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Improving Medicaid Further In New York Is Challenging But Vital

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Medicaid is the largest single item in the New York State budget, comprising 34 percent of the $156 billion State budget adopted in April, so taxpayers have a major stake in ensuring its efficient operation. The State's Department of Health and its Medicaid Redesign Team have developed and implemented strategies that have yielded significant quality improvements and savings, but much more is needed. Longer-term improvements will be more difficult to achieve and yet will be crucial to maintaining the sustainability of this vital service at a time of ever-rising health care costs.

Medicaid, the joint federal-state program that finances medical care for low-income people, provides access to medical care for 6.3 million New Yorkers or nearly one-third the state's population. The program has been criticized historically as unnecessarily costly and as providing low-quality care. Not surprisingly it has been the target of recurring efforts at reform.

One of Governor Andrew Cuomo's early actions, after taking office in January 2011, was to appoint a Medicaid Redesign Team to design strategies to restrain Medicaid spending and improve the quality of the program's services. The Team is composed of 27 members from health care stakeholder groups and headed by Jason Helgerson, the Governor's Deputy Health Commissioner and Medicaid Director.

The Medicaid Redesign Team proposed more than 300 specific initiatives by 2015 and deserves recognition for its achievements. The Citizens Budget Commission released a report last month assessing the Team's strategies and the Department's progress in implementing them. Titled "What Ails Medicaid In New York, And Does The Medicaid Redesign Team Have A Cure?", the report finds that the initiatives have been successful in containing total program costs even with a one-third increase in enrollment due primarily to changes in funding and eligibility related to provisions of the federal Affordable Care Act of 2010. Average cost per enrollee between 2010 and 2014 declined 17 percent from $10,432 to $8,620, including declines in the more expensive categories of enrollees.

The redesign strategies involve more reliance on managed care, promotion of specific delivery models (Health Homes and Performing Provider Systems) with greater coordination of care, and use of value-based payments that create incentives for better outcomes rather than greater volume of care. Continued implementation and refinement of these strategies is expected to yield

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additional substantial recurring savings - with an annual savings target for state fiscal year 2020 of between $1.3 billion and $1.9 billion.

Realizing these benefits requires successful implementation of the strategies in coming years; however, full implementation will confront major challenges:

First, more progress is needed toward the goal of enrolling nearly all Medicaid-eligible individuals in managed care plans. About three-quarters of all enrollees are now in a managed care plan, but only about half of the total spending is through managed care organizations, because the most expensive groups - the elderly and disabled - are underrepresented. Further progress is hampered by the non-mandatory nature of the initiative for many people with extensive service needs including the dually eligible (Medicaid and Medicare) population.

Second, greater use of coordinated service delivery models is needed. Progress in the use of Health Homes to coordinate the care of those with multiple conditions is similarly hampered by the voluntary nature of the program. Since the initiative was launched in 2012, only about half of the 250,000 people intended to benefit have enrolled as Health Home members. The development of Performing Provider Systems, 25 newly formed coalitions that coordinate care for targeted populations in specific counties, is slowed by a need for coordination among multiple autonomous entities and the absence of preset policies for distributing funds from the lead agencies to other participating providers.

Third, design and implementation of the value-based payment strategy face complex technical issues in identifying appropriate measures, and require difficult policy choices about how to structure the at-risk portion of payments.

Current Medicaid reform policies in New York are headed in the right direction, and further gains should be pursued aggressively. They will need to overcome major challenges, but that should not deter this vital and productive effort to improve the quality and cost of Medicaid.