NEW YORK STATE | Department of Health

New York Medicaid Redesign Team II

Keeping the Medicaid Promise

February 2020

Agenda

I. Introductions – MRT II Co-Chairs
II. Medicaid Budget Overview – Budget Director
III. Successful Strategies in MRT I – Medicaid Director and Director of Program and Policy
IV. Challenges That MRT II Must Address – Medicaid Director
V. Process for Submitting Policy Proposals – Medicaid Director
VI. Discussion

Introduction

MRT II Co-Chairs

Medicaid Redesign Team II Membership

Co-Chairs

- Michael Dowling – President and CEO of Northwell
- Dennis Rivera – former President of SEIU Healthcare

Executive Director

- Donna Frescatore – Medicaid Director and Executive Director of the New York State of Health

Members

- Dr. Steven Corwin, President and CEO, New York Presbyterian
- Thomas Quatroche, PhD, President and CEO, Erie County Medical Center
- LaRay Brown, CEO of One Brooklyn Health
- Mario Cilento, President of New York State AFL-CIO
- Christopher Del Vecchio, President and CEO of MVP Health Care
- Pat Wang, President and CEO of Healthfirst
- Emma DeVito, President and CEO of VillageCare
- Wade Norwood, CEO of Common Ground Health
- Steven Bellone, County Executive, Suffolk County
- T.K. Small, Director of Policy at Concepts of Independence
- Donna Colonna, CEO, Services for the UnderServed (S:US)
- Todd Scheuermann, Secretary of Finance, NYS Senate
- Blake Washington, Secretary of Ways and Means, NYS Assembly
- Paul Francis, Deputy Secretary for Health and Human Services, Governor's Office
- Dr. Howard Zucker, Commissioner of Health
- Dr. Ann Sullivan, Commissioner for the Office of Mental Health
- Arlene González-Sánchez, Commissioner of the Office of Addiction Services and Supports
- Dr. Theodore Kastner, Commissioner of the Office for People With Developmental Disabilities
- Robert Megna, Senior Vice Chancellor and COO, SUNY

Description of MRT II

- Announced by Governor Cuomo in the FY 2021 Executive Budget Presentation
- Comprised of healthcare experts and stakeholders
- Charged with making advisory findings and recommendations
- A package of findings and recommendations will be delivered by the MRT Team to the Governor before April 1

What Governor Cuomo has asked us to do:

"We're going to have to make structural changes to this program. And in 2011 we went through this, and we had something called the Medicaid Redesign Team, MRT, which put all the stakeholders in one room and said we have to save this amount, we have to find this economy of scale, how do we do it? The MRT worked very well. They found efficiencies, they had suggestions. The savings from that MRT has saved New York $19 billion since 2011. We want to do an MRT II, tasked with the assignment of saving $2.5 billion and making structural changes going forward. We went back and reenlisted the original MRT team."

Governor Andrew Cuomo – 2021 NYS Budget Presentation

How MRT I Worked

- Generated new ideas about how to achieve efficiencies while improving quality
- Gained stakeholder consensus around recommendations resulting in $2.2 billion in Medicaid savings
- Outlined areas for savings and longer term structural reforms
- MRT I recommendations led to the $8 billion DSRIP waiver awarded in 2014.

The Approach of MRT II

- MRT II should build on the successful strategies of MRT I, while making course corrections where necessary.
- Restore financial sustainability by implementing immediately actionable reforms.
- Take steps toward longer term structural changes that need more time for implementation.

Long Term Care Advisory Group

- MRT II is creating an Advisory Group on long-term care, the fastest growing expense in Medicaid.
- The purpose of the Advisory group is to generate ideas and proposals on long-term care.
- The Advisory Group will present a summary of proposals to the MRT at its second meeting.

What We Ask of Team Members

- **Be open to change** – even the best strategies need continual refinement

- **Think short-term and long-term**
  - We need to restore financial sustainability now and
  - We need to restructure Medicaid to adapt to a changing healthcare environment

- **Participate** – Team members must lead the process

- **Understand that the Status Quo is not an option**

Process of Developing Proposals

- State staff will solicit and analyze ideas submitted to the MRT website or presented during a public comment day.
- Actionable proposals will be presented to the MRT II at its second meeting.
- A separate Long-Term Care Work Group will develop proposals and present its findings and recommendations to the MRT II at its second meeting.
- A final package of proposals will be scored by DOH and DOB and presented to the MRT II for approval.

Logistics/Timeline

Feb. 4

- Announce MRT membership

Meeting 1
Feb. 11

- Hold first meeting in Albany
- Outline membership, process, timeline and provide overview of Medicaid Program
- Overview of Medicaid program , budget pressures

Meeting 2
Mar. 4

- Review public feedback and policy proposals
- Review condensed list of proposals
- Discuss proposal evaluation framework

Meeting 3
Mid-March

- Review draft reform proposals
- Discuss modifications
- Finalize recommendations

Public Engagement

In addition, DOH will organize the following:

- **Livestream of MRT II meetings**
- **One Public Webinar** to review MRT II and the MRT II process;
- **Three Public Comment Days** held in separate regions of the State; and
- **MRT II Proposal Submission Tool** to communicate proposals directly to State officials

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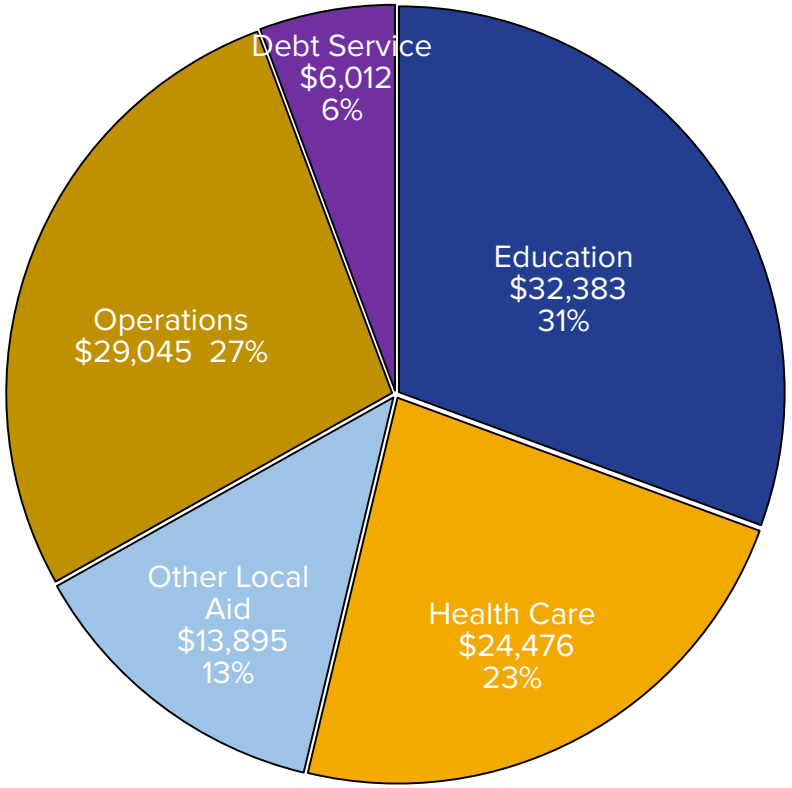
Medicaid Budget Overview

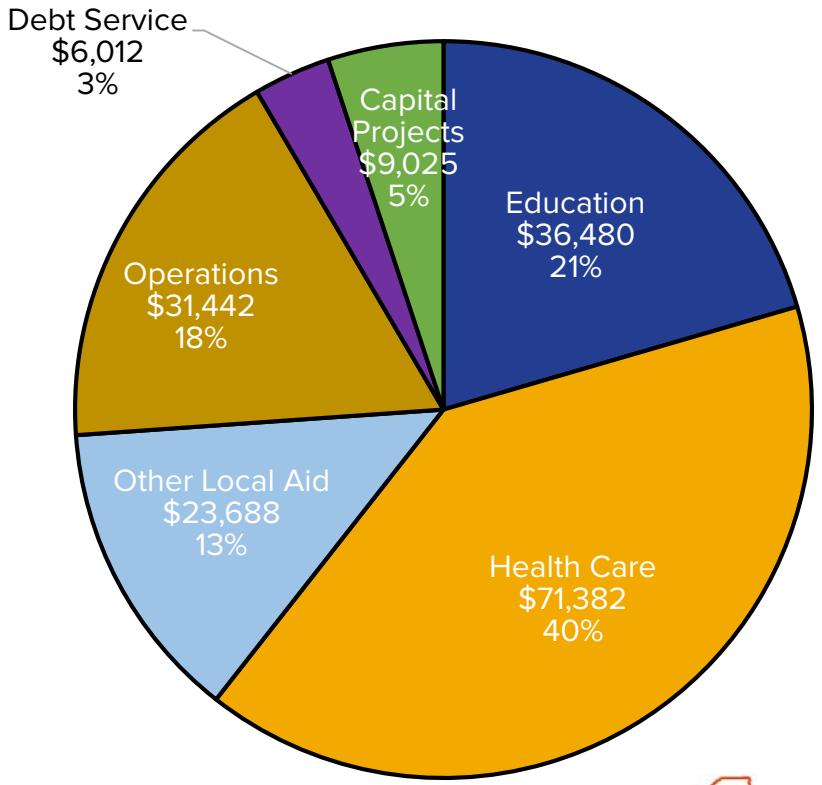
Budget Director

Where The Money Goes: FY 2021 State Budget

State Operating Funds $105.8 Billion

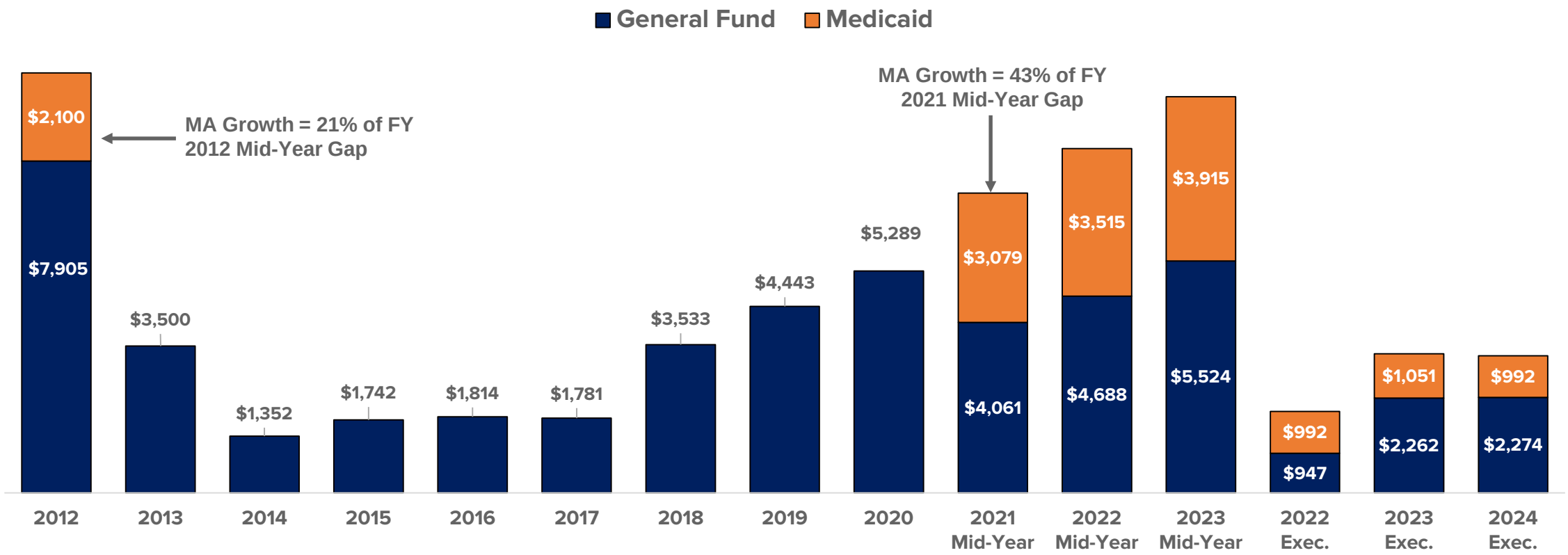


All Governmental Funds $178 Billion



Data Source: FY 2021 Executive Financial Plan

Medicaid Impact on Budget Gaps



Notes

- From FY 2013 through FY 2018 Medicaid spending growth averaged 2.2 percent annually.
- The FY 2021 – FY 2023 Mid-Year Gaps are restated to exclude the recurring value of the FY 2020 Mid-Year savings plan and cash management actions.
- FY 2021 is solved by the Medicaid Redesign Team's identification of $2.5 billion in savings.
- Data Source: Division of the Budget.

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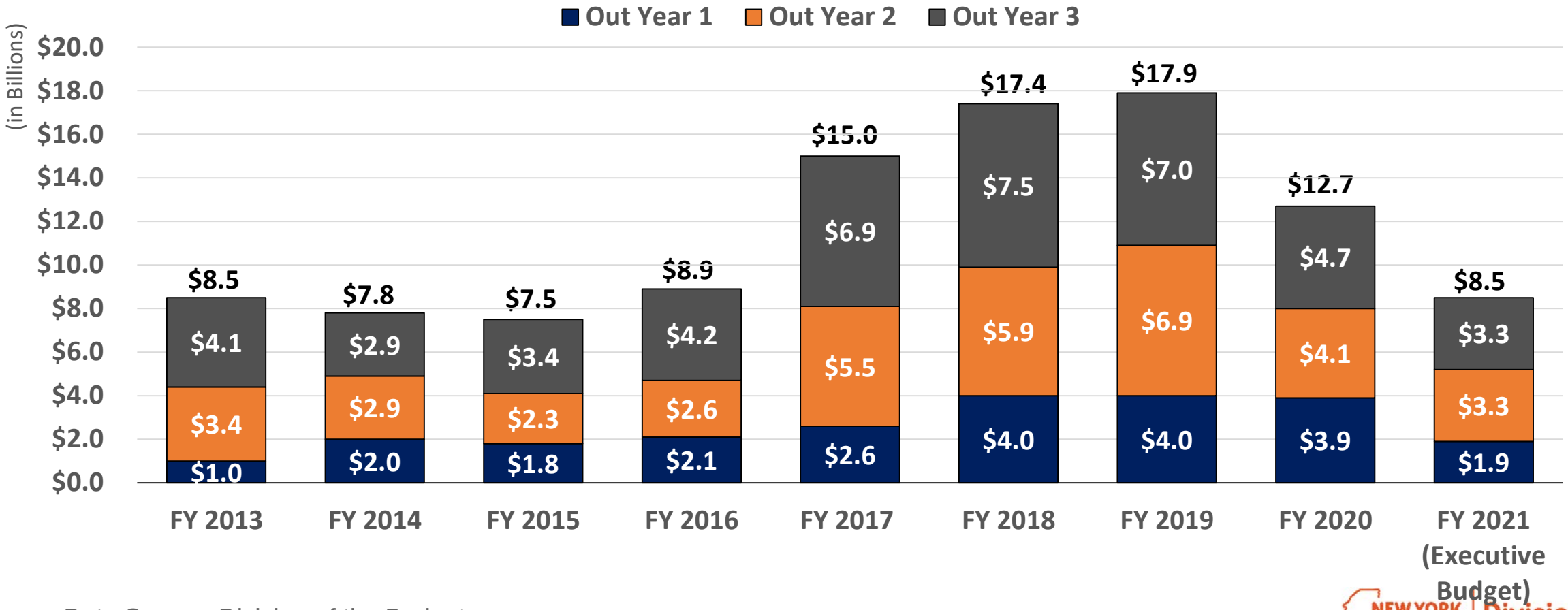
Out Year Budget Gaps Reduced to Lowest Level in 6 Years



Data Source: Division of the Budget.

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Medicaid and Budget Gaps Compared

- In 2011, Medicaid was growing by 13% and contributed 21% of the $10 billion gap.
- For FY 2021 – today – Medicaid is growing at 6% and contributing 43% of the $7.1 billion gap (excluding FY 2020 savings plan and payment restructuring).
- From FY 2013 to FY 2018, State-share Medicaid spending growth averaged 2.2% annually

The Budget Projects 3% Growth Going Forward

($ in Millions)	FY21	FY22	FY23
DOH Medicaid Global Cap Index	$20,006	$20,594	$21,200
Dollar Growth	$573	$588	$606
Percent Growth	3.0%	2.9%	2.9%

Note: Growth factor is consistent with the Medicaid global cap index enacted in FY 2013

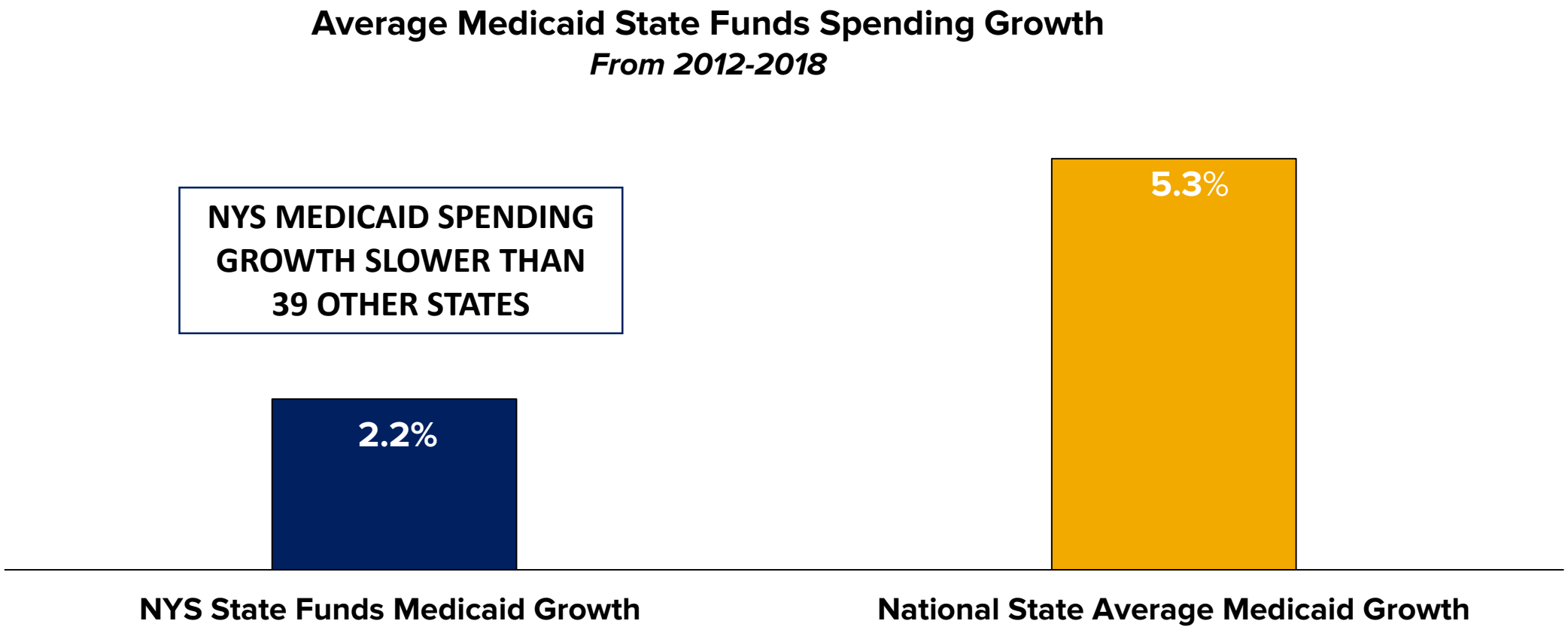
Data Source: FY 2021 Executive Financial Plan.

MRT I Established A Framework For Achieving Financial Sustainability

Actions Taken By MRT I:

- Cancelled automatic inflators in the Medicaid program
- Examined underlying causes of growth and proposed long-term reform
- Established the Global Cap on Medicaid spending

The Global Cap Maintained Financial Sustainability for Eight Years



Source: National Association of State Budget Officers NASBO

Medicaid Spending Is Growing at an Unsustainable Rate

- We project annual growth in excess of 6% through FY 2023

($ in Millions)	FY21	FY22	FY23
Projected Medicaid Spending Gap	**$3,079**	**$3,515**	**$3,915**

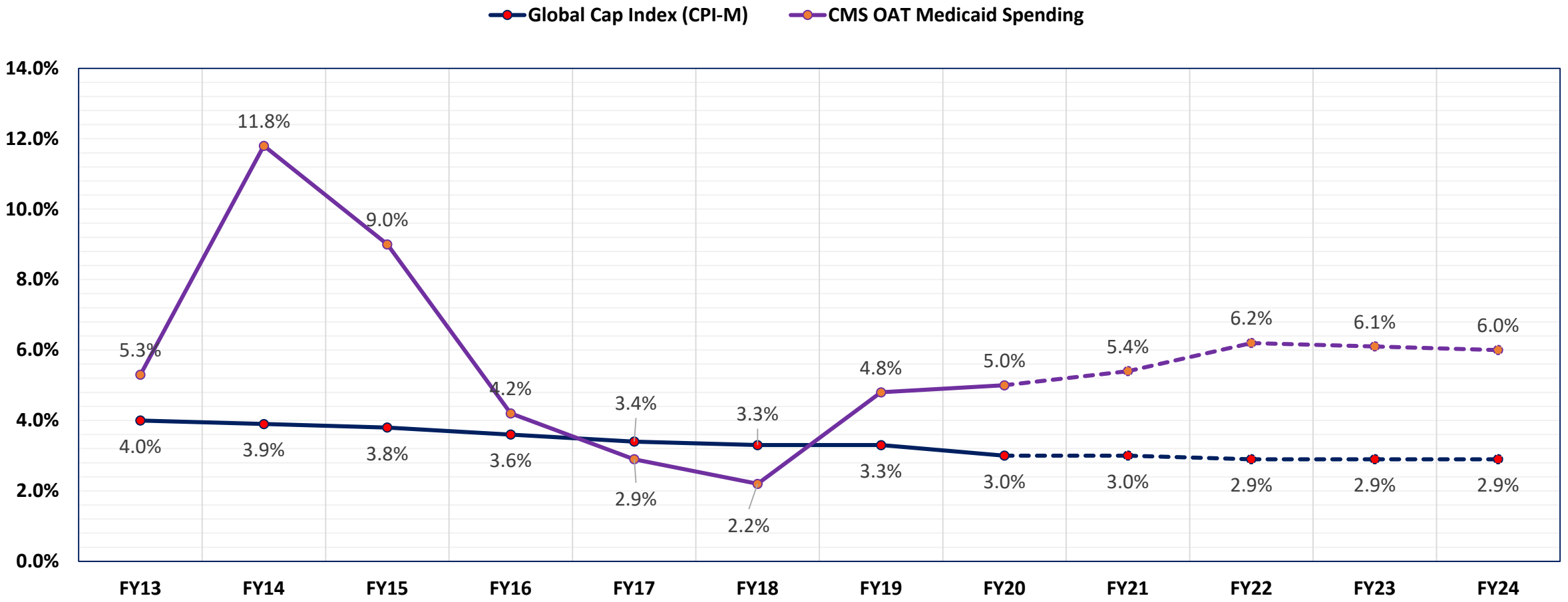
- Must control Medicaid spending and align it with Global Cap spending limits of approximately 3%.

Data Source: Division of the Budget.

Cost Pressures on the Medicaid Program

- **Overall Health Care Costs are exceeding** the 10-year rolling average of the Medical CPI.
- **Managed Long Term Care** spending grew by 301% between FY 2013 and 2019.
- **$15 Minimum wage** has been included in Medicaid spending since 2017 – growing from $44M to $1.8B in FY 2021 and $2B in FY 2022.
- **Local districts have not contributed** additional support to the Medicaid program beginning in 2016 – the State is now assuming $4.5B in local takeover for FY 2021.
- **Support for distressed hospitals** has steadily grown by over 160% to nearly $500 million (state share) in FY 2021.

State Medicaid Global Cap Spending vs. National Health Expenditure Growth



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Data Source: Division of the Budget & Centers for Medicare & Medicaid Services.

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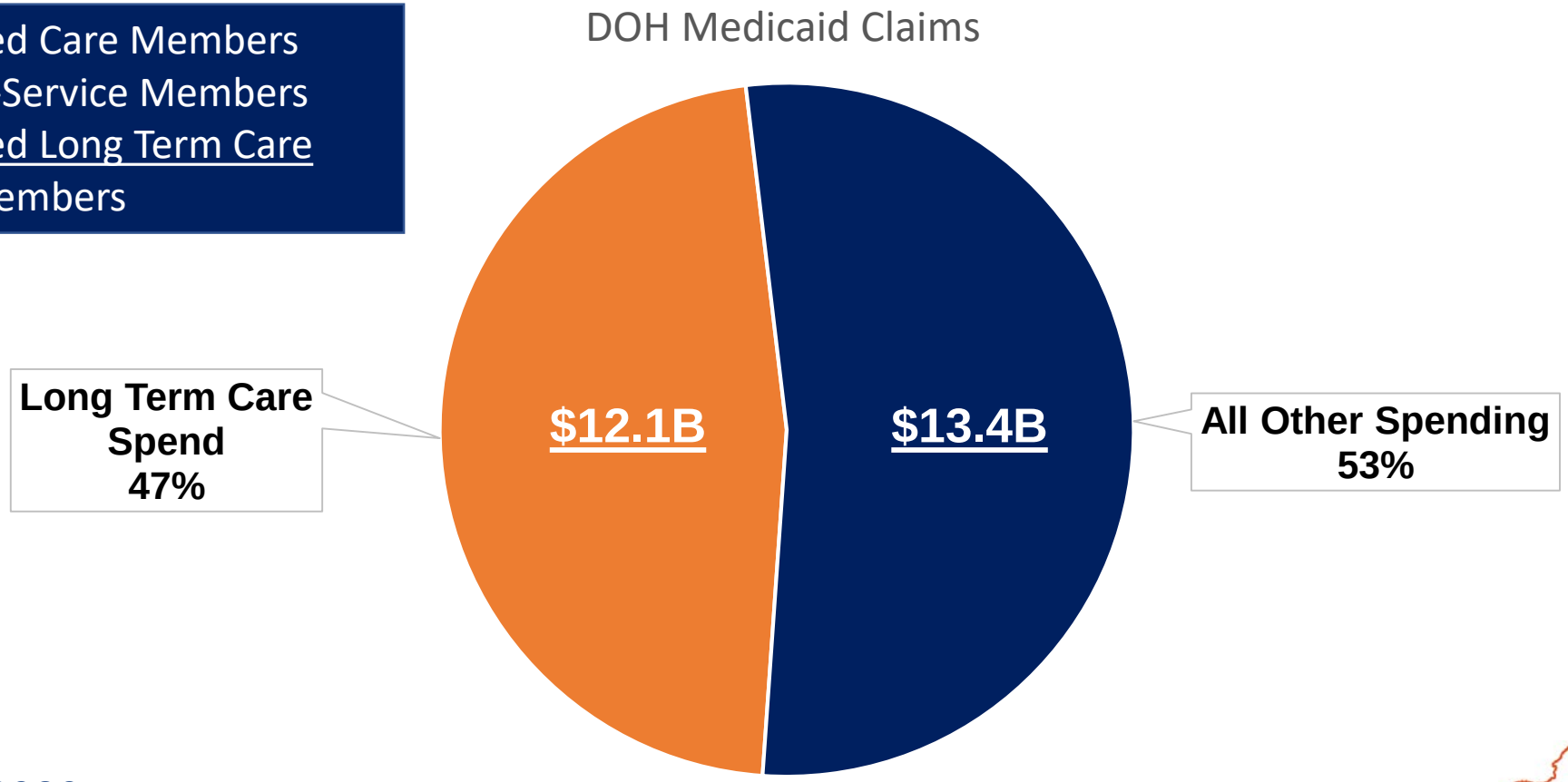
Long Term Care Represents Over $12B (or 47%) of FY 2020 Medicaid Claims

Member Volume

4.4M = Managed Care Members
1.5M = Fee-for-Service Members
0.3M = Managed Long Term Care
6.2M = Total Members



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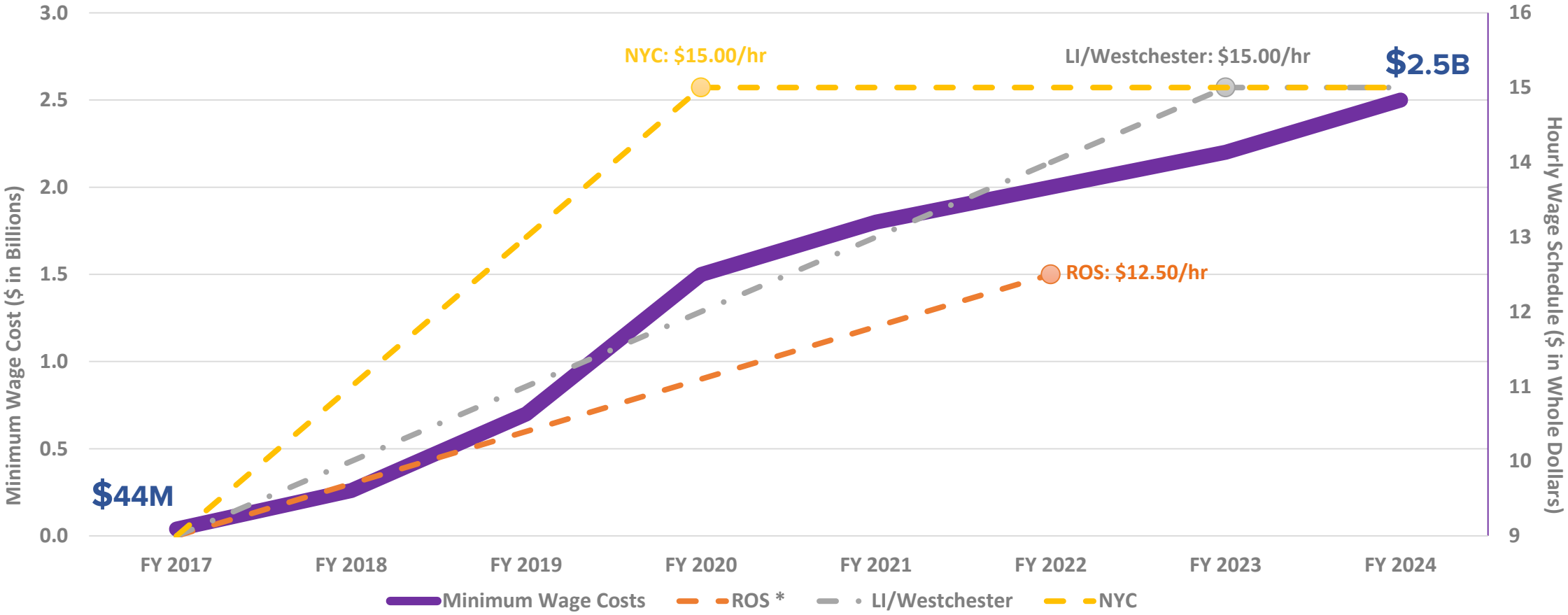
Data Source: Medicaid Data Warehouse Claim Spending Projection

Minimum Wage as a Medicaid Growth Factor Will Flatten



Note: Hourly wage schedules are increased on an annual basis on December 31st; wages are listed in the fiscal year in which they were in effect for the majority of the fiscal year. For example, NYC experienced an increase from $13 to $15 on 12/31/18, which first impacted FY 2019 (Jan. to Mar. 2019), but had the longest impact in FY 2020.

* Annual increases for the rest of the state will continue until the rate reaches $15 minimum wage. Starting in 2021, the annual increases will be published by the Commissioner of Labor on or before October 1. They will be based on percentage increases determined by the Director of the Division of the Budget, based on economic indices, including the Consumer Price Index.

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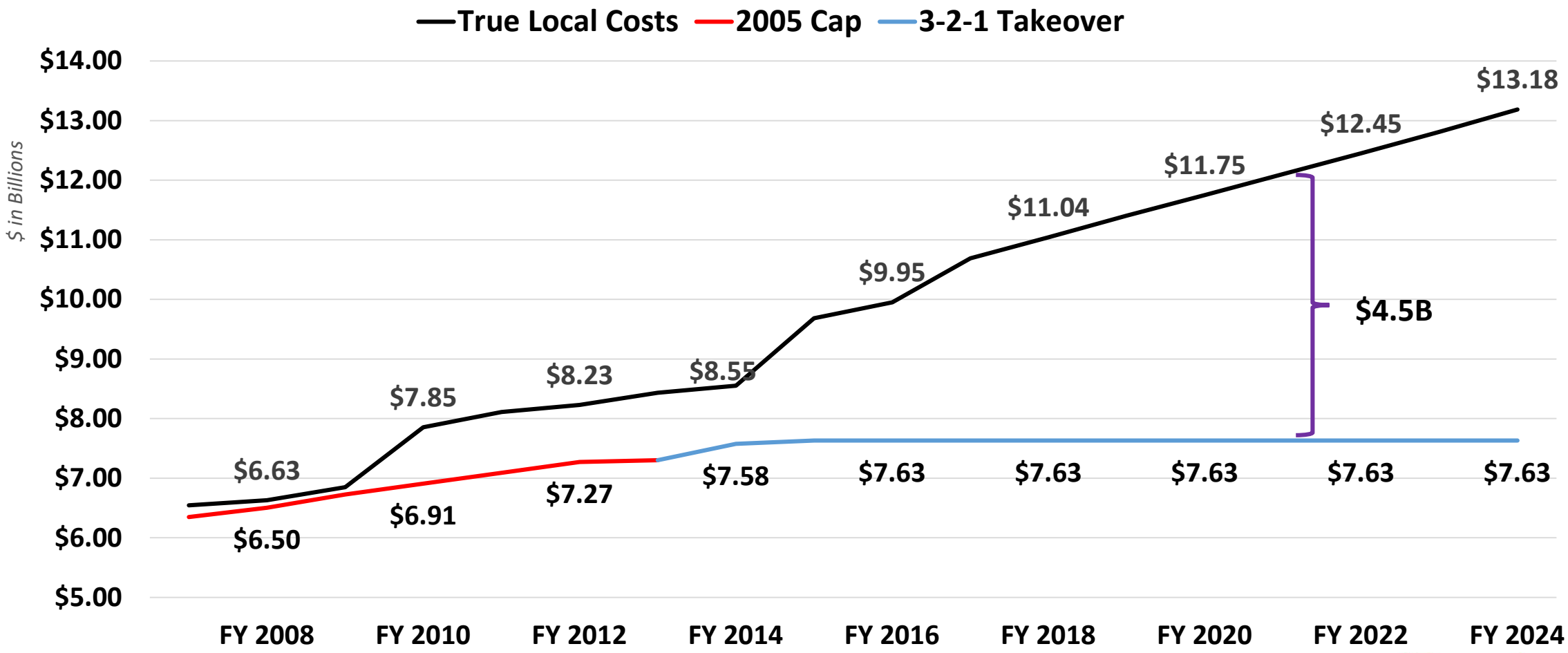
State Cost of Local Medicaid Takeover



Data Source: Division of the Budget.

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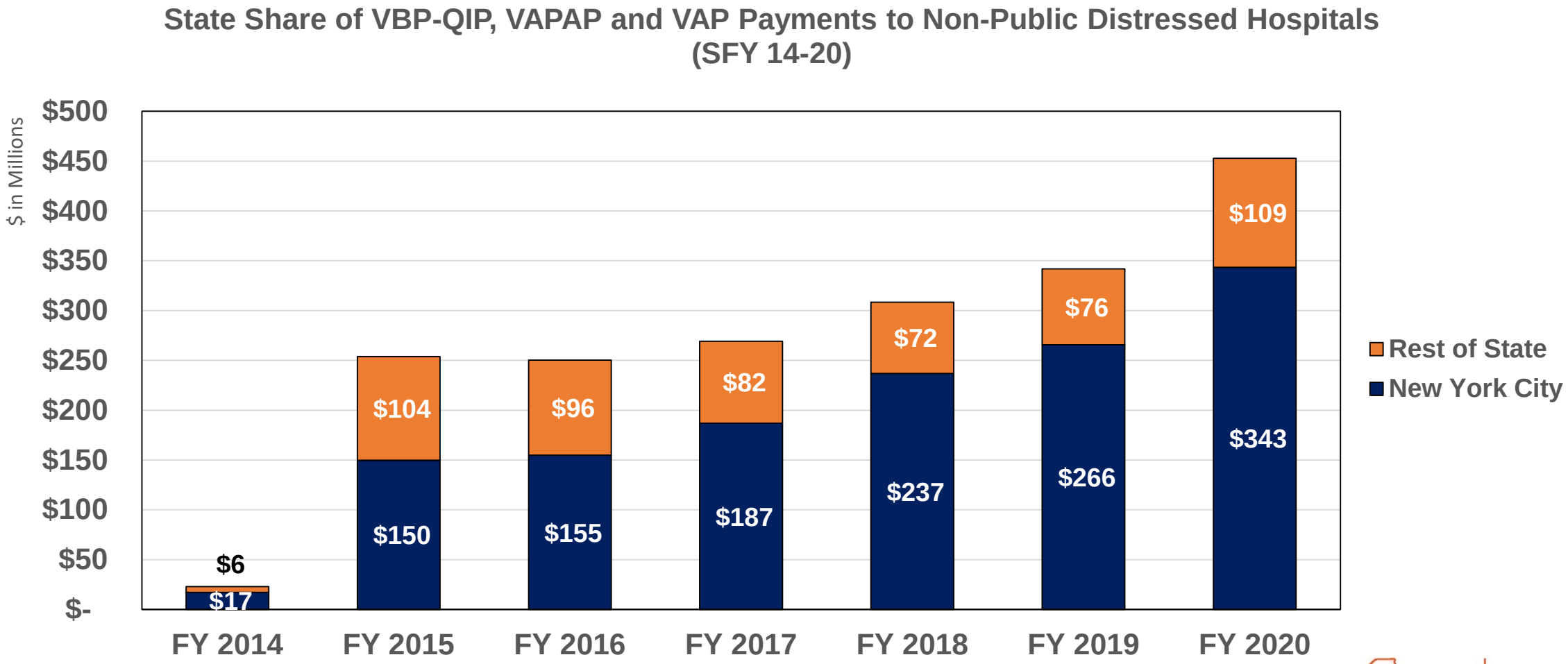
The Takeover of 100% of the Growth in Local Medicaid Costs had Unintended Consequences

- The state takeover of all Medicaid administration has taken longer than anticipated.

- Counties continue to administer key eligibility and program integrity functions, but lack financial incentives to maximize their efforts.

Growing Support for Financially Distressed Hospitals



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Data Source: Division of the Budget.

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What Policy Decisions are Within the Scope of MRT II

- The MRT II should address whether any changes should be made in the components and growth rate of the Global Cap
- Changes in the Local contribution are outside the scope of the MRT
- General revenue recommendations are outside the scope of the MRT

Successful Strategies of MRT I

Medicaid Director and the Director of Program and Policy

February 2020

Overall, MRT I has been a success

Reduced costs: expanded coverage while maintaining financial sustainability for eight years

- Established first in the nation cost metric as a cap on Medicaid spending
- Reduced avoidable hospitalization costs by $500 million since 2014

Improved Health: improved standing on qualitative and quantitative measures

- Improved Commonwealth national scorecard rankings in several key categories
  - Overall system quality ranking, avoidable hospital use, overall access, etc.

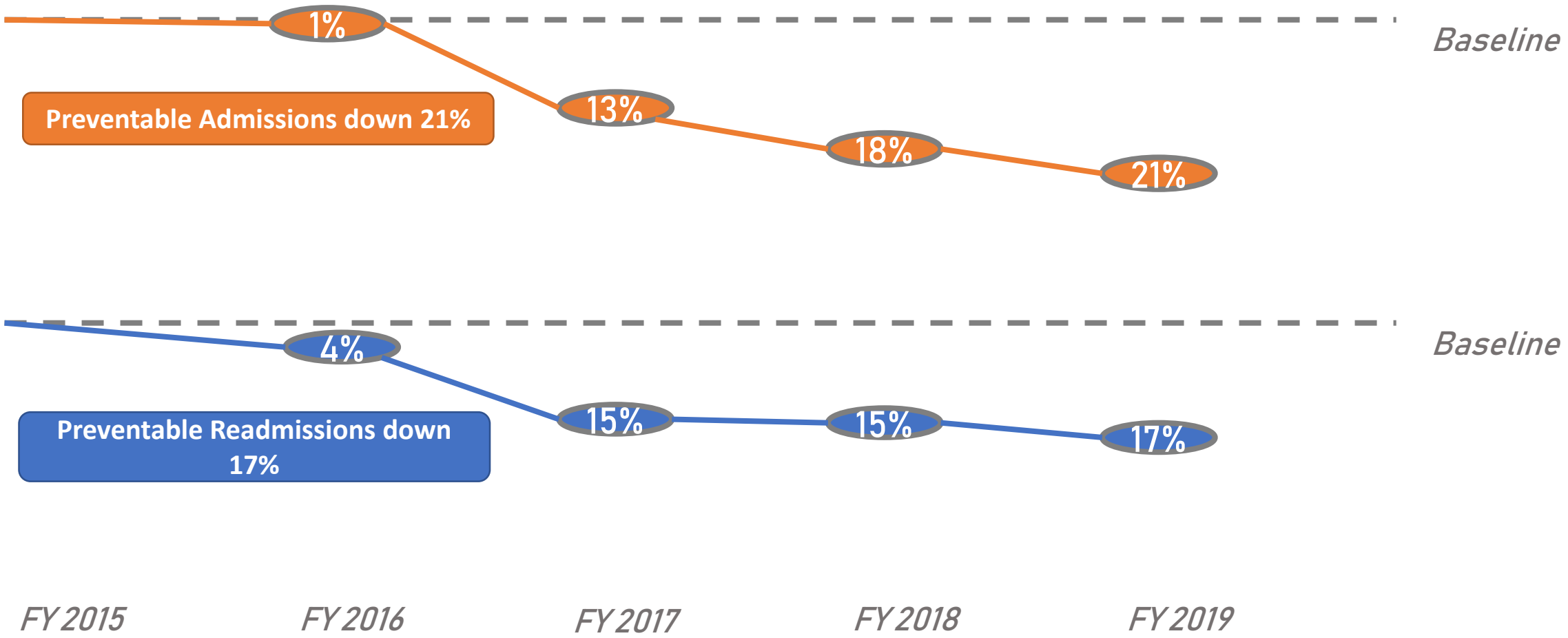
Enhanced care: targeted care management to high risk and complex members

- Health Homes enrolled 176K members and stood up 33 Health Homes
- PCMH supported ~4,000 new practitioners with improved infrastructure and connectivity to other providers
- DSRIP is showing success in delivery system reform including better managing the needs of complex patients, reducing avoidable events while improving objective measures of quality
- Value based payment incorporates quality into the payment model

Dramatic Increase in Health Coverage

- Medicaid enrollment has grown from 4.3 million in 2010 to 6.2 million in 2020.
- The Essential Plan – created for the recommendation of MRT's Basic Health Program Workgroup – now covers over 770,000 working-class New Yorkers.
- Individual market enrollment has increased from ~180,000 in 2013 to 340,000 members in 2020.
- CHIP has grown from ~400,000 in 2011 to ~420,000 members in 2020.
- **Only 4.7% of New Yorkers are uninsured.**

Reduced Preventable Admissions and Readmissions



All figures represent DSRIP attributed population; data presented represents July 2014 through June 2018.
Data source: NYSDOH, Medicaid Data Warehouse.

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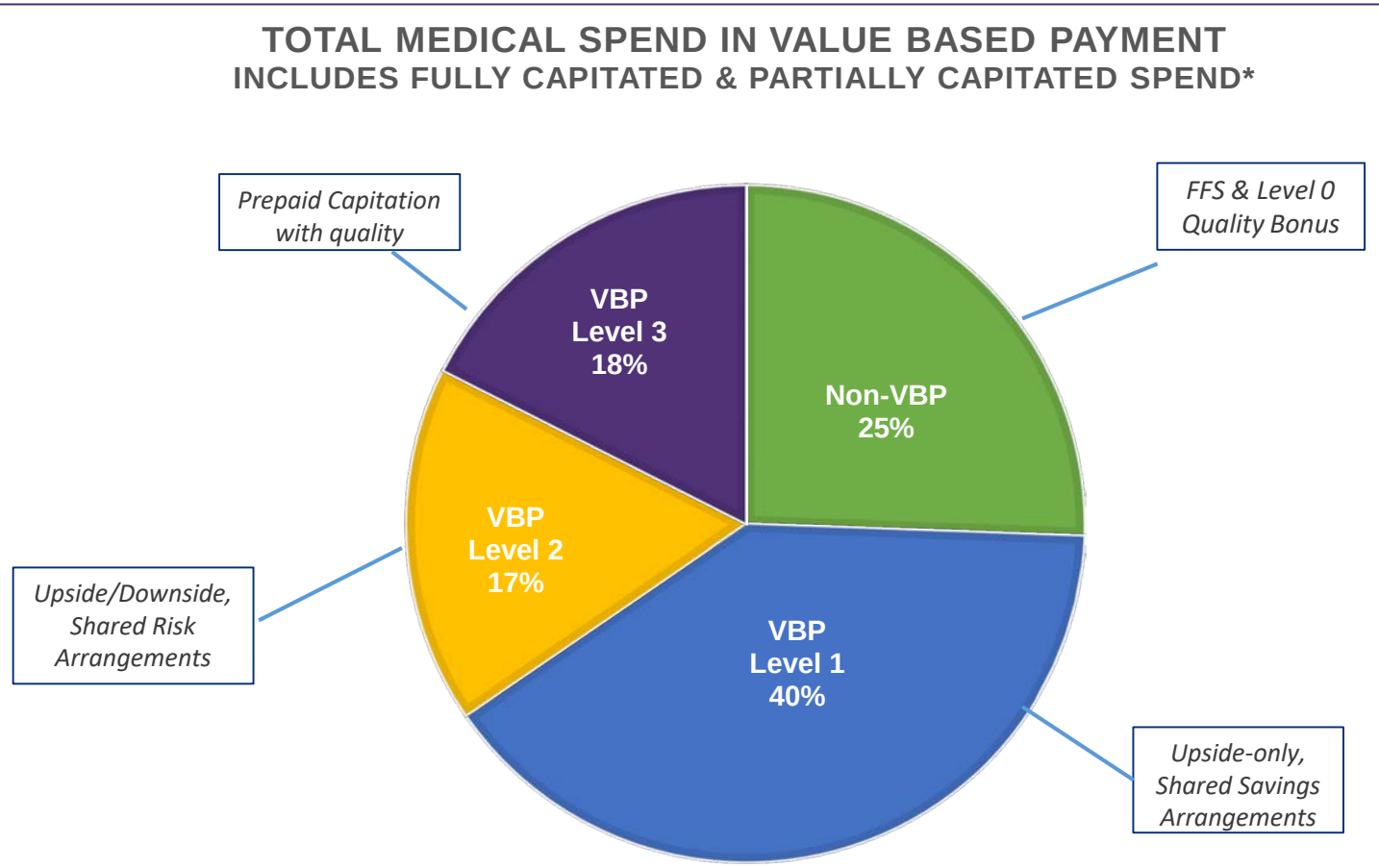
Significant Progress In Adoption of Value Based Payment

- Nearly 75% of Medicaid Managed Care expenditures are in VBP
- 35% of total expenditures (fully & partially capitated) are in risk-based arrangements
  - 48% of fully capitated expenditures alone, are risk-based
- Nearly 20% of expenditures are in fully capitated arrangements



*Progress is based on reporting for the time period 4/1/18-3/31/19
Data Source: NYS Department of Health.

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Improved Access to Patient-Centered Medical Homes

Patient Centered Medical Home (PCMH)

- Approximately 33% of all MMC primary care physicians operate in Patient Centered Medical Home-recognized practices (up from 24% in 2012).
- Most encouraging growth occurred from 2015-2018 due to DSRIP efforts, with 2500 Performing Provider System providers NEWLY achieving PCMH recognition.
- As of December 2018, 65% of Medicaid Managed Care enrollees were assigned to a PCMH-recognized PCP practice (up from 40% in 2012)

December 2018 PCMH Report https://www.health.ny.gov/technology/innovation_plan_initiative/pcmh/docs/pcmh_quarterly_report_dec_2018.pdf
December 2012 PCMH Report: https://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_quarterly_report.pdf

Data Source: NYS Department of Health.

Developed Robust Health Information Exchange Infrastructure

- New York State has the largest and most comprehensive statewide health information exchange network in the country and connects 100% of hospitals, 54% of ambulatory sites and 67% of physicians in NYS.

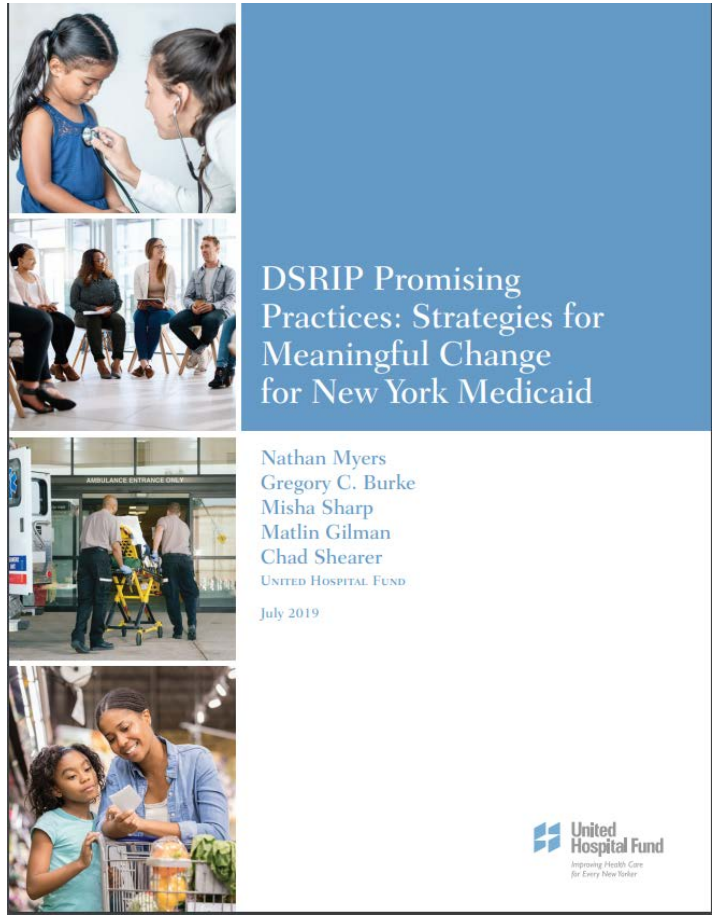
Current SHIN-NY Monthly Usage*

Over 1.1 Million	Over 6.8 Million	~70%	Over 2.4 Million
Patients Supported by SHIN-NY Information Exchange	Alerts Sent to Care Team Members	of New Yorkers Have Provided Patient Consent	Records Exchanged

*Based on QE Self-Reporting SFY Q3 2019

DSRIP Reinforced Successful MRT I Strategies

- Accelerated the focus on social determinants of health by facilitating partnerships between health care providers and community partners
- Supported impactful integration of primary care and behavioral health services including Medication-Assisted Treatment (MAT)
- Strengthened care management through refined health intervention strategies and cross-sector collaborations
- Increased integration of non-clinical workforce improving patient engagement and maximizing clinical team capacity
- Facilitated stronger coordination and transitions more broadly for continuity of health and social care across a Medicaid member's care settings
- Developed promising patient-centered interventions targeting high-risk and complex patients
- Established a value based payment model that shares accountability between insurers and providers to improve quality and efficiency



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Health Homes Improved Member Quality and Services

Health Homes:

- Expanded more intensive care management for highest risk populations;
- Improved quality outcomes despite medical complexity of patients
- Exceeded statewide results on 20 of 24 key performance measures
  - Exceeded statewide performance for
    - All 6 behavioral health hospital follow-up measures
    - Alcohol/drug dependence treatment, medication management, HIV monitoring, and screening for sexually transmitted disease

Measure Description	Health Homes 2018	Statewide Medicaid 2018	Difference between Health Homes and Statewide Medicaid Performance- 2018
Follow-Up After Hospitalization for Mental Illness Within 30 Days	▲ 73.41	52.29	21.12
Follow-Up After Emergency Department Visit for Mental Illness Within 30 Days	79.60	63.12	16.48
Follow-Up After Hospitalization for Mental Illness Within 7 Days	▲ 53.94	38.83	15.11
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence- 30 Days	▲ 37.41	25.35	12.06
Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days	64.24	53.78	10.46
HIV Engaged in Care	94.19	83.92	10.27
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence- 7 Days	28.60	19.40	9.20
HIV Viral Load Monitoring	▲ 70.60	▲ 61.66	8.94
HIV Syphilis Screening	▲ 76.59	▲ 71.46	5.13
Initiation of Alcohol and Other Drug Dependence Treatment	48.23	43.17	5.06
Medication Management for People with Asthma: 75% of treatment period	▲ 48.10	▲ 43.13	4.97
Medication Management for People with Asthma: 50% of treatment period	▲ 72.13	▲ 68.31	3.82
Antidepressant Medication Management-Effective Continuation Phase Treatment	40.84	▲ 37.45	3.39
Colorectal Cancer Screening	54.82	▲ 52.70	2.12
Chlamydia Screening (Ages 16-24)	▲ 71.99	▲ 69.96	2.03
Persistence of Beta-Blocker Treatment after Heart Attack	41.77	40.39	1.38
Adult BMI Assessment	▲ 90.17	▲ 88.96	1.21
Monitoring Diabetes - HbA1c Testing	83.97	83.07	0.90
Antidepressant Medication Management-Effective Acute Phase Treatment	53.15	▲ 52.55	0.60
Controlling High Blood Pressure	▲ 64.03	▲ 63.53	0.50

Key: ▲ Indicates a positive year-over-year change between 2017 and 2018

* Performance data shown is represented as the rate per 100. Data Source: NYSDOH Clinical Datamart (CDM).

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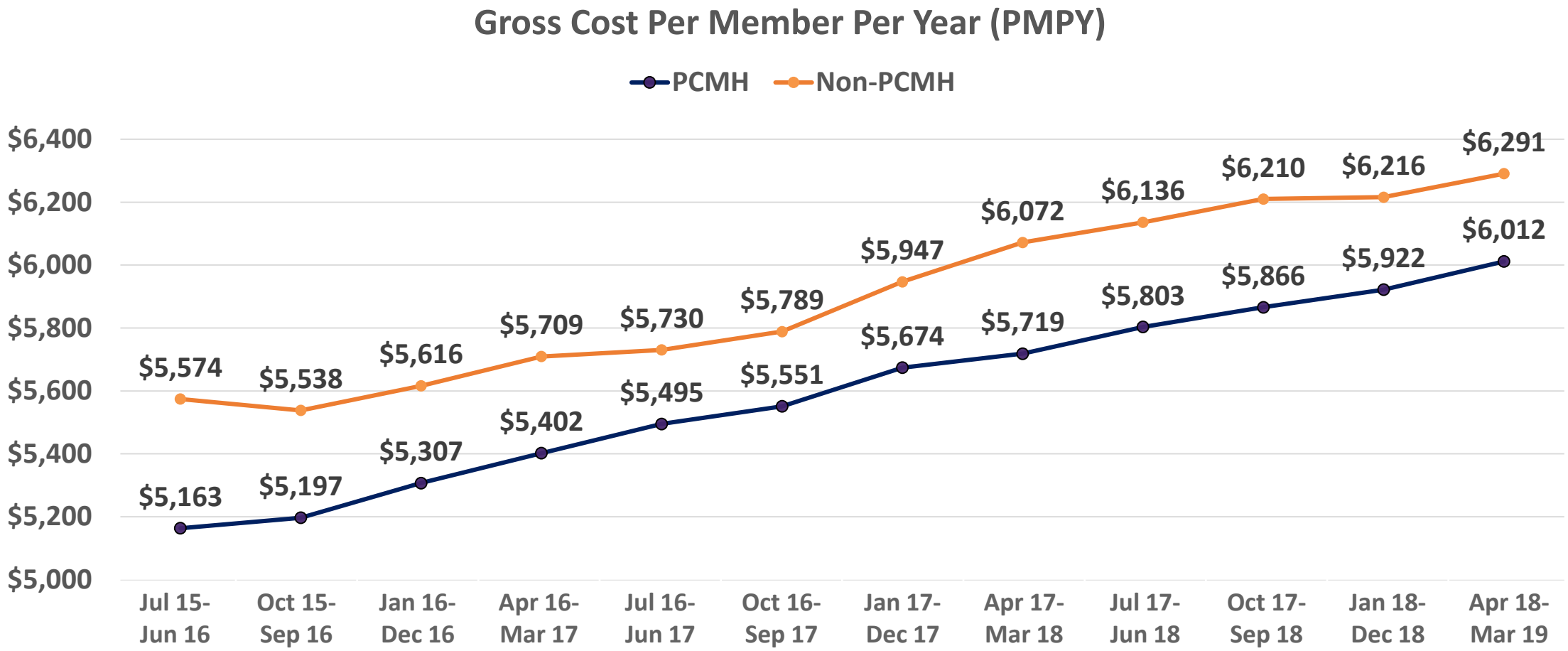
Members in PCMH Practices are Less Costly (Risk Adjusted)



Data Source: Medicaid Data Warehouse (MDW)
Data Notes: Does not include dual eligible or PCMH incentive payments. PCMH site data is from the National Committee for Quality Assurance (NCQA)

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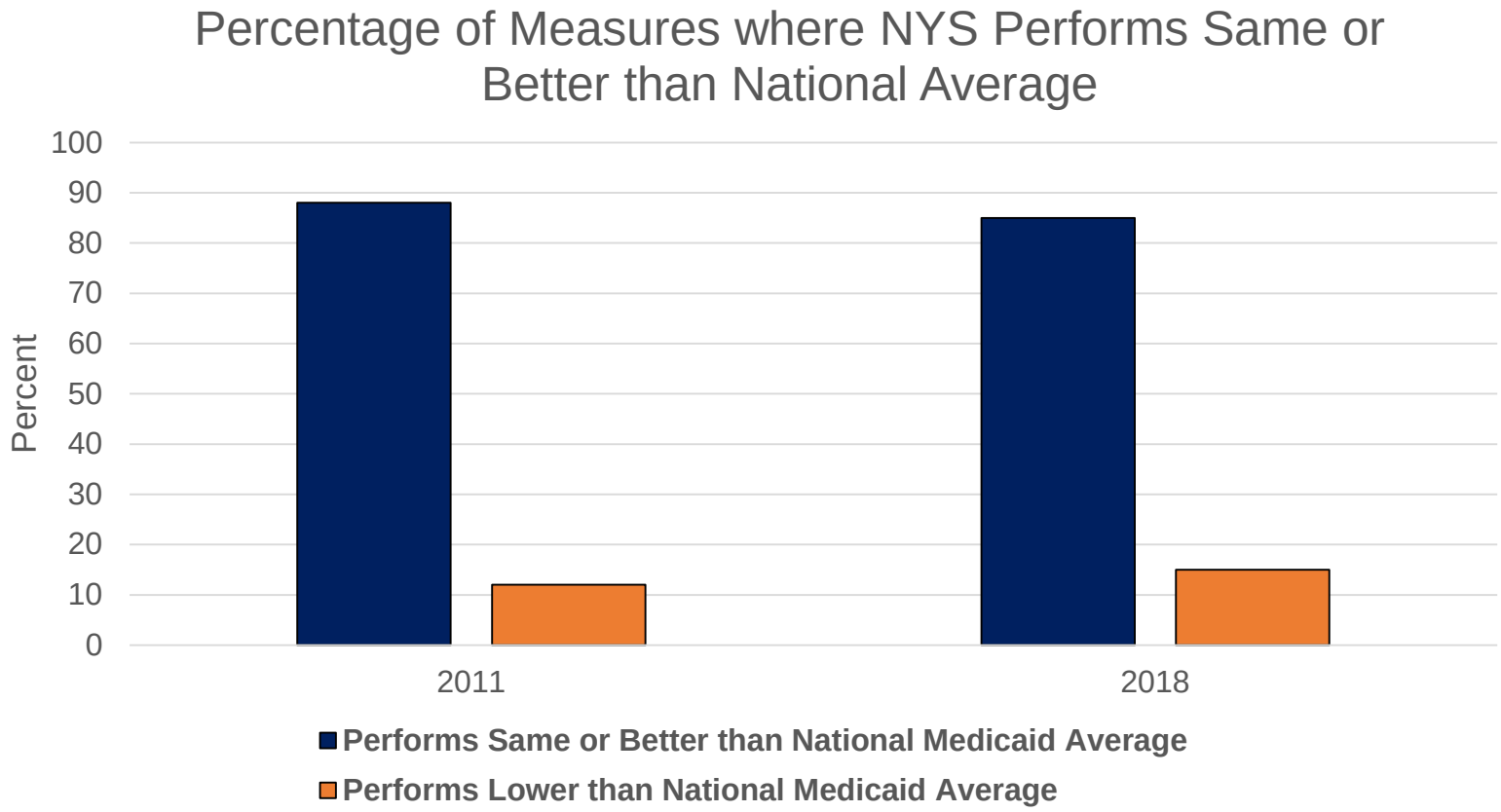
Medicaid Managed Care Outperforms National Benchmarks

NYS Medicaid Managed Care Program consistently outperforms National Benchmarks

Out of the 59 measures that Medicaid plans reported in Measurement Year 2018, 85% of measures met or exceeded national benchmarks.



Data Source: Office of Quality and Patient Safety (OQPS) in the Department of Health

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Challenges That MRT II Must Address

Medicaid Director

The Governor Has Directed MRT II to…

- **Address drivers of greater-than-projected costs** and growth in the Medicaid program;
- **Improve care management and care delivery** for beneficiaries with complex health conditions;
- **Modernize regulations, laws, policies, and programs** that hinder progress on quality or achieving efficiencies in the Medicaid program and for the health care industry; and
- **Ensure a stable and appropriately-skilled workforce**, especially with respect to meeting the needs of an aging population.

The Governor Has Directed MRT II to…

- **Advance the State's successful healthcare reform strategy** while restoring fiscal sustainability and ensuring access to benefits;
- **Strengthen the sustainability of essential safety net healthcare providers** serving vulnerable populations;
- **Reassess Medicaid global cap metrics** and ensure access to quality care for Medicaid members;
- **Maximize service delivery system efficiencies** and align supply and demand; and
- **Reduce waste, fraud, and abuse** to ensure the efficient and effective use of Medicaid dollars.

Areas Where Medicaid Course Correction May Be Needed

- Long Term Care and CDPAS
- Distressed Hospitals and other Supplemental Payments
- Prescription Drugs
- Transportation
- Care Management including Health Homes
- Program Integrity

Growth in Managed Long Term Care and Personal Care is Unsustainable

- The 13% enrollment growth in MLTC is much faster than demographic trends would indicate.
- MLTC spending between FY 19 and FY 21 is growing at an average rate of 13% – or roughly at an increase of $1.2 billion annually in State Medicaid costs.
- 75% of Managed Long Term Care costs reflects personal care – and personal care costs are growing in Mainstream Managed Care as well.
- The Consumer Directed Personal Assistance Program (CDPAP) is a key driver of growth – accounting for a majority of the increase in personal care hours in 2018.

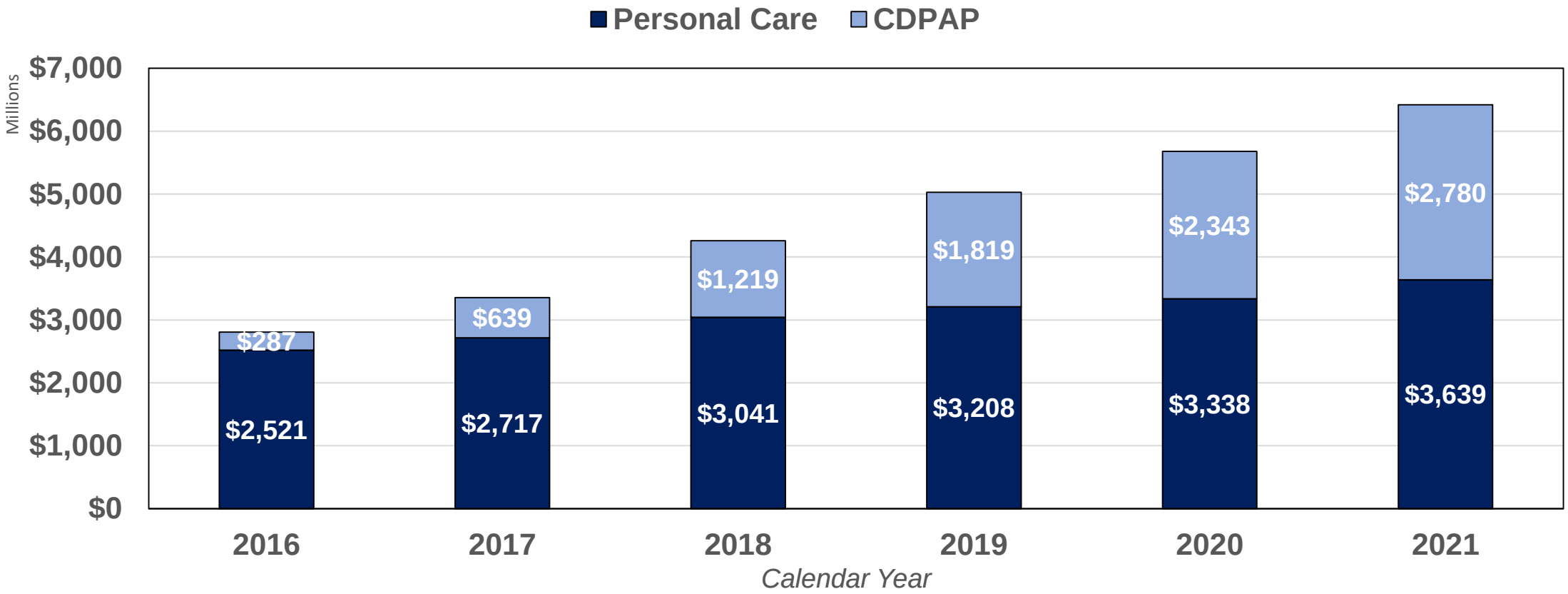
MLTC Spending and Enrollment Growth

$ in State Share				
	FY 2019	FY2020	FY2021	FY2022
MLTC Adjusted Spend*	**$6,840**	**$8,131**	**$9,322**	**$10,600**
Year-to-Year Growth		*$1,291*	*$1,191*	*$1,278*
Percent Change		*19%*	*15%*	*14%*
MLTC Enrollment	**257,924**	**288,434**	**319,940**	**361,366**
Percent Change		*12%*	*11%*	*13%*

** Spending is modified to account for payment adjustments*

Data Source: Division of Budget

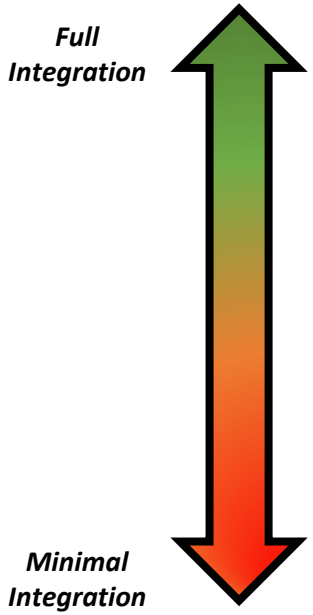
CDPAP Spending in MLTC is Growing Dramatically – Projected to Grow by Over 800% from CY 2016 to CY 2021



**Spending is trended for utilization and price growth attributable to minimum wage. From 2019-2021 the CDPAS share of total spending is based on an assumed growth rate that is consistent with trends through 2018.*

Few Dual Eligibles are Enrolled in Integrated Plans

- There are over 770,000 duals (individuals enrolled in Medicare and Medicaid) in New York State who make up 15% of the Medicaid population and account for 36% of Medicaid Spending.
- Only 3% of duals are enrolled in Managed Care integrated products (Medicare and Medicaid coverage are provided by the same entity).
- Integrated products provide opportunities to coordinate care and improve member experience and achieve efficiencies by aligning clinical and financial incentives between Medicare and Medicaid.



Duals	March 2019 Enrollment			
Medicaid Advantage Plus (MAP)	14,800	High Integration	26,000	3.4%
Medicaid Advantage (MA)	5,400			
Programs for All Inclusive Care for the Elderly (PACE)	5,800			
Partial Managed Long-Term Care (MLTCP)	227,700	Some Integration	227,700	29.4%
Fee-for-Service (Well Duals)	520,000	Minimal Integration	520,000	67.2%
Total	773,700			

Data Source: Department of Health Managed Long Term Care Enrollment Roster Reports.
Data Notes: Figures Rounded

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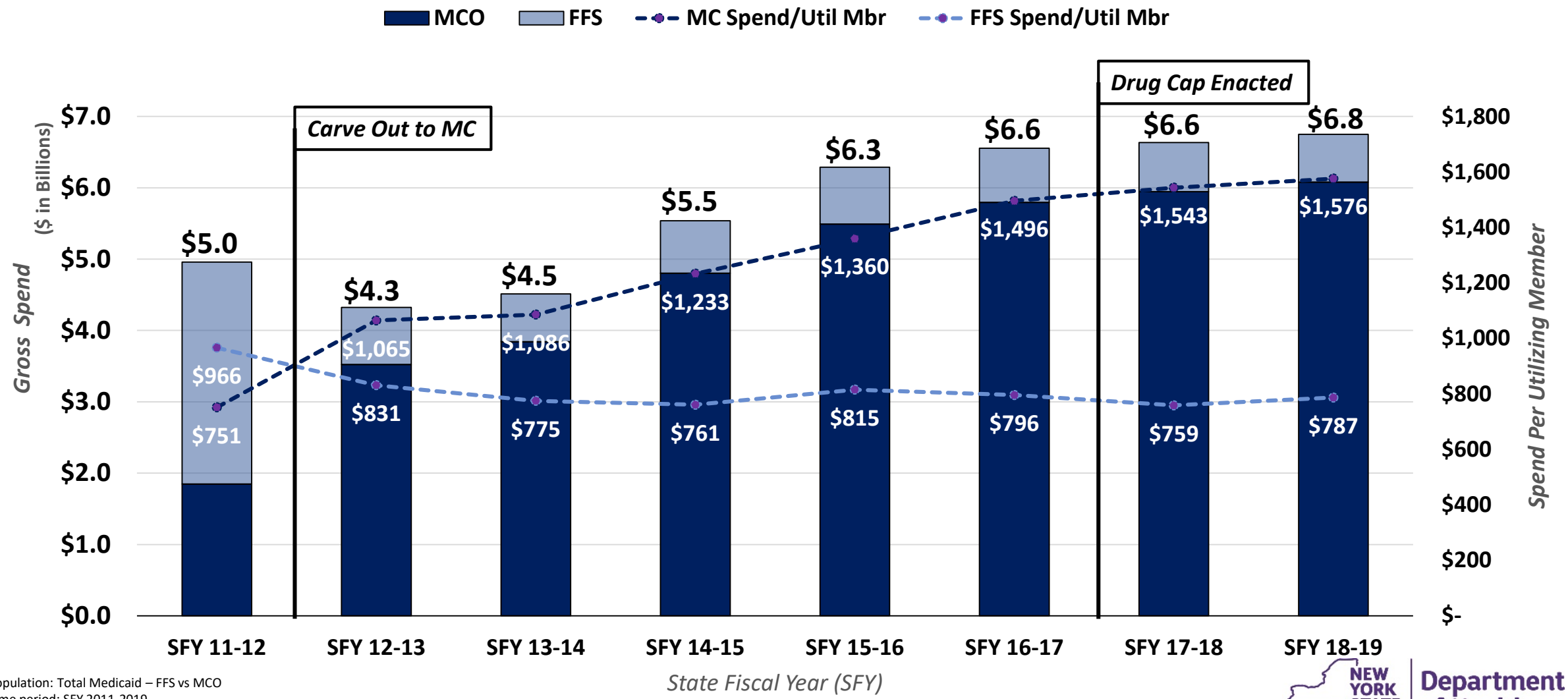
NYS Medicaid Pharmacy Spend Rising Faster than CPI



- Population: Total Medicaid – FFS vs MCO
- Time period: SFY 2011-2019
- Data Sources: Managed Care spend based on encounter data from the Medicaid Data Warehouse (MDW), plan reported pharmacy claim cost – does not include Physician Administered Drugs. Based on Date of Service, reported with three months of runout (06/30). Eligibility Count from Monthly Medicaid Eligibility Counts, Grand Total from June of each year.

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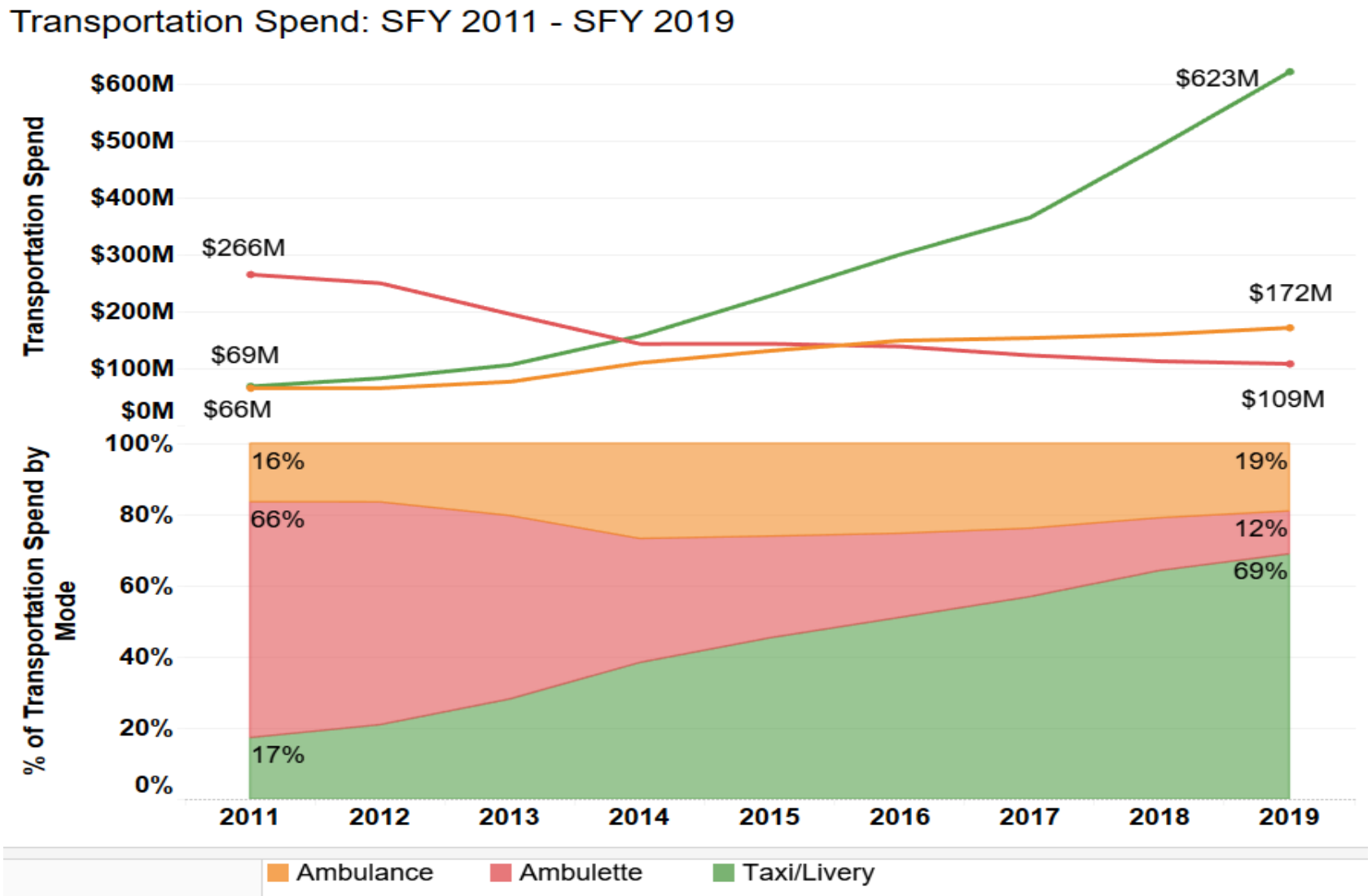
Taxi/Livery in Medicaid Transportation has Grown Dramatically since 2016

- Total Transportation Spend up ~131% SFY 2011 → SFY 2019
- Taxi/Livery Spend increased by nearly 800% from 2011 → 2019
- Shift in volume from Ambulette to Taxi/Livery: Ambulette Down to 12% of total volume in 2019 from 66% in 2011

- Population: Total Medicaid
- Time period: SFY 2011-2019, Dates of Service
- Data Source: Medicaid Data Warehouse (MDW)

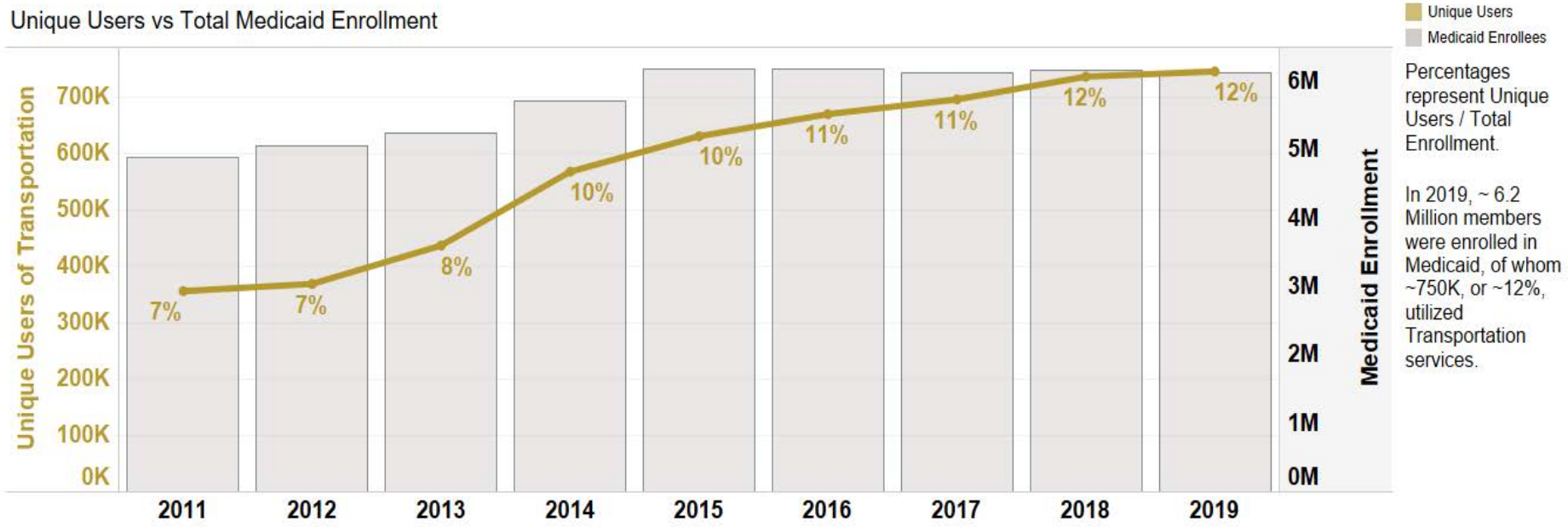
February 2020



Transportation (cont'd)

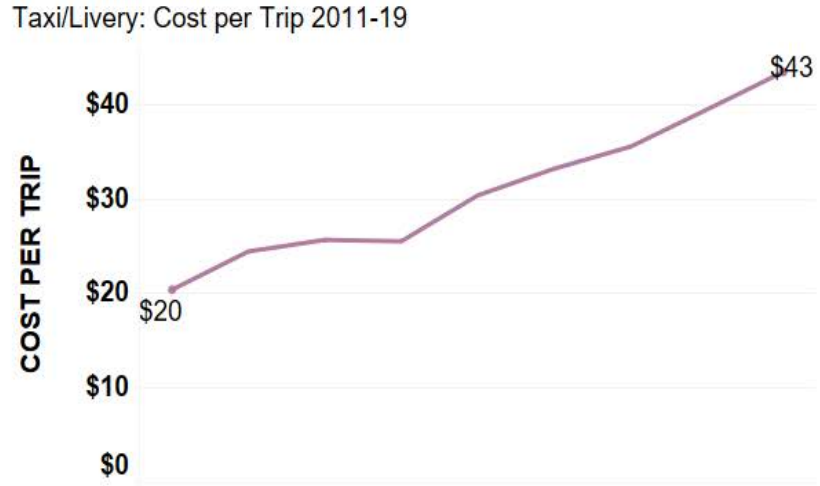
- Utilization increasing more rapidly than Medicaid enrollment. Medicaid enrollment up 25%; Unique Utilizers up 110%

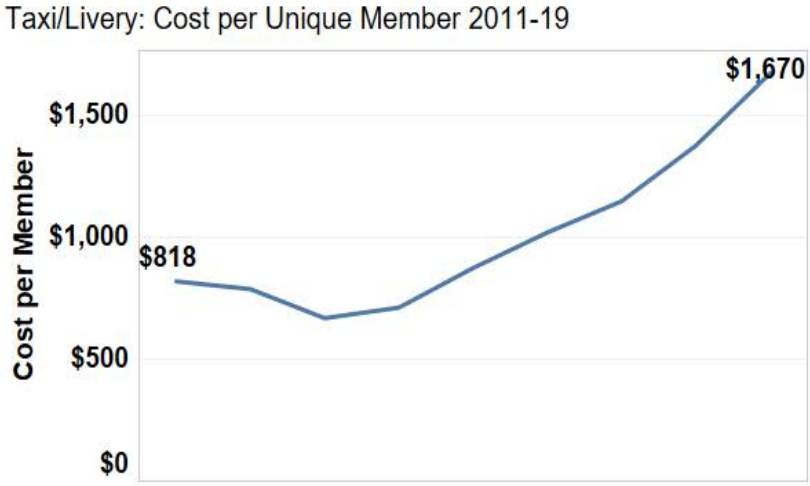
- Cost/trip and cost/member also increasing over time (115% and 104%, respectively)



Percentages represent Unique Users / Total Enrollment.

In 2019, ~ 6.2 Million members were enrolled in Medicaid, of whom ~750K, or ~12%, utilized Transportation services.

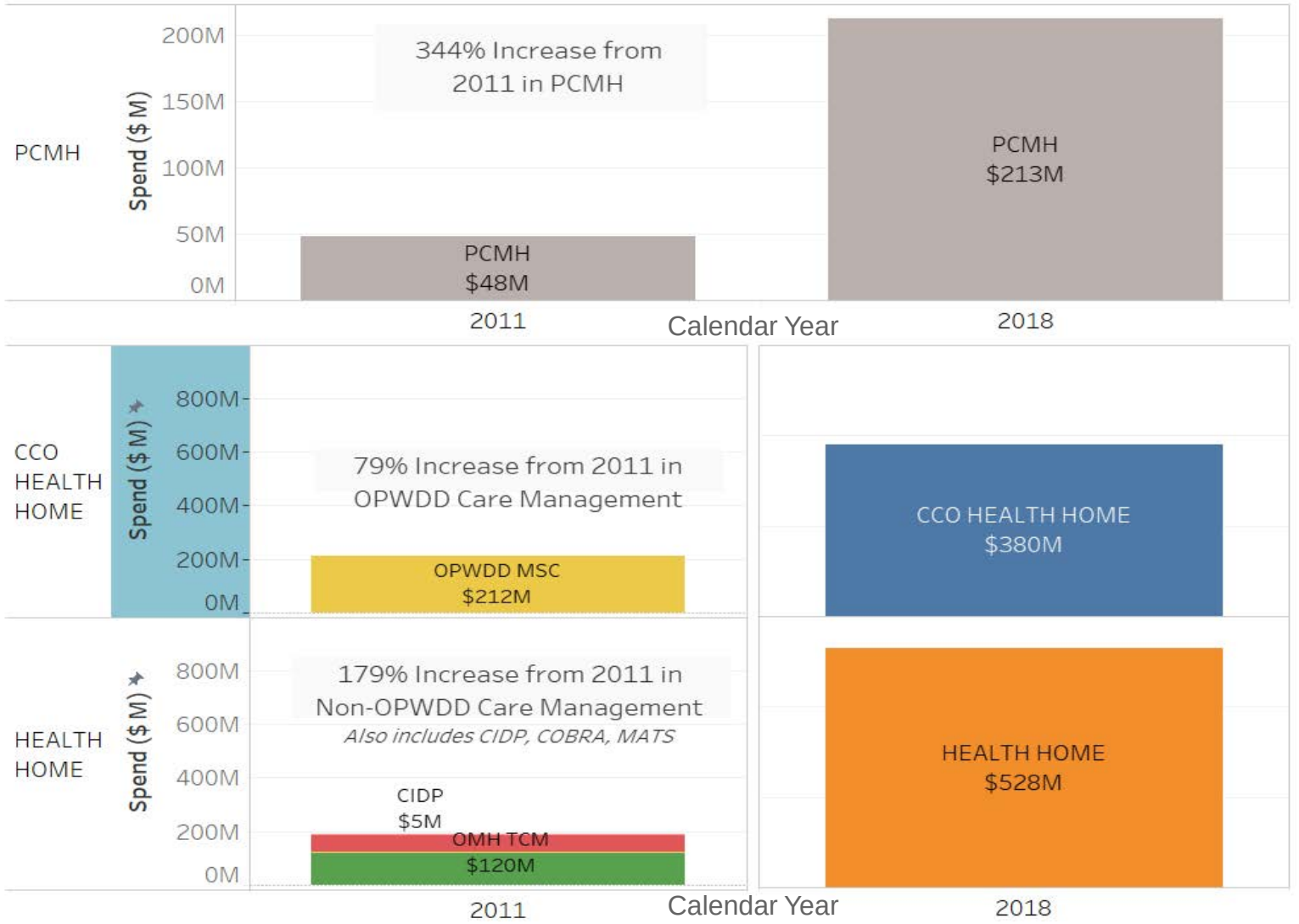




- Population: Total Medicaid
- Time period: SFY 2011-2019, Dates of Service
- Data Source: Medicaid Data Warehouse (MDW)

Care Management is Expensive

- Total Care Management spend increased 149% from ~$450M to ~$1.12B
- Increase in PCMH and non-CCO health home related primarily to enrollment growth
- Increase in CCO Health Home primarily related to rate increases.



- PCMH Data Source: MMCOR Cost Reports and Medicaid Data Warehouse.
- HH/CCO HH Data Source: Medicaid Data Warehouse (MDW)

Program Integrity Efforts Need to Be Enhanced

- Enhance focus on elements of program integrity that go beyond traditional retrospective recovery efforts.
- Examine reimbursement rules that create inefficiencies.
- Leverage external resources and enhanced computing power that can analyze large repositories of Medicaid data.
- Expand efforts reflecting the shift from fee-for-service into managed care, including:
  - Better leverage encounter data and acuity scores
  - Plan and provider risk-profiling
  - Complex VBP payment methodologies and associated program impact.

Process for Submitting Policy Proposals

Medicaid Director

Process for Submitting Policy Proposals

- Proposals should be submitted through the MRT II website.
  - Many stakeholders have been offering policy proposals knowing that significant changes will be necessary to address the Medicaid structural deficit.
- Proposals will be synthesized, evaluated, and presented to the MRT II at its second meeting.
- Proposals must be submitted through the "MRT II Proposal Submission Form" at the following link: https://health.ny.gov/health_care/medicaid/redesign/mrt2/

❖ Proposals must be submitted by no later than **12:00 pm on or about February 21st.**

Discussion