

**Medicaid in
Transition:
A Progress Report
on Reform in
New York**

Russell Sykes

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EXECUTIVE SUMMARY

A 2012 Empire Center report, *Taking Ownership: The Patient Role in Medicaid*, recommended that efforts to reform New York's Medicaid program should place a greater focus on enlisting patients as active, responsible partners in managing and improving their own health.

This paper reviews major elements of the state's ongoing Medicaid overhaul, putting special focus on efforts to incentivize patient behaviors that can reduce the incidence of chronic disease, improve outcomes and lower costs.

Recognizing that many of the most costly-to-treat conditions, such as diabetes and heart disease, are caused or exacerbated by lifestyle choices, the state has begun offering modest financial rewards to patients who cooperate in improving their own health — by, for example, improving their diet, attempting to quit smoking or faithfully following doctors' instructions.

Research has shown that well-designed programs of this kind can both improve health and lower costs of care over time.

So far, however, New York's efforts in this direction have been disappointing. Officials have moved slowly in implementing programs, undermined their effectiveness with arbitrary restrictions, and, as of August 2015, reached only a few thousand recipients — less than one-tenth of 1 percent of the state's Medicaid enrollment.

When it comes to changing the behavior of hospitals, doctors, nursing homes, clinics and other providers, by contrast, the state is making aggressive and effective use of its financial leverage.

Convinced that Medicaid's traditional "fee-for-service" payment system incentivized quantity over quality of care, state officials are completely overhauling their reimbursement models to reward providers not just for doing procedures, but for producing good outcomes.

They're also doling out billions in grants that effectively pay providers to form coalitions, collaborate more efficiently, emphasize primary care, modernize record-keeping and make other improvements.

These promising reforms have enabled the Cuomo administration to hold Medicaid spending growth to 5 percent or less per year even as it absorbed a 15 percent spike in enrollment driven by President Obama's Affordable Care Act.

But as we wrote in 2012: "Even the best-designed and best-coordinated system of managed care will fail to deliver the desired results if too many patients continue to smoke, or fail to exercise adequately or indulge eating and drinking habits that make their health problems worse."

Given the disproportionate burden of lifestyle-related illness among the Medicaid population, and the demonstrated effectiveness of incentive programs in other states, the patient-ownership approach deserves more vigorous exploration in New York.

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A HISTORY OF HIGH COSTS AND WEAK OUTCOMES

Medicaid is the nation's principal government-funded health plan for the poor.

Jointly managed and financed by the federal and state governments, it covered 68.9 million individuals in 2015, or about one in five Americans, an increase of nearly 17 percent since 2013.¹ The program costs over \$474 billion nationwide.² (Medicaid should not be confused with Medicare, a federal-only program that primarily covers people 65 or older.)

New York's version of Medicaid, with some of the loosest eligibility rules and broadest benefits of any state, currently covers nearly a third of its population, or 6.4 million people.

New York's program is also disproportionately costly, with a budget of \$54.94 billion for 2013-14, which is projected to rise to just over \$62 billion in fiscal year 2015-16.³ With about 6 percent of the nation's population, New York accounts for 12 percent of its Medicaid spending.

Under the Federal Medical Assistance Percentage, which is calculated based on per capita income, Washington covers 50 percent of the costs for most Medicaid patients in New York, the lowest share possible.

The state's contribution, at about \$22 billion a year and rising, is the single largest expense in its annual budget. New York is one of 16 states that also shifts part of the cost onto local government.⁴ As a result, Medicaid is also a major budget expense for New York City and the 57 other counties.

Despite this massive investment from three levels of government, there are longstanding concerns about the quality of care. No definitive state-by-state comparison of Medicaid quality is available.⁵ However, in a 2007 analysis by Public Citizen, New York's Medicaid plan ranked a mediocre 13th on quality-of-care benchmarks, scoring 83.1 out of a possible 200 points.⁶ A 2009 scorecard from the Commonwealth Fund ranked New York 21st for overall health system quality, and 50th (second to last) on a combined measure of cost and avoidable hospital admissions.⁷

Critics have argued that a more efficient Medicaid system could both save money and improve care by, for example, better managing chronic conditions such as asthma and diabetes to keep patients healthier while avoiding costly emergency room visits and hospital stays.

Almost since the program's creation by Gov. Nelson Rockefeller in 1966, governors of both parties have tried to overhaul Medicaid. But they have met with limited success, largely because health-care industry groups and labor unions — which are traditionally among the biggest spenders on lobbying and campaign donations in Albany — prevailed on legislative leaders of both parties to resist almost any reforms that slowed spending, framing them as harmful to patients. The most that governors could usually achieve was across-the-board cuts in payments to providers, which strained their finances while doing nothing to improve efficiency or quality of care.

A NEW STRATEGY FOR REFORM

The political dynamic surrounding Medicaid changed dramatically after Governor Andrew Cuomo took office in January 2011.

Having campaigned on a platform of fiscal responsibility and no tax hikes, and facing a Great Recession-induced deficit of \$10 billion, Cuomo had a clear mandate to control spending. A constitutional maneuver pioneered by his predecessor, David Paterson, also gave him added muscle in budget negotiations with the Legislature.

Cuomo used that leverage to win key changes in Medicaid:

First, he repealed statutory “inflation factors” that automatically increased fees to providers on a yearly basis unless modified by lawmakers, obliging governors to expend political capital just to hold them steady.

Second, he instituted two-year budgeting for the program, giving the health-care industry more predictability and allowing for longer-term planning.

Third, he imposed a global cap on the state’s Medicaid spending growth. It was set at 4 percent for that first year – a departure from the typically double-digit increases of the recent past – and tied going forward to the 10-year average of medical inflation.

Fourth, he assigned the task of meeting that target to a Medicaid Redesign Team, to which he appointed many of the industry and union representatives who had stymied reform in the past, along with other experts and stakeholders.

Fifth, if that team failed to find enough savings, he empowered his health commissioner to unilaterally make whatever cuts would be necessary to live within the cap.

In effect, Cuomo shifted management control of Medicaid reform from elected legislators to an appointed group of insiders and technocrats – which insulated the process from political pressure to a degree, and set the stage for longer-term planning and consensus decision-making.

Five years later, the Cuomo administration has so far succeeded in keeping Medicaid spending below its global cap – in spite of a sharp increase in Medicaid enrollment, and without the need for the health commissioner to exercise his budget-cutting authority.

The state met that goal while implementing some of the most profound and far-reaching reforms to New York’s Medicaid program in modern memory.

Among them are small experiments with “patient ownership,” in which Medicaid recipients receive financial rewards for healthy behavior, such as quitting smoking, losing weight and keeping medical appointments.

The specifics of those reforms – and what we know about their effect on quality of care – are discussed in the body of this report.

THE NATIONAL CONTEXT

Complicating the task of Cuomo's Medicaid Redesign Team — and raising the stakes for reform — was the Patient Protection and Affordable Care Act, also known as the ACA.

President Obama signed the ACA into law on March 23, 2010. Congress had approved the legislation by a narrow margin of 219-212. No Republicans voted for it, and 34 Democrats voted against it.⁸ The law was meant to move the country toward universal health insurance coverage.

It requires most citizens to maintain health insurance coverage, except under limited circumstances, with tax penalties for those who fail to enroll. It also calls for establishing purchasing exchanges through which people can shop for insurance plans and, depending on their income, qualify for tax credits to offset premiums.

States could establish their own exchange, form a partnership with the federal government's insurance exchange or rely solely on the federal exchange.

At the same time, the law expanded eligibility for Medicaid so that it would cover adults and children up to 133 percent of the poverty level.⁹ Children ages 18 and under are eligible up to the same income level or higher in all states under the Child Health Insurance Program (known as Child Health Plus in New York).

As originally passed, the ACA mandated broader coverage in all states, with the federal government fully absorbing the additional cost in the early years. That mandate was struck down by the Supreme Court in its 2011 decision in *National Federation of Independent Business vs. Sebelius*.¹⁰

Unlike many states, New York was quick to fully embrace the ACA.

An insurance exchange known as the New York State of Health was established by Cuomo's executive order in 2012.¹¹ Through this site,¹² qualifying low-income consumers who enrolled in a health plan could apply for and receive ACA subsidies to reduce their health insurance costs.

New York is among 12 states, along with the District of Columbia, that operate their own insurance exchanges. Eighteen other states rely exclusively on the federal exchange, some because they were worried about cost or technical difficulties, others because they took issue with the ACA itself. In the remaining 20 states, responsibility for exchange management is shared between the state and federal governments.¹³

New York was one of the first states to take advantage of enhanced federal funding in support of expanded Medicaid eligibility. Thirty other states and the District of Columbia have also opted into Medicaid expansion, and more may do so in the future.¹⁴ (See Map 1 on next page.)

Through 2016, the enhanced federal reimbursement rate on newly-eligible patients is 100 percent (that is, no state match required), dropping to no less than 90 percent on a permanent basis.¹⁵

Between the 2013 launch of ACA enrollment and November 2015, Medicaid rolls nationwide have increased by 14.1 million or 25.3 percent, according to data from the Center for Medicare &

Medicaid Services (CMS). That increase has been driven largely by 34 percent growth in states that have enacted the Medicaid expansion option. In states not taking the expansion option, enrollment has grown by 10 percent.¹⁶

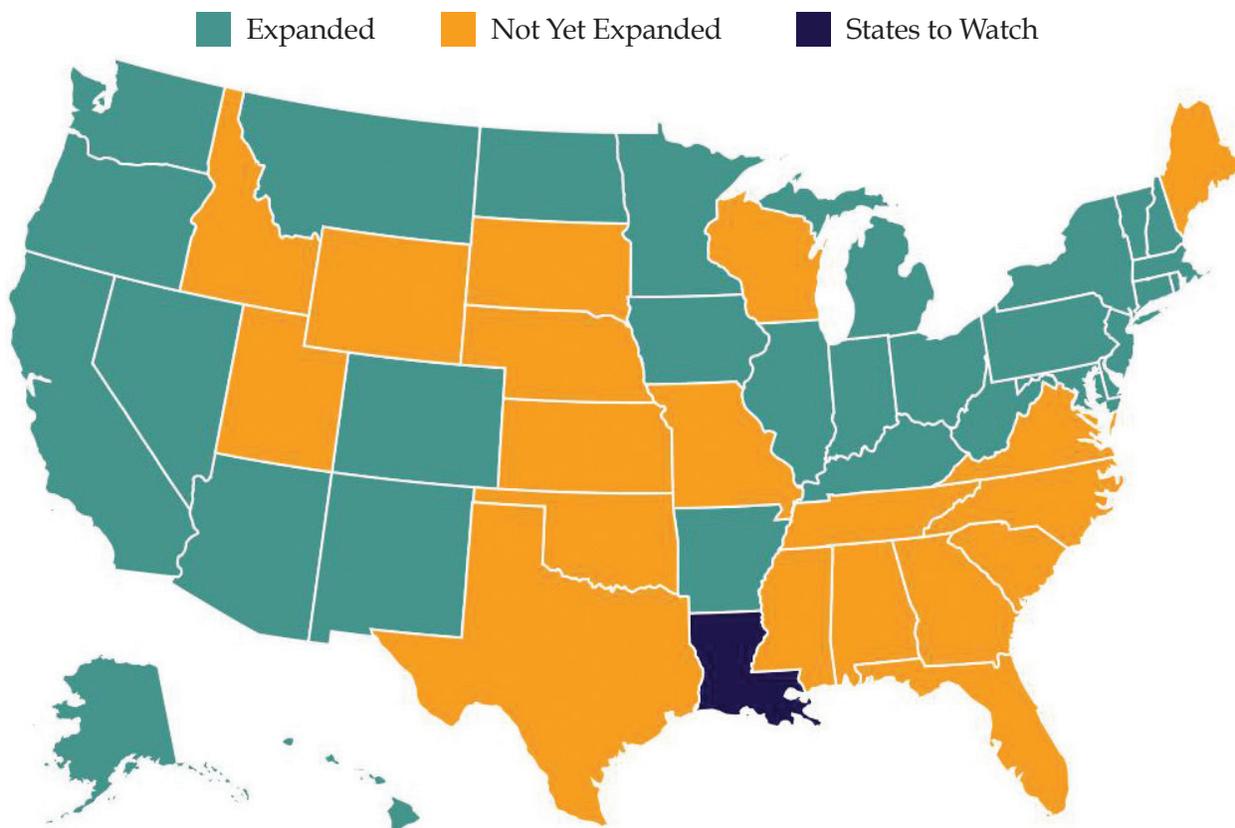
More than 2.1 million New Yorkers enrolled in a plan in the open-enrollment period for 2015 coverage, including nearly 1.73 million enrollees in Medicaid and Child Health Plus.¹⁷ Those who enrolled in private insurance previously had an 86 percent renewal rate.¹⁸

New York opted for the Medicaid expansion because its eligibility levels were already high and the prospect of enhanced federal reimbursement to make up any gap was enticing. The state also anticipated that the overall impact and cost of the expansion would be relatively modest because of its already expansive Medicaid coverage.

However, as a result of publicity surrounding the ACA and the New York State of Health’s outreach efforts, many New Yorkers who were previously eligible but not enrolled have joined Medicaid since 2012. This is known as the “woodwork effect.”¹⁹ The State does not receive the enriched federal match rate for individuals who were previously eligible.

According to data from the New York State Department of Health, shown in Table 1 (page 6), only 29 percent of the recent Medicaid enrollment growth consists of newly eligible individuals, and 71 percent, or more than 587,000 people, were previously eligible.

Map 1: States Expanding Medicaid



Source: Families USA

A COSTLY AUDIT

In July 2014, a federal audit of New York’s Medicaid spending on individuals with disabilities resulted in a “disallowance notice” for \$1.26 billion in reimbursements.²⁰ CMS also said it would conduct similar audits in each of the next two years, with comparable amounts of planned reimbursements at risk for those periods as well.

After a failed appeal, the state had no choice but to enter into a costly settlement agreement with CMS, resolving the \$1.26 billion in disallowance for FY 2011 and all related payment disputes for state-operated services, including home- and community-based waiver services, prior to April 1, 2013. The settlement also addresses other related audit findings for services delivered by the Office for People with Developmental Disabilities. Under the agreement, the state provided an \$850 million payment to the federal government in April 2015, and annual payments of \$100 million are planned for each of the next 11 years beginning in FY 2017.²¹

THE MEDICAID REDESIGN TEAM

The current push for Medicaid reform in New York began with the creation of the Medicaid Redesign Team. Cuomo signed the order to establish the 25-member panel on his fifth day in office, Jan. 5, 2011, which came less than nine months after Obama signed the ACA.²²

Cuomo’s appointments to the panel include the commissioners of several health-related state agencies, four members of the Legislature, the heads of the state’s two largest hospital associations, executives of health workers’ unions, health-care and insurance executives, business officials and consumer representatives.

Its initial charge was to help Cuomo find cuts in the Medicaid budget that would keep spending growth below his 4 percent target. In the years since, the panel has gone on to launch more than 200 initiatives, implemented by the Health Department and other agencies, designed to improve the care delivered to Medicaid recipients while constraining historically high costs.

Among its earliest priorities was a push to end fee-for-service coverage and institute managed care for all groups of Medicaid recipients.

Under the fee-for-service approach, an insurer pays a fee for each office visit, test, operation, nursing home stay, etc. Once the norm for all health insurance, this system can create a perverse incentive for providers: The longer a patient stays sick, the more work providers do and the more revenue they collect.

Under managed care, Medicaid pays providers – or, more likely, an organization of providers – a fixed amount to provide whatever care an individual needs over a period of time. This is meant to give providers an incentive to manage the patient’s health as efficiently as possible, emphasizing low-cost prevention instead of high-cost intervention.

Table 1: Medicaid Enrollment

As of October 19, 2015

Period	Total Enrollees	Newly Enrolled Under ACA with 100% FFP
March 2015	6,180,011	250,458
December 2013	5,350,053	8,220
Total Change	829,958	242,238

Source: NYS Department of Health

New York’s Medicaid program has enrolled its younger, healthier recipients in managed care plans going back decades. Under the Medicaid Redesign Team’s plan, the state expanded the approach to sicker, costlier groups for whom managed care had previously been voluntary, experimental or nonexistent. These include elderly and disabled candidates for nursing homes, the mentally ill, and people with substance abuse issues.

EASING THE BURDEN ON LOCAL GOVERNMENT

Since 2006, in an effort to ease the fiscal burden of Medicaid on local government, the state had capped growth in the share paid by New York City and the 57 others counties at 3 percent per year. In Cuomo’s second budget, for FY 2012-2013, the state committed to eliminate all growth in the local contribution over a three-year period. This shifted \$2 billion to the state tax base as of 2015-16.²³

In his 2016-17 Executive Budget, Cuomo proposed exempting New York City from the cap, which would have saved the state – and cost the city – \$180 million in the first year. However, the Legislature rejected that proposal in the adopted budget.²⁴

WINNING A WAIVER FROM WASHINGTON

In 2011, the Cuomo administration applied for a so-called Section 1115 waiver from the Center for Medicare & Medicaid Services. Its goal was to seek Medicaid reimbursements for health-related services that were not previously eligible for federal matching funds, such as supportive housing, public health programs and capital construction costs.

In its waiver application, the state estimated that its then-enacted Medicaid reforms would save the federal government \$17 billion over five years, and asked that the state be allowed to reclaim \$10 billion of that amount for investment in further modernization of its health care system. The savings were to be used to expand and emphasize primary care and to save struggling hospitals in poor communities, among other priorities.

After negotiations, CMS awarded New York a scaled-down waiver in April 2014. The state received \$8 billion rather than \$10 billion, and payments would be spread over nearly six years, including a planning year, starting in 2015.

The Medicaid waiver is being closely monitored and evaluated by CMS on how well it achieves certain milestones, forcing New York to take very seriously the mutual goals of cost-containment and improved health outcomes. A March 2015 report on Medicaid by New York State Comptroller Thomas DiNapoli outlined this reality:

The anticipated increase in federal funding associated with the new waiver amendment increases the State's fiscal incentive to restrain growth in Medicaid spending in coming years. It comes with performance goals known as "milestones" aimed at both the statewide Medicaid system and the new health care provider systems required by the waiver. If New York fails to improve efficiency and reduce average costs as required by these benchmarks, new federal funding would be reduced by hundreds of millions of dollars, potentially increasing budgetary pressure to reduce services. DOH has already taken steps to achieve cost savings through restrictions in services, setting new limits in recent years in areas such as home care.²⁵

The \$8 billion reinvestment was allocated in the following ways:

- \$6.42 billion for Delivery System Reform Incentive Payments, including planning grants, provider incentive payments and administrative costs. This was subsequently increased to \$7.3 billion.
- \$500 million for the Interim Access Assurance Fund. Temporary, time-limited funding to ensure that trusted and viable Medicaid safety-net providers can fully participate in the reform without disruption.
- \$1.08 billion for other Medicaid redesign purposes. This funding will support "health home" development as well as investments in long-term care, expansion of the health-care workforce and enhanced behavioral health services.²⁶

DELIVERY SYSTEM REFORM

As the Center for Medicare & Medicaid Services declared in January 2015:

[The ACA] offers many tools to improve the way providers are paid to reward quality and value instead of quantity, to strengthen care delivery by better integrating and coordinating care for patients, and to make information more readily available to consumers and providers. Doing so will improve the coordination and integration of health care, engage patients more deeply in decision-making, and improve the health of patients — with a priority on prevention and wellness.²⁷

In keeping with this spirit, New York is using \$7.3 billion of its Medicaid waiver funding for the Delivery System Reform Incentive Payment program, or DSRIP. The program's goal is to deliver services in a more preventive and cost-effective fashion, emphasizing greatly expanded primary

and preventive care, and reductions in unnecessary hospitalization and emergency room use. It calls for a “value-based” payment system that rewards positive health outcomes and healthy behavior among Medicaid recipients (detailed on page 9).

Through a competitive grant process, the program seeks to promote community-level collaborations between hospitals and local providers to achieve a specific goal: a 25 percent reduction in avoidable hospital admissions and readmissions over five years.^{28,29}

That core commitment is highly ambitious. It focuses on diverting frequent Medicaid users with chronic diseases from emergency rooms to alternative community-based settings. DSRIP has several goals: expanding primary care; emphasizing preventive treatment and wellness; reducing emergency room use; and providing bridge funding to safety-net hospitals that serve a high proportion of patients who are homeless, in poverty, or in the country illegally.

To qualify, safety-net providers will have to collaborate in innovative projects focused on, “system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply.”³⁰ Grantees must commit to achievement of project milestones, and will be subject to evaluation and potential penalties if milestones are not reached.

PERFORMING PROVIDER SYSTEMS

As a key strategy for reducing unnecessary hospitalization, New York is encouraging providers to form partnerships known as “performing provider systems.”

PPS include both major public hospitals and safety-net providers, with a designated lead provider for each funded group. Safety-net partners can include an array of providers: hospitals, health homes, skilled nursing facilities, clinics and Federally Qualified Health Centers (FQHCs), behavioral health providers, community based organizations and others.³¹

Through a competitive process, New York has awarded DSRIP grants to 25 performing provider systems at the local and regional level to help it achieve reform goals over the next five implementation years. System members will share data electronically on Medicaid recipients within their networks and offer certain specialized services. Medicaid recipients can opt out of data sharing if they choose, as they can in private coverage, but most will see the benefit of coordinated and non-duplicative care made possible by data sharing.³²

All but two of these 25 provider systems operate under hospital leadership. These networks represent a positive start to expanding primary care and focusing on quality outcomes, assuming they are monitored.^{33,34}

HEALTH HOMES

To reshape the medical delivery system and encourage better care coordination, New York is emphasizing the concepts of “patient-centered medical homes” and “health homes.”

The patient-centered medical home concept, originally promoted in the 1960s by the American Academy of Pediatrics, is a care delivery model under which a patient’s treatment is coordinated through his or her primary care physician to ensure that the patient receives care when and where it is needed and in a manner the patient can understand. The objective is to have a centralized setting that facilitates partnerships between patients and their personal physicians and, when appropriate, patients’ families. Care is facilitated by registries, information technology, the exchange of health information, and other means.³⁵

Health homes, as defined by the ACA, are care-management services for high-risk Medicaid recipients who have two or more chronic illnesses, HIV/AIDS or persistent mental illness, and who are at high risk for hospitalization, nursing home stays, or death. A health-home care manager works with the recipient to help organize behavioral and physical health care and to address issues related to the social determinants of health. This intense level of support helps the recipient learn to engage in management of his or her care, thus improving compliance.

VALUE-BASED PAYMENT

Through DSRIP, New York is seeking to address a fundamental problem within Medicaid: a payment system that focuses on inputs rather than outcomes and pays too little attention to prevention and coordination. As part of its waiver, New York over the next five years must implement a tectonic shift in its payment system to one that emphasizes and rewards value. The new value-based payment system is needed because paying providers fees for service incentivizes volume over value, for inputs rather than outcomes. An avoidable readmission is rewarded more than a successful transition to integrated home care. Our current payment system does not adequately incentivize prevention, coordination or integration.

By waiver Year 5, all Managed Care Organizations (MCOs) must employ non-fee-for-service payment systems that reward value over volume for at least 90% of their provider payments. Additionally the waiver requires that realized transformations in the delivery system will be sustainable and that value-destroying care patterns (avoidable admissions, [emergency department] visits, etc.) do not simply return when the DSRIP funding stops in 2020.³⁶

New York is moving toward a better-integrated health delivery system that emphasizes primary and preventive care. Without accompanying changes to its payment system for providers, the new delivery focus will not work. For this reason, New York has secured approval from CMS to move deliberately over time to a value-based payment system so that providers will be paid for health outcomes rather than the volume of service.

This is leading to new efforts by hospitals to rapidly penetrate the primary care arena in their communities. For instance, Albany Medical Center has played a lead role in affiliations with both Saratoga Hospital and Columbia Memorial Hospital, each of which is a community hospital about 30 minutes away. These affiliations come “as government-led health reforms seek to reduce the need for costly hospitalizations and private insurers are changing the way they pay for care.”³⁷

As it implements the value-based payment system in its Medicaid program, New York is also working on a long-range pilot partnership with CMS to also move Medicare to a value-based payment system. Like Medicaid, Medicare currently focuses payments more on medical procedures than healthy outcomes. In New York, 800,000 Medicaid recipients are dually eligible for Medicaid and Medicare, while nationally the figure is about 9 million.³⁸ A shift in Medicare payments to align with New York’s value-based reform would help the dual-eligible population and represent a bold step forward for health care delivery in general.³⁹ Time will tell if this potential reform with CMS is successful.

A KEY OPPORTUNITY: INCENTIVES FOR HEALTHY BEHAVIOR

While most people do not ignore their automobile’s ‘check engine light’ – many routinely skip their own body’s preventive maintenance warnings, thus making poor choices about their health. The result is a poor collective health quality in the country that spends much more on health care than anywhere else in the world.⁴⁰

– *National Association of Chronic Disease Directors*

While the debate over the ACA and health care policy continues, there is little dissent regarding the need for healthier behavior, expanded capacity in primary preventive care, and the use of incentives as a way to prevent or treat costly chronic disease. CMS has clearly articulated why this should be a priority in health care policy:

A disproportionate share of health care spending in the United States is used to provide care to a relatively small group of patients, with 1 percent of the population accounting for 22 percent of total health care expenditures annually. The distribution of spending is even more uneven within Medicaid, with just 5 percent of Medicaid beneficiaries accounting for 54 percent of total Medicaid expenditures and 1 percent of Medicaid beneficiaries accounting for 25 percent of total Medicaid expenditures. Among this top 1 percent, 83 percent have at least three chronic conditions, and more than 60 percent have five or more chronic conditions.⁴¹

A 2013 report and Gallup poll found that adults with health insurance coverage from an employer or union are in significantly better health than those whose primary health insurance is Medicaid. The report found, “more than three in 10 adults on Medicaid are obese, and more than two in 10 say they are being treated for depression (22 percent) and high blood pressure (24 percent). Medicaid recipients also struggle disproportionality with asthma and diabetes.”⁴²

The data in Table 2 (page 12) are based on more than 28,000 interviews conducted as part of the Gallup-Healthways Well-Being Index from Jan. 3 to March 1, 2013. The high rates of health problems among the Medicaid respondents indicate that lifestyle choices and treatments could be effective in reducing chronic illness and lowering government Medicaid costs. Given the ACA expansion, the enrollment of lower-income populations in Medicaid is expanding and, with it, the number of recipients with chronic illness.⁴³

In 2012, our paper, *Taking Ownership: The Patient Role in Medicaid*, scrutinized national efforts to promote healthier behavior among individuals enrolled in publicly funded health insurance programs, particularly Medicaid.

As that paper noted, a small minority of New York's Medicaid patients, some 10 to 15 percent, account for most of the cost of Medicaid. Successfully reducing the costs of chronic care and unnecessary hospitalizations while improving Medicaid outcomes will require multiple approaches, cultural changes that emphasize patient responsibility, innovation and time.⁴⁴

New York has been intensifying efforts to incentivize and require healthier behavior. These efforts are essential because costly medical treatments and emergency room spending in Medicaid are still largely caused by smoking, heart disease, obesity, diabetes and other factors driving long-term chronic care, all of which may be modifiable through better patient compliance and engagement.

Simply moving patients into a managed care system will not be enough to achieve meaningful savings or better outcomes. Patients themselves must take a leading role by assuming greater responsibility for their health. That means changing certain habits and behaviors that can cause or aggravate illness, such as smoking, poor diet, obesity and lack of exercise. At the same time, patients must agree to respect the healthcare process itself by following treatment plans, taking prescribed medications, keeping doctor appointments, and seeking early preventive care.⁴⁵

Incentives that encourage and reward healthy behaviors offer a strong long-term opportunity to improve health outcomes, contain costs and ameliorate the disparities between the health of patients that have Medicaid as their primary insurer and the health of patients with other insurers. By broadening the use of incentives, some of the most at-risk people in the system – patients with diabetes or pre-diabetic patients, those with cardiovascular problems, and people with manageable mental disorders – can become significantly healthier. That, in turn, can lead to substantial cost savings.⁴⁶

Medicaid recipients can face unique obstacles to receiving care that may limit the effectiveness of incentives. Obstacles can include:

- lack of transportation and childcare needed to get to appointments;
- lack of access to technology to utilize web-based programs or help lines;
- language barriers and cultural competencies; and
- activities not covered by Medicaid that could help achieve health goals.⁴⁷

Incentives are also at the center of growing efforts designed to improve access to primary care.

Table 2: Chronic Health Problem Rates by Primary Health Insurance Source

	Medicaid	Medicare	Employer or Union	Military/ Veteran Benefits	Something Else	Uninsured
Diabetes	15%	22%	8%	13%	9%	9%
Obese	34%	28%	27%	22%	20%	20%
High Blood Pressure	24%	51%	20%	25%	19%	14%

Source: Gallup-Healthways Well-Being Study

An expansion of primary care capacity is critical if Medicaid patients are to receive care outside of hospital emergency rooms, which are often these patients’ first and sometimes only choice. Emergency room visits may continue to rise nationwide if clients, including those newly insured through Medicaid expansion, have difficulty finding primary care physicians who accept the small payments offered by Medicaid or have ingrained habits of seeking care in the ER.⁴⁸

Evaluations of incentive and wellness programs remain sparse, but some assessments are under way, including a major independent evaluation of the Medicaid Incentives for the Prevention of Chronic Disease program, which was enacted by Section 4108 of the ACA. However, programs that existed prior to the enactment of MIPCD can provide some insight on what works and what needs rethinking. These programs focused on areas as diverse as weight management, substance abuse, smoking cessation, preventing and treating chronic conditions, and giving individuals more responsibility for their health.

Incentives that reflect the most basic of expectations, such as keeping physician appointments and getting children immunized, have led to modest success in many instances.

However, the long-term value of incentives and requirements remains unclear, and there is not yet a sufficient research base to determine if incentives and requirements can lead to longer-term behavior change. Nevertheless, the push to promote healthier behavior is in full swing.

THE NATIONAL CONTEXT

Since 2012, states have redoubled efforts to incentivize and require healthier behavior in Medicaid and other health care systems. Providers, employers, insurers, and local government entities have all intensified efforts to promote and incentivize wellness. As the incidence of chronic disease continues to grow, states are paying greater attention to managing care at the provider level, creating coordinated provider delivery systems, changing consumers’ behavior and habits, and expanding preventive and primary care capacity.

Some states, including New York, are addressing these questions by participating in Medicaid Incentives for the Prevention of Chronic Disease programs, developing preventive care programs and building incentive programs into their Medicaid waivers.

Taking Ownership offered an analysis of several state incentive and compliance efforts in Medicaid and other areas that predated the Affordable Care Act. The report included analysis of Opportunity NYC, Healthy Indiana, Idaho's Preventive Health Assistance program, Florida's Enhanced Benefits Reward\$ program and West Virginia's Mountain Health Choices program.⁴⁹ A September 2014 Kaiser Family Foundation paper provided further findings on and evaluations of pre-ACA incentives in Medicaid as well as discussions of other private incentive programs in drug treatment, weight control, and workplace-situated health and wellness programs. It noted that some waivers existing prior to the ACA have either been ended by CMS or combined with broader Medicaid waivers.⁵⁰

As a result of the ACA, states, insurers, and employers are paying increased attention to incentivizing healthy behaviors. Over the last several years, many states have sought new Section 1115 Medicaid waivers for such programs. CMS has developed requirements that must be complied with to receive these waivers.⁵¹ Some of these proposals have been approved; others have been denied or are still pending. The Medicaid Incentives for the Prevention of Chronic Disease program, a 10-state pilot, continues to operate, awaiting final evaluation in 2016.

Florida

Florida has ended its Enhanced Benefits Reward\$ Program, suspending new credits and ending participants' ability to access credits as of June 30, 2015. But the state's newly approved Managed Medical Assistance Medicaid waiver requires every county to establish programs through their local managed care organizations to encourage and reward healthy behavior. This mandate applies to weight loss and smoking cessation programs.⁵²

West Virginia

West Virginia's Mountain Health Choices program required participants to follow healthy behavior outlined in a health improvement plan, including keeping doctor appointments and following drug treatment. If patients complied, they received an enhanced benefit package; if not, they received fewer services than are offered under the state's traditional Medicaid program. CMS made such programs illegal through 2010 regulations stating that enrollment must be voluntary, forcing West Virginia to end the program in 2014.⁵³

Idaho

Idaho's Preventive Health Assistance (PHA) program is still operating and encourages healthy behavior services for Medicaid participants, including immunizations, well-child visits, and weight management programs.⁵⁴

Under PHA's Weight Management program, participants receive a \$200 annual benefit to help pay for weight management program fees at participating organizations. The program encourages healthier lifestyles through physical fitness, balanced diets and personal health education.

The Wellness Benefit of PHA is targeted to those children that are enrolled in the Children's Health Insurance Program (CHIP) and have a monthly premium, typically \$10 or \$15, based on

family income. Participants can earn a \$10 deduction in monthly premiums by keeping well-child checks and immunizations current.⁵⁵

Indiana

In January 2015, Indiana received approval for a waiver that expands the use of upfront, required patient premiums that go into health savings accounts:

Indiana will enroll people into health plans with Personal Wellness and Responsibility (POWER) accounts that are similar to high-deductible health plans with health savings accounts (HSAs). But unlike people with employer or other private plans who have HSA accounts that make monthly deposits optional, Medicaid beneficiaries with incomes between 100 percent and 138 percent of the federal poverty level will be required to contribute 2 percent of their income to their POWER accounts.⁵⁶

This approach forces Medicaid recipients to be responsible for compliance and pursue healthier behavior, as they must manage their HSA effectively in seeking services. State officials believe that compliance will be high and not result, as some contend, in the denial of health services. CMS will rigorously evaluate how well the program promotes patient responsibility without limiting access to necessary care. Under another waiver, Indiana “received approval to charge higher-cost sharing for non-emergency use of the emergency room than otherwise allowed under federal rules.”⁵⁷

Iowa

Iowa received approval in 2014 for a waiver allowing it to charge premiums of up to \$10 a month for beneficiaries with incomes between 100 percent and 138 percent of the poverty line, and up to \$5 a month for those with incomes between 50 percent and 100 percent of the poverty line. To promote healthier behavior, the state will waive premiums in both groups for individuals who complete a health risk assessment and wellness exam or who attest to financial hardship. If the premiums are not waived and beneficiaries do not pay, the unpaid balance becomes a collectible debt to the state. However, individuals cannot be dis-enrolled from Medicaid coverage if they do not pay their premiums, even though the state originally sought such a provision.⁵⁸

Arkansas

As states weigh whether to expand their Medicaid programs, a few states have considered using Medicaid funds to purchase commercial coverage for newly eligible Medicaid beneficiaries as an alternative to traditional Medicaid. This is allowed under current Medicaid law, and Arkansas has chosen to pursue this avenue.

CMS approved Arkansas’ Section 1115 demonstration in September 2013. The waiver allows Arkansas to use Medicaid funds as “premium assistance,” purchasing coverage for newly eligible adults from commercial health plans. Parents with incomes from 17 percent to 138 percent of the federal poverty level and childless adults with incomes up to 138 percent of the federal poverty level are automatically enrolled in private plans instead of traditional Medicaid, and Medicaid funding is used to pay their health plan premiums.

According to a summary by the Kaiser Family Foundation, Arkansas' demonstration requires newly eligible adults to enroll in qualified health plans to receive Medicaid services. Certain services outside the standard commercial benefit package, such as family planning and non-emergency medical transportation, are provided through the state's Medicaid fee-for-service delivery system.⁵⁹

CMS approved another amendment to Arkansas' demonstration, based on changes required by state legislation in December 2014. The approved amendment allows Arkansas to establish health savings accounts, to which certain non-medically frail beneficiaries can make monthly income-based contributions, ranging from \$5 to \$25, to be used for co-payments and co-insurance. Failing to contribute does not terminate Medicaid eligibility. It also imposed co-payments for beneficiaries above 100 percent of the federal poverty level who do not make monthly HSA account contributions.⁶⁰

Work Requirements

Several states sought to build work requirements into Medicaid for certain recipients, not as incentives for healthy behavior, but as an avenue to personal responsibility.

In Pennsylvania, former Governor Tom Corbett asked CMS to approve a requirement that anyone on Medicaid working less than 20 hours a week must register with the state's unemployment office and report at least 12 job-search contacts each month. Similarly, Indiana Governor Mike Pence wanted Medicaid eligibility for those working fewer than 20 hours a week to be tied to participation in job training or job search efforts. Utah sought a similar work requirement tied to Medicaid eligibility. These three waivers were denied by CMS.

Indiana refers households with employment of fewer than 20 hours a week to a voluntary work program, Gateway to Work. New Hampshire is also pursuing voluntary job training participation for underemployed Medicaid recipients. CMS' stance is that health benefits under Medicaid should not be tied to work.⁶¹

MEDICAID INCENTIVES FOR THE PREVENTION OF CHRONIC DISEASE

To encourage states to experiment with patient incentives, the Affordable Care Act created the Medicaid Incentives for the Prevention of Chronic Disease program (MIPCD). In September 2011, New York, along with California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, Texas, and Wisconsin, received demonstration grants to implement chronic disease prevention ideas for their Medicaid enrollees. New York was granted up to \$10 million over five years. The goal was to test how well incentives encourage behavior change. The 10 states are required to demonstrate changes in risky behavior and health outcomes for Medicaid beneficiaries.⁶²

The federal government also contracted with the Research Triangle Institute, also known as RTI International, to conduct an independent, national evaluation of the 10 state programs. This evaluation is to examine how such programs affect patient utilization; how much participation they get from special populations (such as adults with disabilities and chronic illnesses and children with special needs); how satisfied Medicaid beneficiaries are with accessibility and quality of services; and how much the programs cost states to administer.

Programs supported by MIPCD grants target one or more of five medical conditions or behaviors: smoking, diabetes, obesity, hyperlipidemia, and hypertension. New York has focused on diabetes prevention and control, hypertension prevention and control, and smoking cessation.

RTI International's interim report on the MIPCD program, which was released in November 2013, tracked results from the program's inception in September 2011 through June 2013. The interim report concluded that eight of 10 participating states were "significantly below their goal of project participants or have not yet started enrollment in the second year of their grant. However, Texas is close to achieving its enrollment goal of 1,250 participants."⁶³

The interim report singled out New York for being especially slow in getting started, having enrolled just five participants at the time. New York has made significant progress since then.⁶⁴

A final report to Congress, expected by July 2016, will recommend whether the MIPCD grants should be extended and brought to scale.

A RESEARCH OVERVIEW

The use of financial incentives as a way to control weight was the subject of a 2012 National Institutes of Health study, reviewing research conducted between 1972 and 2010. The extensive study showed a higher effectiveness of incentives in promoting initial weight loss, but a drop-off in retaining weight loss over the longer term and after incentives were no longer available.

The study noted that results are still inconclusive and "vary widely due to differences in incentive size and schedule." It also found that existing studies only look at those who volunteer for weight loss programs and that studies are "particularly sparse so that long-term efficacy and thus value in addressing the public health problem of obesity is unclear." The report reached this conclusion:

Financial incentives clearly increase the effectiveness of weight loss programs in the short-term. Larger and increasing incentives are better, negative reinforcement procedures like deposit contracts (where participants put their own money at risk for failure) are more effective than positive reinforcement, and group contracts are more effective than individual contracts. Weight losses induced by financial incentives are equally vulnerable to regain as are weight losses without use of incentives once treatment is withdrawn, but not more so. It is not yet clear what financial contingencies might promote long-term maintenance of weight loss.⁶⁵

In another rigorous NIH study, 20 years of incentive programs for substance abuse treatment showed good success. The 2014 study contended that these substance abuse programs could serve as models for improving the use of incentives and offered examples of how to replicate the approaches in Medicaid:

One recent evaluation of several Medicaid incentive programs concluded that they are producing mixed results, especially with more challenging behaviors such as smoking cessation. This is surprising given the extensive scientific literature supporting the efficacy of incentives to treat complex behavioral disorders such as SUDs and suggests that efforts to apply the lessons learned in scientific evaluations of incentives could improve the implementation and effectiveness of Medicaid incentive programs. Indeed, it would be unfortunate if the potential for wide-scale dissemination of incentive interventions for healthy behavior change is handicapped by preventable errors in design and implementation.⁶⁶

The most important design changes recommended for other incentive programs are two tactics that have worked in substance abuse treatment: more immediate benefits and bigger benefits. Incentives should be delivered up front and, where possible, daily. This is unlike most Medicaid financial incentives, which often require extensive verification. This slower process undermines the link between the incentive and the desired behavioral change. For instance, Florida's Enhanced Benefit\$ Program required three verification steps and four months before benefits could be delivered, and incentives were relatively small.

Referring to previous research, the 2014 NIH report notes "human decision-making also has a natural bias toward preferring larger over smaller rewards, given equal immediacy." The report notes that rewards of \$5 a day were effective in maintaining ongoing abstinence from drugs, and that \$16 daily rewards produced even longer-lasting compliance. The conclusion: timely and ample incentives work better in Medicaid, and additional costs are likely to be more than offset by savings from positive behavioral change.⁶⁷

One thing all parties seemingly agree upon is that preventing and treating chronic disease among Medicaid recipients is a fertile area for further exploration and evaluation — to study how financial incentive and compliance programs can most effectively promote behavioral changes, better health outcomes and cost efficiency.

BEHAVIORAL ECONOMICS

Behavioral economics is a method of economic analysis that applies psychological insights into human behavior to explain economic decision-making.⁶⁸ Increasingly, it is being viewed as a potential tool in the field of human services, as a way to influence and promote positive behaviors among clients receiving public benefit programs such as Temporary Assistance for Needy Families, Medicaid and the Supplemental Nutritional Assistance Program (also known as food stamps).

A relatively new construct within the field is “executive functioning,” which refers to efforts to help recipients achieve goals and make their own decisions. Executive functioning is grounded in brain science about how people make decisions and set goals. It focuses on life-management skills and their importance at home, school, and work, and it holds promise as a new service-delivery model somewhat akin to intensive case management. Included among executive functioning skills are: organization, time management, planning and prioritization, response inhibition, flexibility, emotional control, metacognition, task initiation, sustained attention, goal-directed persistence, stress tolerance, and working memory.⁶⁹

Executive functioning skills are now being explored in the research field of employment for TANF recipients, as a way to help individuals plan, set goals, act upon goals, and be resilient.⁷⁰

With these same skills, Medicaid recipients could learn to practice healthier behavior, maintain treatment regimens, and take ownership of their care. This is a field worthy of deeper exploration in New York, because transforming the Medicaid delivery and payment systems requires patient cooperation and informed decision-making. A burgeoning field of new literature on the application of executive functioning skills has been developed as an informative way to practically apply these theories in service delivery.⁷¹

NEW YORK'S PROGRAM

As previously stated, New York was one of 10 states to receive a competitive federal grant under the Medicaid Incentives for the Prevention of Chronic Disease (MIPCD) program in 2011. The state Department of Health is using the grant for a pilot program that offers cash and non-cash rewards to patients who participate in smoking cessation, exercise and nutrition education, obesity and diabetes prevention, and other programs that seek to prevent chronic disease.

New York uses four incentive schedules that are based on process measures, outcome measures, a combination of both measures, and a comparison group. For those randomized to an incentive schedule, Medicaid recipients have the potential to earn up to \$250. All incentive schedules provide direct payments for achievement of milestones.

Prevention of diabetes:

To promote diet and exercise changes among adult Medicaid recipients who are at high risk for diabetes or diagnosed with pre-diabetes, participation in the Diabetes Prevention Program is incentivized. The program is a 16-week lifestyle modification curriculum conducted by trained coaches who teach lessons in three areas: nutrition, physical activity, and behavioral self-management. Enrollment in this program began in January 2014.

Diabetes management:

To improve the blood glucose control of those diagnosed with diabetes, this pilot program incentivizes primary care visits, the use of diabetes-related medications, and efforts to reduce and maintain HbA1c levels. Enrollment for this disease area began in April 2014.

Hypertension:

To lower high blood pressure levels in those diagnosed with hypertension, New York incentivizes primary care visits, the use of antihypertensive medications, and the reduction of blood pressure below targets set by the Joint National Commission on Management of Hypertension. Enrollment in this disease area began in July 2014.

Smoking cessation:

To promote smoking cessation among adult Medicaid recipients, the state is incentivizing individual and group smoking cessation counseling, use of smoking cessation products, and confirmation of quit status. Enrollment in this disease area began in February 2015.

State Health Department data as of 2015, as provided by CMS, show the state's pilot program has grown since June 2013, when RTI International reported just five enrollees. As of August 2015, New York had 4,026 participants enrolled in the Medicaid Incentives for the Prevention of Chronic Disease Program: 507 in diabetes prevention study, 915 in diabetes management, 809 in hypertension management and 1,795 in smoking cessation.⁷² That amounts to less than one-tenth of 1 percent of the state's 6.4 million Medicaid beneficiaries.

New York's initial slow start was at least partly a function of its commitment to relatively modest incentives. In this sense, New York could learn a few lessons from Texas, which has initiated a straightforward approach offering larger incentive bonuses, enrollment assistance, and bonuses to participating providers.

The Texas program is particularly appealing, offering flexible spending of up to \$1,150 for wellness activities for up to three years. Texas pays for "patient navigators" to facilitate the process in participating managed care plans. Through this program, Texas has modified how it recruits people into the program to encourage greater patient enrollment. New York does not pay providers to help enroll individuals in its incentive program.⁷³

States participating in the MIPCD program are given the opportunity to share promising approaches. CMS has convened two face-to-face discussions each year among CMS grantees, contractors, and CMS staff. These discussions focused on education, experience sharing, problem-solving, and planning. Additionally, RTI International hosted and facilitated telephone forums in which grantees and CMS shared information. Because states were given flexibility in designing programs, and because these programs target a variety of conditions and behaviors, components of these demonstration pilots are of interest to New York.⁷⁴

The final report to Congress in 2016 will determine the future of the 10-state pilot based on updated data, a determination as to whether enrollment can be scaled up, and evaluations of program effectiveness in individual states. Even as New York and other states await these results, there is no prohibition against testing the expanded use of incentives in Medicaid beyond the pilot. New York has taken initial steps in this direction by establishing a new Advocacy and Engagement Sub-Committee of its Medicaid Redesign Team to discuss the design and broader use of incentives across the Medicaid population in managed care.⁷⁵

This subcommittee has proposed providing incentive payments on a more timely basis, so they are more directly linked to the behavior being rewarded. Additionally, New York currently imposes an arbitrary cap of \$125 on the amount that managed care organizations are allowed to provide patients as incentives for preventive care. The subcommittee has recommended removal of this \$125 cap.⁷⁶

The Advocacy and Engagement Subcommittee also stressed the need for intensive education and involvement of patients, including the right to know detailed information about incentives available to them and about value-based payments to providers.

Providers are encouraged to utilize “patient-reported outcome” measures in order to assess members’ well-being, feelings, and functioning over time, to engage members in developing their treatment plans, and to facilitate shared decision-making between members and providers. All of this can be done through brief surveys or patient questionnaires.

The subcommittee has urged expansion of patient incentive programs statewide under a set of guiding principles, including the timely provision of rewards to ensure success, assistance with cost and other barriers to accessing incentive programs, and an independent third-party evaluation of existing and new incentive programs.

New York is incorporating some new efforts to involve Medicaid patients in their own health care by requiring that “health homes” be incorporated into each performing provider system and stressing the importance of patient cooperation and compliance.

The state is also employing what is referred to as the Patient Activation Measure, a detailed patient survey licensed by Insignia Health. This instrument has been actively tested as a reliable way to predict such things as future emergency-room visits, hospital admissions and readmissions and patient compliance with medical treatment plans.⁷⁷

The survey covers motivators, attitudes, behaviors, and outcomes for individual patients. One top official with the state Department of Health has said the use of the survey, in conjunction with health homes, can motivate patient involvement and compliance:

Each [performing provider system] is required to include Health Homes in its provider network to ensure access to care management services. PPSs are required to assess their communities and identify issues related to health disparities and address the same in the implementation of the projects. These will include addressing health literacy, language, cultural, social and ethnic issues that are barriers to compliance with required care and providing solutions congruent with the affected persons. Additionally, for Medicaid recipients who are low utilizers or non-utilizers, some of the PPS are implementing a project using the Patient Activation Measure (PAM) and interventions to improve recipients’ engagement in health care by improving their confidence in managing care and improving their self-actualization. It is our belief that by addressing these fundamental causes of non-compliance, the Medicaid program will improve patients’ ability to be compliant with health care recommendations.⁷⁸

Policymakers should expand these approaches significantly. Over time, they potentially could be coupled with penalties for failure to comply without good cause.

THE COST PICTURE

Medicaid enrollment and costs are projected to grow annually both nationwide and in New York. The Office of the New York State Comptroller estimates that state costs, although slowing in growth, will increase by \$700 million annually between now and FY 2018-19. This represents an aggregate increase of \$2.8 billion over the same period, according to estimates in the Executive Budget for New York State fiscal year 2015-16. (See Table 3 below.)

Federal costs for New York’s Medicaid program are projected to rise by \$6.9 billion by fiscal year 2018-19; local costs are expected to remain basically flat at \$8.6 billion. New York’s overall Medicaid costs to all payers (federal, state, and local governments) are projected to be \$68.38 billion by 2018-19, an increase of \$13.44 billion or almost 25 percent above the \$54.94 billion spent in 2013-14. Because of the waiver, the federal government will absorb the largest share of this projected growth.⁷⁹

With expanded enrollment and higher income eligibility levels, New York’s Medicaid program now costs more than the Pennsylvania, New Jersey and Massachusetts programs combined.⁸⁰ Despite the increasing caseload, the state has successfully slowed the rate of cost increases at the state and local level.

Table 3: Medicaid Spending by Source (in billions, by FY)

	2011-12 Actual	2012-13 Actual	2013-14 Actual	2014-15 Projected	2015-16 Projected	2016-17 Projected	2017-18 Projected	2018--19 Projected
State	20.8	20.7	21.3	22.0	22.5	22.6	23.8	24.8
Federal	24.9	23.9	24.8	28.0	30.7	31.8	33.9	34.9
Local	8.1	8.5	8.8	8.7	8.9	8.8	8.7	8.7
All Funds	53.9	53.2	54.9	58.8	62.0	63.2	66.5	68.4

Source: NYS Division of the Budget

In part, this reflects a trend nationally of slower growth in Medicaid. However, California has now edged above New York as the highest-cost Medicaid state.⁸¹ This reflects the implementation of New York’s Medicaid Redesign Team goals, which emphasize eventual managed care for all, a shift to value-based payments, and the state’s efforts to shift costs to the federal government under the waiver.⁸²

Going forward, caseload growth may increase the number of New Yorkers on Medicaid who practice unhealthy behavior and have chronic health problems. If this holds true, it could further increase future program costs.

Other potential cost drivers include the state's newly adopted increases in the minimum wage - which will go from the current \$9 to \$15 in New York City by 2018, and in Long Island and Westchester County by 2020, with the rest of the state moving to a minimum of \$12.50 by 2020.

PITFALLS FOR REFORM

The Delivery System Reform Incentive Payment program was designed as a temporary stopgap while hospitals find ways to replace revenue that will be lost by cracking down on emergency-room admissions for non-emergent conditions. How to sustain that behavior, if DSRIP is not renewed, will be a key to the program's success.

It is unclear if adequate primary care capacity can be achieved over the five-year lifespan of the Medicaid waiver and sustained thereafter. Also unclear is whether community-based care providers and hospital-based primary care facilities can operate effectively as partners.

As noted in a *Times Union* article: "To survive, hospitals have in recent years sought to become the hub of health care systems that provide all levels of care, acquiring doctor's practices and building community-based primary care and urgent care offices."⁸³

Finally, it is uncertain whether the performing provider systems will be sustainable after the waiver expires and the \$8 billion in federal funding is gone.

Community health providers can be part of one or more system, but their role could be different in each one depending on how the hospital-led organization defines it. This can create confusion, and how money flows to them will be critical to success. According to an article in *POLITICO New York*:

Thousands of providers and community-based organizations (CBOs) of varying size and strength are vying for a finite pot of money, a struggle bound to cause lots of internal battles among the very groups needed to make the state's ambitious reform a success. The \$7.3 billion in DSRIP funding is not awarded unless the goal of reducing avoidable hospitalizations by 25 percent is achieved. And that goal can't be achieved unless everyone is working together, Jason Helgerson, New York's Medicaid Director, says. The challenge is that smaller provider groups and community-based organizations will likely need to invest cash and other resources up front to change how they deliver care or integrate with several PPS, and then take it on faith that they'll receive the money back when the DSRIP funds start flowing. That's money most don't have, so they'll want to be assured they are well compensated for that financial risk.⁸⁴

Hospitals, seeing new money available for primary and preventive care, have rushed to occupy the field by co-locating clinics near emergency rooms, opening urgent care clinics, and in some cases annexing existing community care providers. Many community-based providers are concerned with this trend, fearing that they may not survive. The predominance of hospital-led systems — which include some community providers while leaving out some other potential

partners, such as independent physician associations and retail clinics — sends a cautionary note for Medicaid redesign, because it can stifle healthy competition:

In the wake of the Affordable Care Act, the number of hospital merger and acquisition deals jumped from 52 in 2009 to more than 100 in 2014, according to Irving Levin Associates. But the economic evidence suggests consolidation drives costs up, not down — and may even hurt patient care.

Hospitals are the biggest single share of U.S. health care spending, and often, what's good for hospital revenues is a lost opportunity to keep someone healthy. True clinical integration that incentivizes cost-efficient, quality care is a laudable goal for hospitals and is already permitted under antitrust guidelines. We just shouldn't rely on hospitals to compete against their financial interests, any more than we'd expect Best Buy to invent Amazon. Competition remains vital as ever, and the industry's future belongs to the states willing to lead the way.⁸⁵

The value-based payment system must not damage the financial sustainability of providers. For instance, the new model must avoid punishing providers' efforts to prevent avoidable admissions and reduce administrative waste, and it must move closer to a model in which the delivery of high-value care financially benefits providers.

Payment reform, then, is required to ensure that changes in the care-delivery system funded by DSRIP are sustained well beyond the waiver period. In this way, patient-engagement and care coordination activities, including peer-based activities, can be reimbursed, and value-destroying care patterns (avoidable admissions, re-admissions, and ER visits) will not simply return when the DSRIP dollars stop flowing.⁸⁶

Payment reform must also maintain a stable and well-trained primary care and community-based workforce, and it must ensure that dollars saved are reinvested in the Medicaid delivery system.⁸⁷

Another danger for Medicaid reform in New York is a dispute with the federal government. CMS aims to hold Medicaid payments to a level no higher than what Medicare would pay for the same service, a policy known as Upper Payment Limits (UPL). As noted by *POLITICO New York*, "the calculations (around UPL) may be complex but the consequences of delay are not."⁸⁸

Until a deal is reached on the issue, the federal government is withholding billions of dollars in Medicaid payments. The providers most affected by this stalemate are hospitals serving the largest number of Medicaid patients and some of the very community-based providers that New York is relying on to expand primary care. For example, the New York City Health and Hospitals Corporation, the state's largest Medicaid provider, is awaiting \$1.2 billion in disputed federal funds. Federal qualified health centers could see a 50 percent reduction in current funding because, until UPL is resolved, they will not be able to access the federal share of the uncompensated care pool, a pot of money available for treating the uninsured. Similarly, safety net hospitals and other providers that are integral parts of the DSRIP program are awaiting \$500 million in federal funding.⁸⁹

UNCERTAINTY ABOUT THE ACA

While New York's Medicaid redesign and waiver will not be affected, uncertainty and controversy around the ACA could have effects on the New York State of Health exchange, commercial insurance markets and future federal funding for Medicaid.

Both houses of Congress recently passed a bill that would have repealed the ACA. President Obama vetoed the measure but, despite two Supreme Court rulings upholding the law, the ACA is showing signs of possibly collapsing under its own weight.

In 2012, the U.S. Supreme Court upheld the constitutionality of the ACA in a 6-3 decision, Chief Justice John Roberts wrote the opinion.

The language of the law states that the failure of uninsured individuals to comply with a requirement by buying an insurance plan through health care exchanges would result in a penalty – a provision that was a focus of the assertion that the law was unconstitutional. Roberts' majority opinion interpreted the penalty as a tax, which was therefore allowable.⁹⁰

This allowed the individual mandate to stay in place, and it permitted the Internal Revenue Service to assess tax penalties against those who failed to comply. At the same time, the original decision thwarted the Obama administration's attempt to require that states expand their Medicaid eligibility levels and coverage to certain populations. The court held that this provision was a federal overreach and made Medicaid expansion a state-by-state choice rather than a requirement.⁹¹

In 2015, the U.S. Supreme Court, led once more by Roberts and Kennedy in a 6-3 vote, ruled again in support of the ACA. In *King v. Burwell*, the Court upheld the provision of tax subsidies to income-eligible enrollees through exchanges. The challenge claimed the law did not allow for subsidies through the federal health exchange, but only through exchanges established by the states. Since New York has its own exchange, a ruling for the plaintiffs would not have directly affected its ability to provide subsidies, but could have disrupted the law nationwide.

Now, states that maintain their own exchanges may have a financial incentive to switch to the federal exchange or to jointly establish regional exchanges.⁹²

Additional challenges to the ACA remain. A lawsuit brought by Congress, *U.S. House of Representatives v. Burwell*, was adjudicated at the federal district court level in September 2015. The court ruled that Congress has standing to challenge the president for spending funds that were never appropriated, allowing this case to move forward even as the ACA remains in force.⁹³

Another case now on the Supreme Court docket contends that religious organizations should have the right to opt out of the ACA.⁹⁴

Beyond these legal challenges, the ACA faces numerous problems.

The law remains confusing to many, and exchanges suffer frequent technical problems and are often difficult to navigate.

Although more than 11 million individuals have enrolled in private insurance nationwide through the exchanges, the ACAs long-term success in covering the uninsured and offering affordable policies remains unproven.

The scope of services required of health plans sold on ACA exchanges is broad, requiring services that may be unnecessary for many enrollees and forcing others to lose existing policies. The Congressional Budget Office estimates that by 2021, over 10 million individuals will be forced off their chosen employer-based coverage because of the rigidity of ACA plan requirements.⁹⁵

The tax penalty on those who do not comply with the mandate to buy health insurance is escalating over time.

Some employers are reducing workers' hours to avoid the requirement to offer health care coverage for those working 30 hours or more weekly.⁹⁶ Others are providing a capitated amount of dollars to employees to purchase insurance through exchanges.

Many individuals who seek coverage through the exchanges are ending up on Medicaid, driving up caseloads.

Concerns also remain about the redistributionist effects of the ACA, as insurance premiums for healthier enrollees already in the insurance marketplace rise to offset the higher costs of the newly insured, who are often less healthy.

Many of the 23 large co-op insurance plans that emerged under the ACA are beginning to fail because they grossly underestimated both enrollment and costs. Twelve of them have gone out of business, including Health Republic Insurance of New York.⁹⁷

An audit of the ACA by the U.S. Government Accountability Office, released in October 2015, revealed a significant number of instances in which beneficiaries were receiving duplicate coverage from both Medicaid and a private insurance policy purchased through an exchange. It also found overpayments to states, because CMS cannot distinguish between newly eligible Medicaid recipients (for whom the federal government pays 100 percent of costs) and recipients who were eligible for Medicaid prior to passage of the ACA (for whom reimbursements should be as low as 50 percent).⁹⁸

An audit of the New York State of Health insurance exchange by the Office of the State Comptroller showed similar but far smaller problems of duplicate payments and continued Medicaid payments for deceased individuals.⁹⁹

Nationally, approximately 71 percent of those enrolled under the ACA have not been enrolled in private plans but instead were determined to be eligible for Medicaid. Because there are continued shortages of primary care physicians, New York and other states are attempting to expand primary and preventive care networks. Moreover, health outcomes under Medicaid remain mixed at best, falling short of outcomes for similar patients with private insurance.¹⁰⁰

UnitedHealthcare, the nation's largest insurer and a major presence in New York, is considering withdrawing completely from the exchanges due to unsustainable costs.¹⁰¹

Open enrollment periods under the ACA have been extended for more than 30 categories of individuals, destabilizing insurance markets and driving up premium costs. Individuals enrolled through these extended open enrollment periods use up to 55 percent more services than their counterparts who enrolled in the standard open period.¹⁰²

Due to higher-than-expected enrollment in Medicaid, the Congressional Budget Office projects the cost of the ACA will rise to \$1.4 trillion by 2026, \$136 billion higher than previous estimates.¹⁰³

Another problem has been the significant underestimation of implementation costs by those states that have accepted the option of taking more federal funding to expand their Medicaid coverage.¹⁰⁴

These and other provisions of the ACA will remain subject to debate in Congress and during the 2016 presidential election campaign.

If a Republican president is elected and Republicans retain their majorities in Congress, efforts to repeal and replace provisions of the law likely will strengthen. One option worthy of consideration is the creation of a new Universal Exchange Plan proposed in 2014 by Avik Roy, a senior fellow at the Manhattan Institute. The plan “seeks to substantially repair those problems caused by the ACA and those that predate it.”¹⁰⁵

RECOMMENDATIONS

To begin to address these continuing challenges in publicly funded health care, New York State policymakers should consider a wide range of policy recommendations:

Expand patient incentives:

The state’s very limited financial incentive program should be offered broadly to all categories of patients who could benefit throughout the Medicaid population, and the \$125 cap on incentive payments by managed care organizations should be lifted. This expansion should go forward whether or not federal grant funding continues under the Medicaid Incentive for the Prevention of Chronic Disease program. Existing databases such as the New York State Department of Health’s State and County Indicators¹⁰⁶ and the New York All Payer Database¹⁰⁷ should be used to monitor and evaluate incentive programs.

Strengthen compliance requirements:

New York, like many other states, places too little emphasis on requiring patients to comply with treatment plans and encouraging patients to take more direct ownership of, and accountability for, their health. A number of states charge modest premiums and/or require copayments for certain services. New York waives most copays for the managed care population and other categories of Medicaid recipients. New York should study baseline compliance rates and the effect of current and future requirements aimed at improving compliance.

Implement Health Savings Accounts:

Implementing pilot HSAs, such as those allowed in Indiana, Iowa and Arkansas, should be a priority to encourage patients to take ownership of and manage their own health care.

Leverage public assistance to incentivize healthy behavior:

Widespread childhood obesity prompted controversial legislation in Puerto Rico that would fine households with obese children between \$500 and \$800.¹⁰⁸ Fines like these, and policies that result in denial of health care, are not good ideas.¹⁰⁹ However, since many Medicaid recipients also participate in SNAP or TANF, failure to comply with treatment programs could trigger some form of sanction in those other programs. New York should consider pilot-testing such a policy.

Discourage overuse of emergency rooms:

Policymakers must address the ingrained behaviors of previously uninsured patients and Medicaid patients who traditionally have sought primary care in the costly setting of emergency rooms. Broadened coverage may actually expand rather than constrain such ER use. Preliminary results from an Oregon study reinforce this concern.¹¹⁰ Building increased primary care options is critical, but it cannot happen overnight, and reimbursement rates in Medicaid remain low. Patients will need to be taught — and required to adopt — alternatives to seeking primary care in costly settings. Policies that divert patients from ERs to nearby or co-located primary care facilities for non-emergency treatment will have to be rigorously enforced.

Increase fees for primary care:

A two-year federal expansion of primary-care physician payments for those who see Medicaid patients under the ACA has now expired, and New York opted not to continue higher payments with state funds. If physician reimbursement rates seem to be limiting preventive care access, they should be increased so that primary care physicians more readily accept Medicaid clients.

Expand the Patient Activation Measure:

New York should take better advantage of PAM questionnaires as a tool to anticipate and accurately predict poor outcomes among certain patients.

Embrace retail clinics as providers:

Retail clinics in pharmacies, grocery stores, and large stores continue to grow, as do independent physician associations. These should be utilized as another way Medicaid patients can receive various preventive services, such as immunizations and advice on prevention and wellness. Consideration should be given to allowing them to join performing provider systems.

Improve care coordination:

Providers must aggressively coordinate care to avoid overlapping or duplicative treatment. The growth of shared electronic medical records and the burgeoning health-home movement, in which a patient has a single place for care coordination, are both vital to success. New York must also closely monitor the effectiveness of health homes.

Expand the use of electronic medical records:

The use of shared electronic medical records, which is still being rolled out, must be further expanded as a tool to coordinate care and avoid costly duplicative care.

Reform food stamps:

Programs such as the Supplemental Nutrition Assistance Program (SNAP), better known as the food stamp program, allow the purchase of unhealthy products, particularly sugar-sweetened beverages, with public funds. Since SNAP serves clients who also receive Medicaid, it should not work at cross-purposes with health and wellness efforts. SNAP must be changed federally to align with public health goals by forbidding purchases of food that lead to obesity, diabetes and heart disease. In the short term, if Congress will not take this action, New York should again seek federal authorization for a demonstration project to ban the use of SNAP funds for sugar-sweetened beverages.¹¹¹

Follow through on value-based payment:

This approach can be vital to changing health care delivery in New York by shifting the focus from the numbers of procedures performed to the achievement of healthy outcomes. However, caution must be taken that providers do not manipulate the system by screening out the sickest patients. New York should expand nascent efforts, in partnership with CMS, to persuade the federal government to align Medicare payments with the same value-based system that the state is implementing in Medicaid.

Convert Medicaid to a block grant:

Congress should seriously consider converting Medicaid into a block grant program in which states would receive a guaranteed level of funding. This would give states more ownership over the cost and design of their program, while allowing them to innovate and quickly launch program reforms. The federal government should establish minimum requirements and assure that funds meant for Medicaid are not diverted to other purposes. But states should have broad flexibility within those parameters. States would receive federal funds at their current aggregate levels plus an annual increase tied to the rate of health care inflation. This approach, which is similar to New York's current global cap on Medicaid, would allow the federal share to remain adequate over time. It would also enable New York and other states to design the program in a way that best serves their diverse Medicaid populations, pursue innovative reforms that improve care and save money without the cumbersome process of applying for waivers.

CONCLUSION

After years of political battling and stalemate, the Cuomo administration deserves credit for bringing long-term thinking, thoughtful reform, and fiscal discipline to the management of New York's Medicaid health plan.

By any measure, however, it remains among the nation's costliest Medicaid programs, and likely to draw even more on the public purse as enrollment continues to climb.

Patient incentives — and their promise for both improving health and saving money — are an opportunity for further reform that New York cannot afford to miss.

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