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Payment Reforms in NY Medicaid Program Face Challenges

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The report discovered that the payment reforms being initiated have helped contain Medicaid program costs even though the enrollment numbers increased.

The state of New York has been working toward redesigning their Medicaid program and fixing the various problems plaguing this system. In particular, payment reforms within the New York Medicaid program are being implemented to advance medical care for beneficiaries.

Starting in 2014, Governor Andrew Cuomo worked with federal agencies to establish a waiver that would let the state renew $8 million in federal funds to redesign their Medicaid program. The funding would be used to supplement the Delivery System Reform Incentive Payment program.

A recent report from the Citizens Budget Commission (CBC) outlined the quality improvements and cost savings that these payment reforms have brought as well as the issues still standing in the way of continuing with these transformations, according to a CBC press release.

The report - called What Ails Medicaid In New York, And Does The Medicaid Redesign Team Have A Cure? - discovered that the payment reforms being initiated have helped contain Medicaid program costs even though the enrollment numbers increased by one-third due to the Medicaid expansion provisions of the Affordable Care Act.

The total costs for each Medicaid beneficiary actually dropped 17 percent between 2010 and 2014 for the state of New York. This even included beneficiaries who are disabled or elderly, the report found. Previously, Medicaid spending in the state of New York was rising faster than the national average.

The payment reforms and redesigning techniques for the New York Medicaid program have focused on managed care and home nurse visits. The CBC report outlined how relying on managed care organizations has often led to lower costs since it incentivizes physicians to avoid wasteful spending on unnecessary medical services and also enables managed care providers to negotiate lower prices.

There has been greater stress on care coordination, value-based care payments, and incentives related to patient outcomes instead of volume of services as in the fee-for-service reimbursement system.

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

As policymakers continue to implement and tweak the payment reforms within the New York Medicaid Program, it is expected that there will be a continuation of significant cost savings over the coming years, according to the release.

At this point in time, the Delivery System Reform Incentive Payment program is projected to reach anywhere from $1.3 billion and $1.9 billion in savings by the year 2020. However, the CBC report outlines some major obstacles that are standing in the way of obtaining these savings.

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

First, the report discusses how only about half of Medicaid spending in New York is positioned through managed care plans due to a nonmandatory arrangement where Medicaid beneficiaries who need a greater amount of medical care do not receive services through a managed care program. Additionally, more time is needed to develop new managed care platforms to handle patients with more specific disabilities.

“In 2013 CMS authorized a program to provide comprehensive (that is acute and long-term care) services to people eligible for Medicare and Medicaid (‘dual eligibles’) and requiring long-term care services. The entities to provide this integrated care, Fully Integrated Duals Advantage (FIDA) plans, receive a combined capitation rate from Medicare and Medicaid. Enrollment in FIDAs is not mandatory, but the appropriate dual eligibles were subject to a ‘passive enrollment’ process in which they would automatically be enrolled in a plan if they did not explicitly opt out of the program,” the report stated.

“The passive enrollment process was implemented during 2015 and the vast majority of those eligible opted out. Two groups previously excluded from managed care but with specialized and expensive care needs are those with severe mental illness, including substance abuse, and those with developmental disabilities.”

“Some in each group are treated in residential facilities such as mental hospitals, residential drug treatment programs, and supervised homes for those with developmental disabilities; others require extensive outpatient treatment for specialized conditions as well as other physical illness. Because mainstream MCOs did not provide these services, individuals in these groups have been exempt from managed care mandates.”

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Another important point mentioned in the report is that more efforts need to be made to improve enrollment for Health Homes, which were created to improve care coordination among patients with multiple medical conditions.

Finally, the Citizens Budget Commission finds that the implementation of value-based care payments will be faced with technical challenges regarding the right clinica measures to analyze and the policies to follow when designing payment contracts. Creating more risk-based payment systems is likely to take longer and may only gain momentum starting in 2020, according to the press release.

Over the next five years, the state of New York will need to meet these challenges and overcome any obstacles in order to continue its path of reducing healthcare spending for its Medicaid program.