Medicaid Redesign Team Meeting

October 5, 2011 – Albany, New York

Working together to build a more affordable, cost-effective Medicaid program

Opening Remarks

Michael Dowling, Co-Chair

Dennis Rivera, Co-Chair

Introductions and New Members

New Members *(appointed as of 8/4/11)*

- **Joseph W. Belluck**, Founding Partner, Belluck & Fox, LLP.
- **Courtney E. Burke**, Commissioner, Office for People with Developmental Disabilities.
- **William Ebenstein**, Ph.D., University Dean for Health and Human Services, City University of New York.
- **Tina Gerardi**, MS, RN, CAE, CEO of the New York State Nurses Association.

New Members *(appointed as of 8/4/11)*

- **Robert J. Hughes**, MD, President-Elect of the Medical Society of the State of New York.
- **Wade Norwood**, Director of Community Engagement for the Finger Lakes Health Systems Agency.
- **Chandler Ralph**, FACHE, President & CEO of Adirondack Medical Center.
- **Harvey Rosenthal**, Executive Director, NY Association of Psychiatric Rehabilitation Services.

MRT Continuing Members

Continuing Members

- **Co-chair:**
  Michael Dowling
- **Co-chair:**
  Dennis Rivera
- Kenneth E. Raske
- George Gresham
- Dan Sisto
- Frank Branchini
- Eli Feldman
- Carol Raphael
- Linda Gibbs
- Ed Matthews
- Dr. Nirav Shah

Continuing Members

- Mike Hogan
- James Introne
- Arlene Gonzalez-Sanchez
- Lara Kassel
- Stephen J. Acquario
- Ann F. Monroe
- Steve Berger
- Dr. William Streck
- Elizabeth Swain
- Senator Kemp Hannon
- Senator Tom Duane
- Assemblyman Richard N. Gottfried serves
- Assemblyman Joseph Giglio

Phase I Implementation Update

Jason Helgerson

MRT Implementation Process

- ☑ DOH, in concert with other state agencies, is currently implementing the 78 Phase 1 MRT proposals that were approved in the budget.
- ☑ Implementing Phase 1 proposals is a huge challenge for New York State.

MRT Implementation Process

- ☑ **The Department of Health is using a very disciplined approach to project management:**
  - *Each proposal has an assigned lead and team supporting the implementation, consisting of staff within DOH and other state agencies.*
  - *Biweekly meetings are held to report implementation status to the Medicaid Director.*
  - *A master work plan tracks the tasks associated with each proposal and is published and regularly updated on the MRT Web site.*
  - *Next update available on Friday.*

MRT Implementation Process

- **MRT process marks a major shift in NYS – CMS relations:**
  - *To date, DOH has received approval of 20 SPAs related to MRT. There are an additional 32 SPAs related to MRT that are being submitted in the current round of proposals. Currently 85 active SPAs are before the CMS (both MRT-related and non-MRT.)*
  - *Weekly conference calls are held with CMS leadership.*
  - *CMS has appointed a special lead to assist with the MRT process.*
  - *CMS has made New York a real priority.*

MRT Phase 1: Bottom Line

- ☑ Reduces Medicaid spending by $2.2 billion in FY 2011-12.
- ☑ Enacts a series of measures to both control costs in short-term and enact longer-term reforms.
- ☑ Caps Medicaid spending growth in state law.
- ☑ Begins three-year phase-in to care management for all.
- ☑ The MRT is making a real difference.

Phase 1 Implementation Highlights

MAJOR REFORMS MOVE FORWARD

- ✓ **Care Management for All is moving ahead**
  - o *Pharmacy Carve-in.*
  - o *Personal care benefit built into "mainstream" managed care contracts.*
  - o *BHO contracts signed.*
- ✓ PCMH bonus expanded to Child Health Plus.
- ✓ Health Homes moving forward on a regional basis (165 letters of intent received).
- ✓ MIF is now implemented.
- ✓ Transportation manager now working in Hudson Valley.

Phase 1 Implementation Highlights

- **Cost containment being implemented**
  - *CHHA rate reform implemented.*
  - *Pharmacy rate reform implemented.*
  - *Managed Care rate changes.*
  - *Elements of the 2 percent ATB reductions already implemented (tailored to the needs of each sector).*

Phase 1 MRT Proposals Implementation Status

Status	*# of Proposals*	*Original Projected Savings ($M)*	*Current Projected Savings ($M)*	*Current Achieved Savings ($M)*
Completed *(all elements of proposal are completed)*	16	(175.71)	(195.67)	(195.67)
Substantively Completed *(key elements of proposal including those associated with savings are completed)*	10	(337.5)	(288.21)	(288.21)
In Progress *(elements of proposal have been initiated and are in progress)*	48	(747.13)	(750.76)	(112.47)
Merged with other *(certain proposals were merged to ensure better project management)*	3	(0.0)	(0.0)	(0.0)
Cancelled *(unable to be implemented)*	1	(0.0)	(0.0)	(0.0)
TOTAL	78	(1,260.34)	(1,234.64)	(596.35)

Implementation Update
as of October 5, 2011

- **MRT Phase 1 is on path to be implemented as planned.**
  - *We expect to generate the anticipated savings in FY11-12.*
  - *Some reforms will "over-perform" while others will "under-perform"*
  - *Industry-lead Cost Containment Initiative is on path to success.*
  - *Key is to achieve the overall savings target – we must live within the global spending cap.*

Implementation Update
as of October 5, 2011

- Actual savings achieved so far is $596.35 million.
- Challenges and lots of work remain but we are very excited about the progress made to date.
- The MRT is working!

2011-12 Medicaid Global Cap Update

John Ulberg

Background

- The Budget set a Global State Medicaid (DOH) spending cap of $15.3 billion in 2011-12 and $15.9 billion in 2012-13.
- The Global cap is consistent with the Governor's goal to limit total Medicaid spending growth to no greater than the rate for long-term medical component of CPI (currently at 4%).
- DOH and DOB will closely monitor and report on program spending on a monthly basis to determine if spending growth is expected to exceed the Global cap.

Background

- DOH and DOB will develop and implement a plan of actions in the event that program spending exceeds the Global Cap.
  - *These actions could include modifying/suspending reimbursement methods and program benefits.*
  - *DOH shall seek the input of the Legislature and other key stakeholders in the development of these plans and once developed, will be posted on the DOH website. Written copies shall be provided to the Legislature at least 30 days in advance of implementation.*

2011-12 Enacted Budget Savings

As part of the 2011-12 Budget agreement, $2.2 billion in State savings (growing to $3.3 billion in 2012-13) must be achieved so that spending is in line with the projected cap:

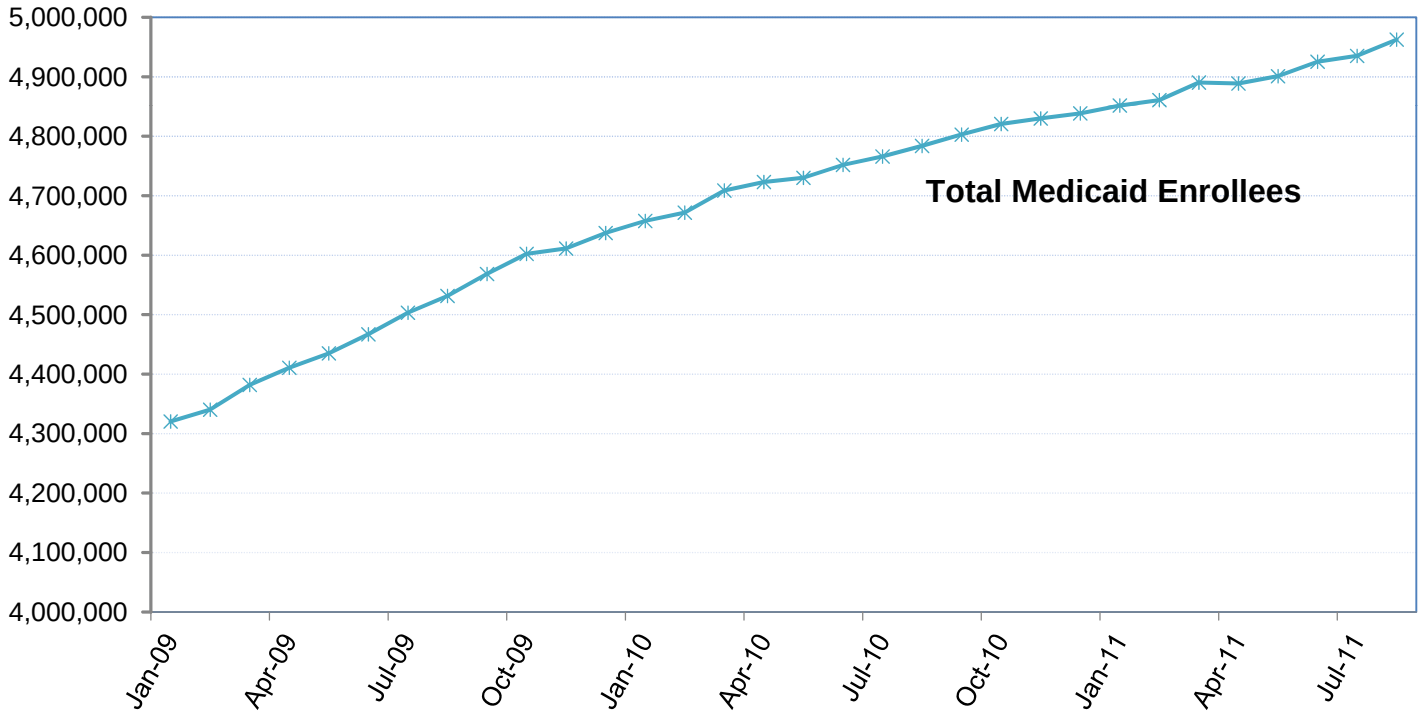
	2011-12	2012-13	Two-Year Total
MRT Savings*	$973	$1,130	$2,103
Trend Factors	$185	$304	$489
2% ATB Reduction	$345	$357	$702
Industry-led Contribution**	$640	$1,525	$2,165
Acceleration of Payments	$66	$0	$66
Total *	**$2,209**	**$3,316**	**$5,525**

***There were 78 discrete Medicaid Redesign Team (MRT) savings actions endorsed by the Legislature that will achieve $973 million in savings in 2011-12 and $1.13 billion in savings in 2012-13. Please see http://www.health.state.ny.us/health_care/medicaid/redesign for more information on these savings items.**

****** The Industry Led contributions ($640 million in 2011-12; $1.5 billion in 2012-13) represent the total amount of additional savings/system efficiencies that may be required (without additional State/Legislative action) to achieve fiscal neutrality under the cap.**

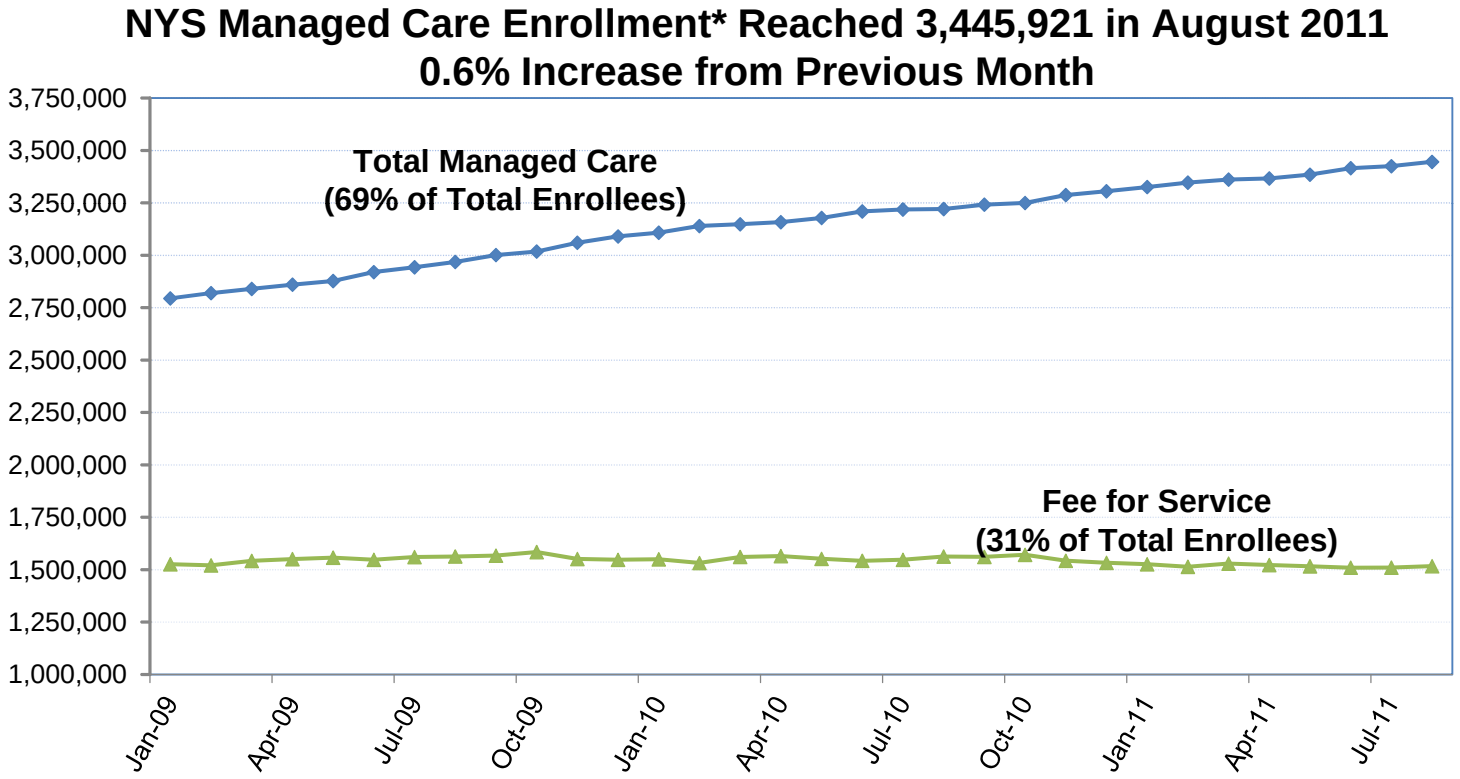
Medicaid Enrollment

NYS Medicaid Enrollment* Reached 4,962,639 in August 2011
0.6% Increase from Previous Month



Source: NYS DOH/OHIP Medicaid Enrollment Database. *Most current four months counts are adjusted for lag factors (3.62%, 1.38%, 0.57% and 0.21%, respectively)

Medicaid Enrollment (continued)



Source: NYS DOH/OHIP Medicaid Enrollment Database. *Includes FHP, Managed LTC, Primary Care Partial Capitation Provider (PCPCP), Medicaid Advantage, Medicaid Advantage Plus and SNP (Excl. CHP)

Global Cap Forecast Methodology

- **Sector Spending** – Monthly cash flow initially modeled based upon actual monthly claiming/spending patterns for SFY 2010-11 adjusted for known anomalies (e.g., one-time rate packages) within each sector. Base sector spending then adjusted for:
  - ***Anticipated spending in SFY 2011-12 (including $475M caseload re-estimate).***
  - ***Savings estimates to reflect timing/implementation of MRT proposals.***
  - ***The $640M Contingency Reduction has been reflected.***

Global Cap Forecast Methodology

- **Offline Spending** – Monthly sector-specific cash flow also adjusted for spending that occurs "off-line" or outside the claiming system (e.g., pharmacy rebates).

- **Reporting** – At end of month following (e.g., April results reported May 31). http://nyhealth.gov/health_care/medicaid/regulations/global_cap/.

Global Cap has Changed the Way DOH/DOB Operates

- **Improved Coordination & Communication** – a team was convened within DOH and DOB that have both programmatic and fiscal focus on various sectors in the global cap.
- **More Disciplined & Analytic** – transactions are more closely scrutinized prior to loading onto the eMedNY system for payment. Variation in spending is analyzed using sophisticated data base mining tools (Salient).

Global Cap has Changed the Way DOH/DOB Operates

- **Streamlined SPA Process** – weekly staff meetings are held with CMS to streamline and expedite SPA review and approval.

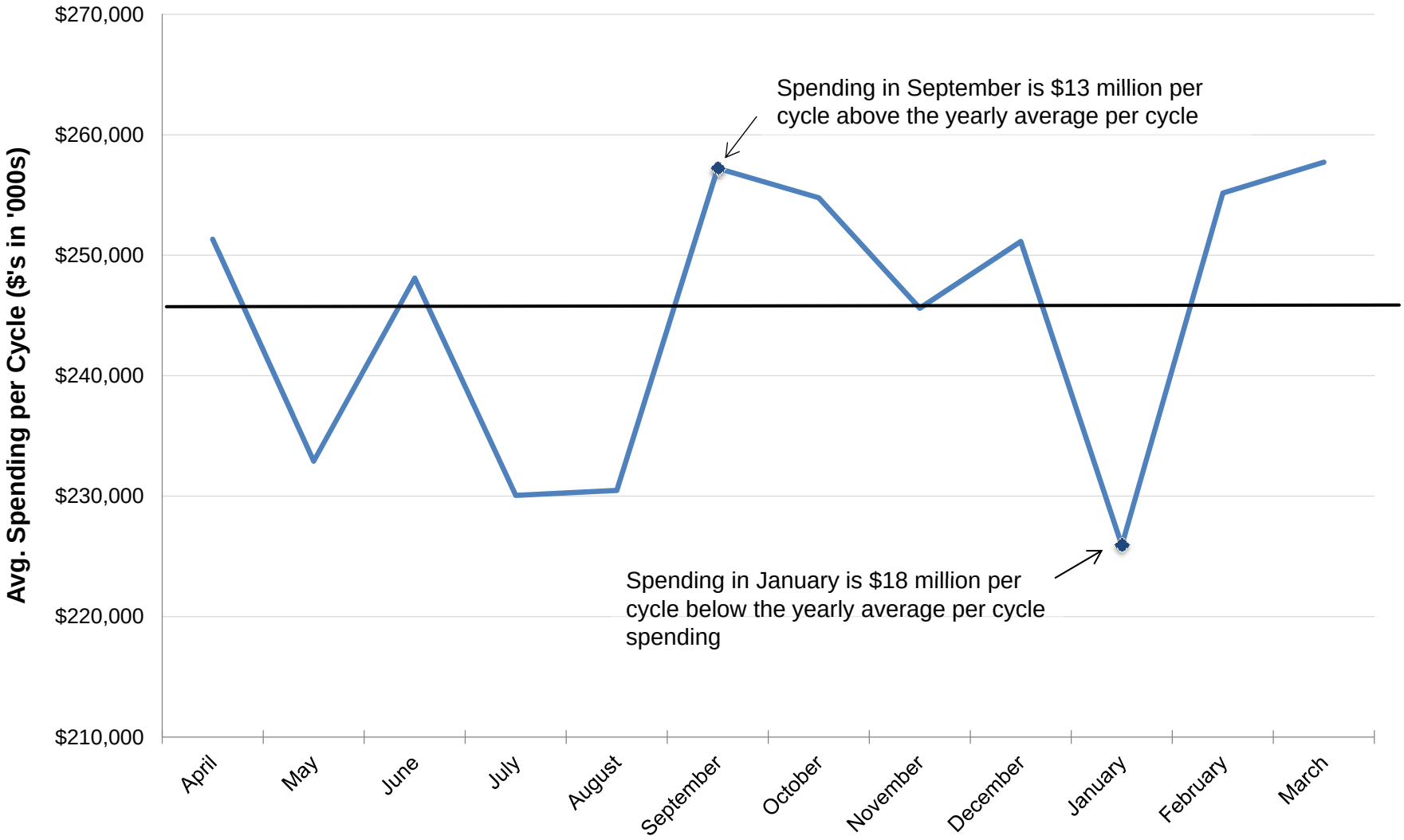
- **Transparency** – materials/reports are posted on the web, including the global cap forecast model and regional spending analyses, which will be posted shortly.

Global Cap Spending Results

Spending is $172.9M below the target (2.5%) through August:

AUGUST SFY 2011-12 Statistics				
Category of Service	Medicaid Spending (Thousands)			
	Estimated	Actual	Variance	% of Variance
Inpatient	$910,346	$900,933	($9,413)	(1.0%)
Outpatient/Emergency Room	$167,357	$145,551	($21,806)	(13.0%)
Clinic	$179,313	$180,701	$1,388	0.8%
Nursing Homes	$1,422,974	$1,402,942	($20,032)	(1.4%)
Other Long Term Care	$843,360	$823,176	($20,185)	(2.4%)
Medicaid Managed Care	$1,421,378	$1,437,784	$16,405	1.2%
Family Health Plus	$277,573	$301,991	$24,418	8.8%
Non-Institutional / Other	$1,900,100	$1,736,690	($163,411)	(8.6%)
Cash Audits	($151,920)	($132,185)	$19,736	13.0%
TOTAL	**$6,970,482**	**$6,797,581**	**($172,900)**	**(2.5%)**

SFY 2010-11 Variance of Medicaid Spending
Adjusted for Known Anomalies (i.e., rate packages)



Variance Highlights

Through August, Medicaid spending in major fee-for-service categories was $115.4 million below projections, this includes:

Inpatient Hospital:

Spending was $9.4 million under the target estimate. Year-to year the Inpatient sector has experienced a decrease in the number of Medicaid claims billed (2.7%), consistent with providing services in more appropriate settings, and the migration of recipients to Medicaid Managed Care.

Outpatient Emergency Room:

Spending was $21.8 million below estimates, a result of lower than expected utilization trends. The Outpatient Emergency Room sector has seen a year-to-year decrease in claims, 2.7%, and a decrease in the number of individuals served, 9.6%. The utilization drop is consistent with the migration of recipients to Medicaid Managed Care.

Variance Highlights

Through August, Medicaid spending in major fee-for-service categories was $115.4 million below projections, this includes:

Non-hospital clinics:

Total expenditures are $1.4 million above target estimates, driven primarily by the increase in individuals served (0.6%).

Nursing Homes:

Spending is $20 million below the global cap estimate through August. The number of individuals served remains slightly down from the previous year.

Variance Highlights

Other Long Term Care services, which include Home Care, Personal Care, and the Assisted Living program:

Spending is $20.2 million less than projected based on the following:

- *The variance is primarily attributable to Personal Care ($9.3 million) which continues to experience lower than projected spending due to efforts to reduce utilization and the inclusion of personal care services in the benefit package for managed care enrollees effective August 1, 2011.*
- *Home Health utilization increases seen in prior months are beginning to stabilize and spending is roughly on track at $2.5 million below projections.*
- *Home Nursing spending continues to reflect declines in utilization and is $7.7 million below projections.*
- *ALP spending continues to be on track with projections.*

Variance Highlights

Non-Institutional services, such as Pharmacy, Dental, Transportation, Supplemental Medical Insurance, etc.:

Spending for these programs were $42.9 million under projections. The variance is principally related to lower than forecasted Medicare rates related to Part A and Part B premiums, and the timing of these payments. Pharmacy spending was $10 million above projections. Per claim, brand drug costs have risen at a rate in excess of 13% when compared to the same period last year, while overall paid prescription drug claims have risen more than 5%.

Variance Highlights

Higher Medicaid Managed Care Spending:

The Medicaid Managed Care program is over budget by $16.4 million, which is the result of higher than anticipated enrollment. Premium increases have yet to be processed and are not reflected in these expenditures.

Higher Family Health Plus Spending:

Increased spending of $24.4 million also continues to reflect higher than anticipated enrollment. Premium increases have yet to be realized.

Variance Highlights

Medicaid Audit Offsets:

Through August, the spending offsets anticipated from Medicaid audit recoveries are $19.7 million below projected levels. This variance may be due to the timing of collections.

Lower Federal Medical Assistance Payments:

Enhanced Federal share payment benefits are $35 million below projections through August. A portion of this variance may be attributed to the receipt of the anticipated benefit through lower payments in other service categories.

Variance Highlights

Lower Local Medicaid Cap Costs:

Under the 2005 Local Medicaid Cap statute, the State is responsible for covering local costs of Medicaid that exceed the annual cap. To date, Local Medicaid Cap expenditures are below projected levels by $70 million. These Local Medicaid Cap costs are related to both fee-for-service and managed care spending variances and may be timing related and, as such, should not be material in an annual spending context.

Lower Other State Agency Offset Transfers:

Medicaid spending by other State agencies is running $39 million above projections through August. This spending is processed by the Department of Health and subsequently offset by transfers from the other agency budgets. This rate of overspending appears to be timing related and, as such, should not be material in the annual spending context.

Looking Ahead…

There are significant variables/transactions that are anticipated over the remaining six months that will affect spending:

- **Medicaid Enrollment** – Continued increase in enrollment that could be affected by a downturn in the economy/unemployment.
- **Large Retro Rate Packages** – Anticipated rate packages that are retroactive (HMO premiums; hospitals; APGs).
- **Implementation of MRT** – Completion of Phase I and development/ implementation of Phase II actions.

Lessons Learned

- Spending remains on target, however enrollment growth continues (influenced by a weak economy).
- Global Cap is transformative in the way DOH/DOB operates.
- Sophisticated analytic tools are being utilized to better understand the program and make appropriate policy changes.

Salient Demo
MRT Impact Measurement

Greg Allen

What We Are Doing

- To monitor the MRT initiatives, DOH has been using Salient Management Company's Medicaid Visual Data Mining system.
- This new tool allows us to track and analyze Medicaid in a very sophisticated way. It has changed how we view the program.
- Over 30 state staff have been trained in the use of this system and are currently tracking progress towards the MRT initiatives.
- We will demonstrate some of the monitoring process today using the actual Salient system.

Presentation Overview

- **Demonstrate cash tracking**
  - *Track trends of the major on-line spend by MRT Sectors and Sub-sectors.*
  - *Examine actual vs. forecasted cash spending.*
- **Measure impact of MRT proposals**
  - *Describe process to monitor initiatives on a continual basis.*
  - *Explore some "early returns" in terms of expenditure reduction.*

MRT Sectors and Sub-Sectors

- Examine expenditure trends of the major MRT sectors and sub-sectors:
  - ***Nursing Homes***
  - ***Non-Institutional Long Term Care***
  - ***Medicaid Managed Care***

Preliminary Measurement of MRT Initiatives

- ***Proposal #17*** - Reduce fee-for-service dental payment on select procedures.
- ***Proposal #24*** - Payment for Enteral Formula with Medical Necessity Criteria.
- ***Proposal #4652*** – Reform Personal Care Program.

MRT #17 - Reduce Fee-for-Service Dental Payment on Select Procedures

Proposal

- Reduce payments to office-based dentists for top 50 procedure codes, to the managed care payment levels, effective 5/1/11.

Tracking

- Examine monthly dental practitioner expenditures, to track savings.
- Examine monthly number of billing dentists, to monitor access.
- Track number of service users.

MRT #24 - Payment for Enteral Formula with Medical Necessity Criteria

Proposal

- Provide coverage of enteral formula only to individuals who cannot obtain nutrition through other means.

Tracking

- Monthly tracking of expenditures for enteral formula.

MRT #4652 – Reform the Personal Care Program

Proposal

- Improve management of personal care services.
- Limit PCA Level I (housekeeping) to eight hours per week.
- Increase technology and improve assessment for personal care.
- 2011-12 Savings; $113.81M state share.

Tracking

- Eight hours per week limit implemented April 1, 2011.
- Examine use of personal care level I utilization for members with over eight hours per week in the four months prior to implementation date of April 1, 2011, and compare to four months post April 1, 2011.

What You Will See in the Demonstration

- Live Salient statewide system being used by DOH
- No Patient Protected Health Information
- Complete data for Dates of Service starting 4/1/05 and updated weekly
- Paid FFS Claims & Managed Care Encounters
- Data set includes:
  - *10M Recipients*
  - *4B Transactions*
  - *$283B in claims*

Phase II
Update and Discussion

Jason Helgerson

Phase II: MRT Work Groups

- In Phase II, the MRT was directed to create a coordinated plan to ensure that the program can function within a multi-year spending limit and improve program quality.
- The MRT has been subdivided into ten work groups, with specific charges.
- Work groups are co-chaired by MRT members and membership is made up of non-MRT members, involving more stakeholders in the MRT process.

Phase II: MRT Work Groups

The Work Groups:

- Managed Long Term Care Implementation and Waiver Redesign
- Behavioral Health Reform
- Program Streamlining and State/Local Responsibilities
- Payment Reform/Quality Measurement
- Basic Benefit Review
- Health Disparities
- Affordable Housing
- Medical Malpractice
- Workforce Flexibility/Change of Scope of Practice
- Health Systems Redesign: Brooklyn (reports directly to Dr. Shah)

Phase II MRT Public Participation: Work Group Meetings

- Web sites have been created for each of the 10 Work Groups formed.
- Members of the public are invited to listen-in to work group meetings through a conference call.
- All meeting materials are posted to work group web sites.
- Meeting audio and minutes are posted within a few days after each meeting.

Phase II: MRT Work Group Process

- Each work group will meet at least three times and submit a final package of recommendations to the MRT for consideration.
- The MRT will review recommendations, vote on whether to include work group recommendations in final report to Governor Cuomo.
- Work groups submit final recommendations in phased process – beginning in mid-October, and finished by early December.
- Recommendations will be posted to work group website, and circulated to MRT members.

Phase II: MRT Work Group Process

- MRT members will have opportunity to review work group recommendations and provide comments to work group co-chairs/lead staff.
- Revised work group recommendations will be presented and voted on at full MRT meeting.
- Final package of approved recommendations will be included in final MRT report to Governor Cuomo.

Phase II: MRT Work Groups

Please refer to handout for detailed timeline information on MRT work group process.

Phase II: MRT Work Group Process

November 1: MRT Meeting (NYC):

- *Program Streamlining and State/Local Responsibilities*
- *Managed Long Term Care Implementation and Waiver Redesign*
- *Behavioral Health Reform*
- *Health Disparities*

December 13: MRT Meeting (Albany):

- *Basic Benefit Review*
- *Payment Reform and Quality Measurement*
- *Workforce Flexibility and Change of Scope of Practice*
- *Affordable Housing*
- *Medical Malpractice Reform*

Phase II: MRT Work Group Process

December 31:

- *Final MRT Report, consisting of approved work group recommendations, submitted to Governor Cuomo.*

Mid-January 2012:

- *Governor Cuomo's Executive Budget Release.*

Spring 2012:

- *MRT Update Meeting.*

MRT Final Product

- ☑ A summary of Phase 1 reforms and the approved recommendations of the ten work groups.
- ☑ This combined product will establish a comprehensive action plan for true Medicaid reform in New York State.
- ☑ The action plan may be turned into a comprehensive 1115 waiver to ensure that the state has sufficient flexibility to enact all of the reforms.
- ☑ The plan will be the most significant overhaul of the New York State Medicaid program since its inception.
- ☑ There is a lot of work still to be done!

Phase II MRT Public Participation: Work Group Meetings

- Multiple ways for the public to stay informed on MRT developments:
  - **MRT website: http://nyhealth.gov/health_care/medicaid/redesign/**
  - **MRT email listserv: http://nyhealth.gov/health_care/medicaid/redesign/listserv.htm**
  - The MRT has a **Facebook page http://www.facebook.com/NewYorkMRT**
  - And you can also follow the MRT on Twitter (@NewYorkMRT)

MRT Work Group Updates

Behavioral Health

Co-Chair: Linda Gibbs

Deputy Mayor of New York City for Health and Human Services

Co-Chair: Mike Hogan

Commissioner, Office of Mental Health

Program Streamlining and State/Local Responsibilities

Co-Chair: Steve Acquario

Executive Director, New York State Association of Counties

Co-Chair: Ann Monroe

President, Community Health Foundation of Western and Central New York

Managed Long Term Care Implementation and Waiver Redesign

Co-chair: Eli Feldman

President & CEO, Metropolitan Jewish Health System and Chairman, Continuing Care Leadership Coalition

Co-chair: Carol Raphael

President & CEO, Visiting Nurse Service of NY

Health Disparities

Co-Chair: Arlene Gonzalez-Sanchez

Commissioner, NYS Office of Alcoholism and Substance Abuse Services

Co-Chair: Elizabeth Swain

Chief Executive Officer, Community Health Care Association of NYS

Payment Reform and Quality Measurement

Co-Chair: Dan Sisto

President, Healthcare Association of NYS

Co-Chair: William Streck, MD

Chair, New York State Public Health and Health Planning Council

Basic Benefit Review

Co-Chair: Frank Branchini

President and CEO, EmblemHealth

Co-Chair: Nirav Shah, MD, MPH,

Commissioner of Health

Health Systems Redesign: Brooklyn

Chair: Steven Berger

Chairman of Odyssey Investment Partners (OIP), LLC

Affordable Housing

Co-chair: James Introne

Deputy Secretary for Health and the Director of Healthcare Redesign

Co-chair: Ed Matthews

CEO of the United Cerebral Palsy of New York City, President of the Interagency Council

Workforce Flexibility/ Change of Scope of Practice

Co-chair: William Ebenstein, Ph.D.

University Dean for Health and Human Services, City University of New York

Co-chair: George Gresham

President, 1199 SEIU United Healthcare Workers East

Medical Malpractice Reform

Co-chair: Joseph W. Belluck

Founding Partner, Belluck & Fox, LLP

Co-chair: Ken Raske

President, Greater NY Hospital Association

Upcoming Meetings

November 1
New York Academy of Medicine
Fifth Avenue and 103rd Street
Manhattan
10:00 a.m. – 4:00 p.m.

December 13
Empire State Plaza,
Meeting Rooms 2-4
Albany
10:00 a.m. – 4:00 p.m.

Open Discussion