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CBC REPORT FINDS COST-EFFECTIVE NEW YORK STATE MEDICAID REFORMS FACE SERIOUS CHALLENGES IN MAKING CONTINUED PROGRESS

Significant Additional Gains Will Require Several Years and Continued Refinement of Reform Strategies

New York, NY – May 23, 2016 – The Citizens Budget Commission today released a report titled "What Ails Medicaid In New York, And Does The Medicaid Redesign Team Have A Cure?" The report describes and assesses the strategies of the Medicaid Redesign Team (MRT) and the progress of New York State Department of Health (NYSDOH) staff in implementing and refining them. It finds that the strategies have yielded significant savings and quality improvements, but realization of their full potential faces serious implementation challenges.

Medicaid, the joint federal-state program to finance 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; it comprises about one-third of the expenditures of the state's health care sector, which employs about 1.2 million people; and, it is funded by more than $60 billion of taxpayer money per year, half from state and local governments. The program has been criticized as unnecessarily costly and as providing low-quality care. Not surprisingly it has been the target of recurring efforts at reform. The most recent such initiative, the MRT stakeholder task force), was launched in 2011, and in 2012 it presented longer-term strategies for redesign. Staff of the NYSDOH have pursued those strategies and continue to develop and implement promising changes.

The report finds that the initiatives have been successful in containing total program costs despite a one-third increase in enrollment due primarily to changes in funding and eligibility rules and procedures 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 aged and disabled, as well as for other adults.

The redesign strategies are more reliance on managed care, promotion of delivery models of Health Homes and Performing Provider Systems (PPSs) 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 additional substantial recurring savings. The annual savings target for state fiscal year 2020 is between $1.3 billion and $1.9 billion, or about 2 to 3 percent of the estimated baseline.

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

- Substantial, but still partial, progress has been made toward the goal of enrolling nearly all Medicaid eligible individuals in managed care plans. Based on the most recent data, about three-quarters of all enrollees are in a managed care plan, but only about half the total spending is via 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. In addition, those with developmental disabilities require new models of managed care that are still in development.

- 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 the 250,000 people intended to benefit have enrolled as Health Home members. New efforts are needed to improve outreach and enrollment practices and to provide clear guidelines and standards for coordination of care by the organizations.
- The development of PPSs, 25 newly formed coalitions which 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.
- The design and implementation of the value-based payment strategy faces complex technical issues in identifying appropriate measures, and requires difficult policy choices about how to structure the at-risk portion of payments. Movement to the most desired forms of payment involving provider risk for a range of services is likely to be slow – with substantial progress after 2020.

“Current Medicaid reform policies are headed in the right direction,” said CBC President Carol Kellermann. “They have already achieved notable quality improvements and savings.”

“Significant additional gains are possible,” said Charles Brecher, CBC’s Director of Research, “but they will require several years and continued refinement in the strategies to realize their full potential.”

The full report is available at www.cbcny.org. For further information, contact Kevin Medina at kmedina@cbcny.org or 212-279-2605 x342.