/statistics/.

⁵ See Section 33-a of Part C of Chapter 60 of the Laws of 2014.

⁶ Long-term care comprised 44.1 percent of the Global Cap budget in fiscal year 2015, and rose each year to an estimated 47.6 percent of the budget last year. See: New York State Department of Health, *Medicaid Global Spending Cap Report: March 2015* (April 2015), p. 3,

www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2014-2015/docs/march_2015_report.pdf; and *Medicaid Global Spending Cap Report: April 2018* (May 2018), p. 3 www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2018-2019/docs/apr_2018_report.pdf.

⁷ See Marc A. Cohen, Ph.D., Co-Director, LeadingAge LTSS Center, “Financing Long-Term Care: Challenges, Opportunities and Financing Alternatives” (presentation to New York State Long Term Care Planning Project, Albany NY, October 25, 2019), www.health.ny.gov/facilities/long_term_care/planning_project/; and New York State Senate Democratic Majority, *Staff Analysis of the 2020-2021 Executive Budget* (January 2020), p. 47, www.nysenate.gov/sites/default/files/article/attachment/staff_analysis_of_the_2020-21_executive_budget.pdf.

⁸ David Friedfel, “Legislators Refuse to End Medicaid Spousal Refusal” (*Citizens Budget Commission Blog*, February 2016), <https://cbcny.org/research/legislators-refuse-end-medicaid-spousal-refusal>; and New York State Department of Health, “MRT Budget Information” (July 2019), www.health.ny.gov/health_care/medicaid/redesign/mrt_budget.htm.

⁹ See Patrick Orecki, *Options for Enhancing New York's Health Home Initiative* (Citizens Budget Commission, May 2018), <https://cbcny.org/research/options-enhancing-new-yorks-health-home-initiative>.

¹⁰ New York State Division of the Budget, *FY 2021 Executive Budget Briefing Book* (January 2020), p. 65, www.budget.ny.gov/pubs/archive/fy21/exec/book/briefingbook.pdf.

¹¹ Bill Hammond, “A Medicaid benefit doubles in 4 years” (*Empire Center NY Torch Blog*, February 2020), <https://www.empirecenter.org/publications/medicaid-benefit-doubles-in-4-years/>

¹² Patrick Orecki, “Medicaid Supplemental Payments: State Workgroup Makes Limited Progress on Part of the Problem” (*Citizens Budget Commission Blog*, February 2019), <https://cbcny.org/research/medicaid-supplemental-payments-0>.

¹³ This value represents the estimated statewide average impact of the HCRA Surcharge and HCRA Covered Lives Assessment on average employer-sponsored family plan premiums and Gold-rated premiums sold on the New York State of Health marketplace. Estimates are based on rate filings of commercial plans for 2020. Surcharge impacts are calculated by applying the HCRA Surcharge commercial rate of 9.63 percent to the portion of rates associated with hospital costs reported in the unified rate review exhibits. Covered Lives Assessment impacts are estimated by applying region-specific rates to approved rates approved by the Department of Financial Services for each plan. Increased health insurance premiums and taxes are generally passed to employees in the form of reduced wages or are paid directly by those purchasing coverage. These estimates will be presented as part of forthcoming research by CBC on the impacts of HCRA. See: New York State Department of Financial Services, “Rate Applications by Company” (accessed January 26, 2020), <https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company>; New York State Department of Health, “2020 Covered Lives/Assessments/Surcharges” (December 2019), www.health.ny.gov/regulations/hcra/gme/2020_surcharges_and_assessments.htm; and Section 2807-j of the Public Health Law; and Katherine Baicker and Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums* Working Paper 11160 (National bureau of Economic research, February 2005) www.nber.org/papers/w11160.pdf.

¹⁴ David Friedfel and Patrick Orecki, *Overdue Bills: Time to Face Reality of Rising Medicaid Costs* (Citizens Budget Commissions, October 2019), <https://cbcny.org/research/overdue-bills>; Patrick Orecki, *Challenges of Enhancing*

Effective Engagement of Community Based Organizations in Performing Provider Systems (Citizens Budget Commission, November 2017), <https://cbcny.org/research/challenges-enhancing-effective-engagement-community-based-organizations-performing>; *Options for Enhancing New York's Health Home Initiative* (Citizens Budget Commission, May 2018), <https://cbcny.org/research/options-enhancing-new-yorks-health-home-initiative>; *Options to Enhance the Coordination of Care for Dually Eligible Individuals in New York State* (Citizens Budget Commission, April 2019), <https://cbcny.org/research/options-enhance-coordination-care-dually-eligible-individuals-new-york-state>; "Medicaid Supplemental Payments: State Workgroup Makes Limited Progress on Part of the Problem" (*Citizens Budget Commission Blog*, February 2019), <https://cbcny.org/research/medicaid-supplemental-payments-0>; and Patrick Orecki and Charles Brecher, *A New Approach to Funding New York City Health+Hospitals* (Citizens Budget Commission, December 2019), <https://cbcny.org/research/new-approach-funding-new-york-city-health-hospitals>.