Community Health Foundation of Western & Central New York

New York's Actions for Improving Quality, Improving Health and Reducing Costs

The 19th Princeton Conference
Council on Health Care Economics & Policy
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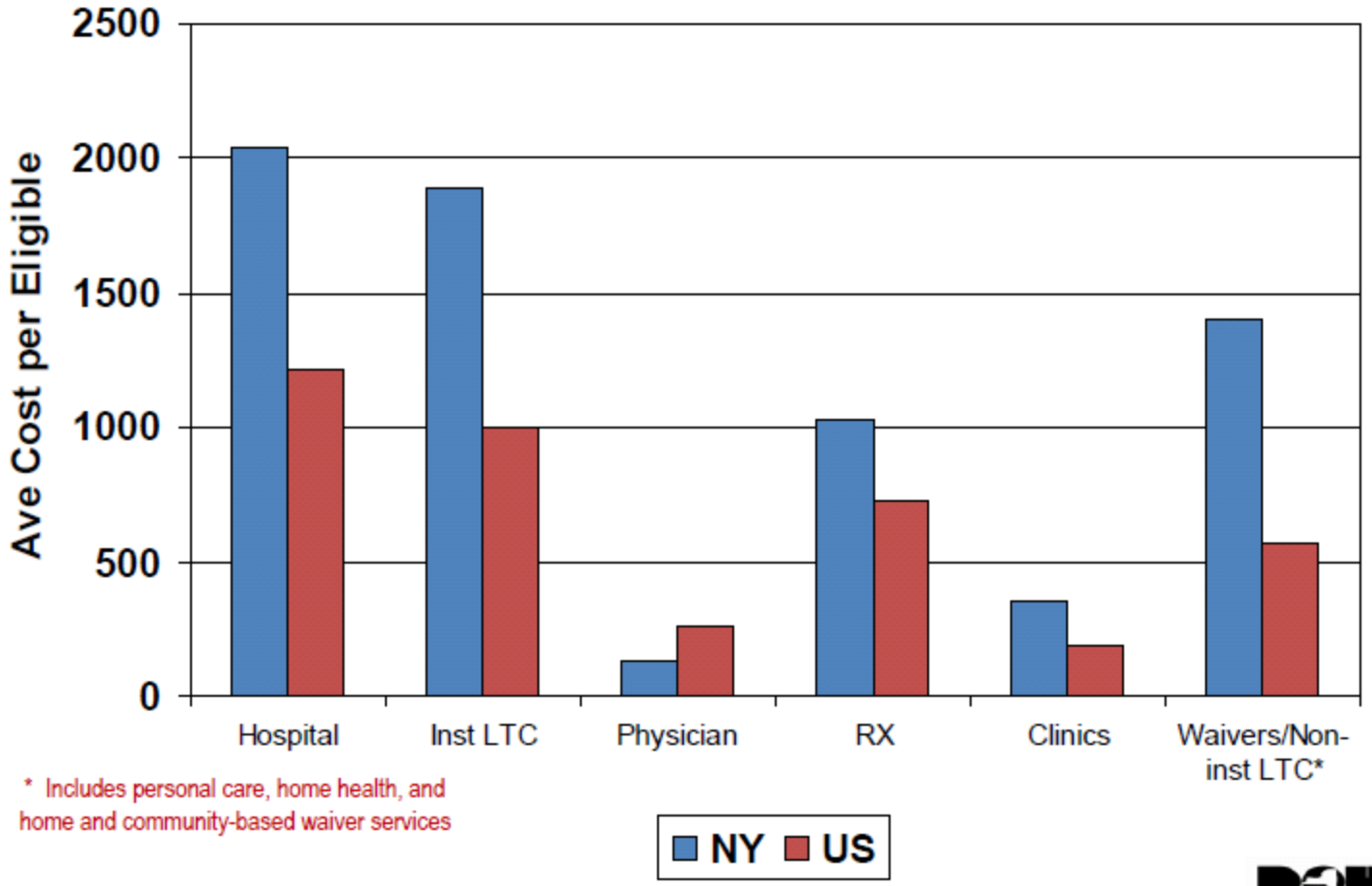
May 23, 2012

New York's Medicaid Legacy

- Nation's Largest Medicaid program
- $53 Billion to serve 5 million people and rising
  - Twice the national average on a per person basis
- Unsustainable financially
- High cost populations' care is uncoordinated
- Little focus on reducing high cost care
- High regional and provider variation on quality

Overview:
Medicaid Spending NYS vs. U.S.

New York is above national average in Medicaid spending in all service categories except for physicians



* Includes personal care, home health, and home and community-based waiver services

State of Medicaid Spending: High Cost Enrollees

20 percent of enrollees drive 75 percent of spend

	Total Medicaid Expenditures in Billions	Enrollees	Pct. Total Expend.	Pct. Total Enrollees	Avg. Costs per Enrollee
Total MA Population incl. Non-Utilizers	**$41.4**	5,104,843	**100%**	**100%**	$8,108
Non-Special Population[1)]	**$10.3**	4,075,222	**25%**	**80%**	$2,528
Special Need Populations[2)]	**$31.1**	1,029,621	**75%**	**20%**	$30,195

1)Includes Non-Utilizers

2)High Need populations are HIV, Intellectual and Developmental Disabilities (I/DD), Mental Health, Chemical Dependence, LTC and Chronic Care/Illness.

State of Quality – All Payer

New York has average performances key quality indicators … but is 50th on avoidable hospital use

2009 Commonwealth State Scorecard on Health System Performance

Care Measure	National Ranking
Percentage of Uninsured Adults	28th
Quality of Health Care	22nd
Public Health Indicators	17th
Avoidable Hospital Use and Cost	50th
▪ Percent home health patients with a hospital admission	▪ 49th
▪ Percent nursing home residents with a hospital admission	▪ 34th
▪ Hospital admissions for pediatric asthma	▪ 35th
▪ Medicare ambulatory sensitive condition admissions	▪ 40th
▪ Medicare hospital length of stay	▪ 50th

NYS appears to be dealing with a systemic quality issue that stretches across payers and across health care deliver sectors.

Medicaid Redesign Team

- Appointed by Governor Cuomo in late 2010
  - Two-fold charge:
    - 2011-12 State Budget
      - Recommend sound ideas on how to improve quality and lower cost and how to reform an ineffective system
        - » High stakeholder engagement
        - » Protect the eligibility and benefits as much as possible
    - Long term reform
      - Payment realignment to reward and incent quality
      - Implementation of national health reform
      - Better coordination between Medicare and Medicaid

Extensive stakeholder involvement

- Totally transparent process; every meeting recorded and posted; all documents posted
- Seven regional meetings – focus on what should change – not on the problem
- Over 150 people spoke at each meeting
- Website to submit suggestions
- More than 4,000 suggestions received and each suggestion numbered and reviewed

Highlights of the process

- In April 2011, legislature adopted 73 of 79 proposals to improve quality and lower cost

- 2 year budget savings of **$2,100,000**

Provisions for Improving Care

- **By 2013, all Medicaid enrollees will be in a care coordination program**
  - Health homes
  - MLTC programs
  - Medicaid Managed Care Plans
- **Standardized assessment tool for long term care services**
- **Extensive re-evaluation of Department of Education requirements for scope of practice in health;**
- **Establishment of mandatory health homes for Medicaid enrollees with complex needs and high costs**
- **Several changes to reduce health disparities: language access, accessible prescriptions, expanded mch and hepc programs and harm reduction**

Significant Cost-reduction Provisions

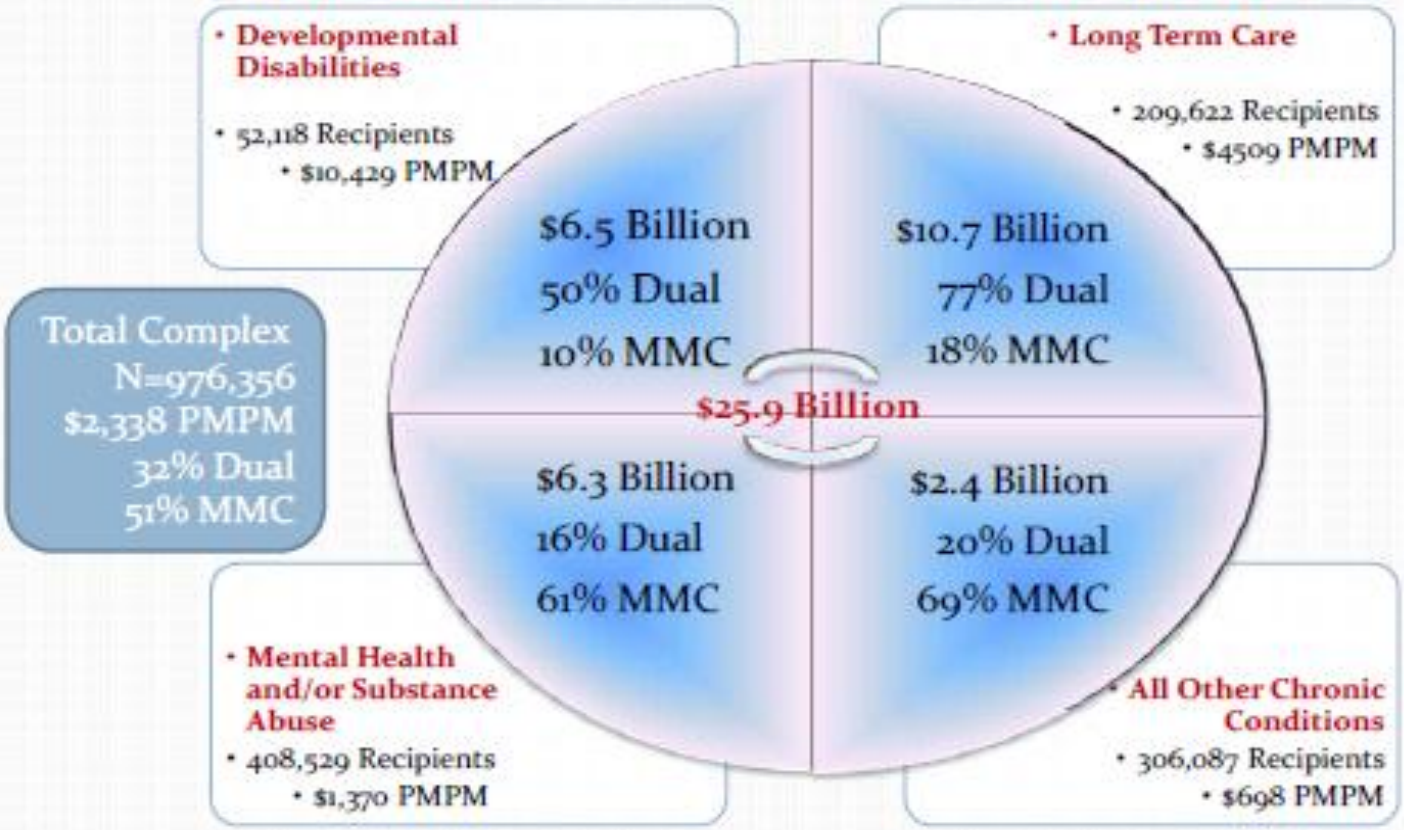
- No reduction of eligibility or benefits
- Statutory Global Medicaid Spending Cap
  - $15.3 billion with annual increase cap of 4%
  - Could be raised in economic crisis but NOT if increase in enrollment
  - Estimated to save the federal government $18.3B over five years.
  - Monthly report to the public on status against cap
- First Medical Indemnity Fund to finance services for neurologically impaired infants
  - Should lower malpractice premiums by $320 million annually
- Elimination of Medicaid FFS payment system; pursue sub-capitation to eliminate FFS payments to providers; ACOs
- Integrate care and financing for dual eligibles thru NY Medicaid

MRT Subcommittee Reports

- Payment Reform
- Basic Benefit Review
- Program Streamlining and State/Local Responsibilities
- Supportive Housing
- Health Disparities
- Behavioral Health Reform
- Workforce Flexibility/Change of Scope of Practice
- Medical Malpractice
- Managed LTC Implementation and Waiver Redesign

Below is a graphic on these four populations with some Medicaid data on each.

HH Populations - 2010



BUT…..

- Federal budget and programmatic proposals loom large over NY's ability to design the Medicaid of the future
- If state share is capped, what happens if more enrollment than anticipated?
- NY counties have a cap as well and are calling for more self-determination of benefits and eligibility
- If primary care can't ramp up, how can high cost care (hospitals and nursing homes) reduce costs?

Lessons learned…one woman's opinion…

1. The process was essential
2. Couldn't have been done without very strong and focused leadership in Governor's office and DOH
3. Design and implementation needs to cross traditional boundaries – health, mental health, housing, education, social services – at state and local levels
4. Communication in communities is essential to keep organizations and people from shutting down; so much change can be overwhelming
5. We must keep our focus on the recipients and what's best for them

Two additional cost containment initiatives

- Reinstated “prior approval” of insurance premium increase requests
  - Insurers asked for weighted average increase of 12.7%; allowed only 8.2%, saving $400M for consumers

- Plan to establish an all-payer claims database that will illuminate cost drivers and prompt quality improvement efforts