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Reimagine Healthcare

What New York State can teach the NHS

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- New York State needed to fix Medicaid system and embed more fundamental reform
- Medicaid budget had seen double digit growth for years
- Reforms designed to look at patient needs and to reduce organisational boundaries
- Healthcare providers think about patient first but still need financial incentives

When considering how best to implement the Five Year Forward View, NHS leaders could do worse than cast their eyes across the Atlantic. New York State is at the midpoint of fundamental reforms of Medicaid, the system which provides healthcare for individuals and families on the lowest incomes.

The reforms were introduced to ease financial pressures and improve patient care. At the centre of the redesign programme are 25 new provider networks, charged with delivering better models of care for the 30 per cent of the state's population covered by Medicaid.

Marc Berg, Principal at KPMG in the US, has been working on the redesign project since its inception. He emphasises the programme is still in relative infancy – it is not due to conclude until 2020 – but adds lessons have already emerged, many of them applicable to the NHS.

How did the Medicaid reform programme come about?

"For years, Medicaid in New York State was a politically impossible beast to deal with. Every year the governor would look at the Medicaid budget – and it would always be growing, by double digits – and every year he would propose slashing the payment rates to providers.

"New York State is a very Democratic state – it's not unlike Britain in some of the ways it thinks about things, and Medicaid not unlike a small NHS. So the reactions to cuts were similar. Hospitals and doctors and patients all came together and said that's not going to happen, and basically the legislature would say we're not going to do this, and it would just end in a standstill.

"When Andrew Cuomo was elected governor [in 2010], he said we've got to stop this. Then Jason Helgerson became Medicaid director, and together they said let's just sit around the table and say: 'We all agree this thing is broken, so can we agree on a couple of things that we can do to make this thing less broken.'

So they updated some of the completely derailed fee schedules that were still in place and introduced a spending cap which would allow for growth in Medicaid spending at the rate of the overall economic growth of the State. And once that was done, they started to think of some more fundamental ways to really fix it."

Providers were asked to join together in networks and to bid for funds to deliver specific projects. What has been established since?

"Ultimately they are all about reducing avoidable hospital use in one way or another, whether it's behavioural health intervention here or improving diabetes care there – there were all these different projects, but they all ended up in that goal."

How did the level of competition between hospitals affect the process of forming networks?

"What we're trying really hard to do is not think in terms of institutions, and not think in terms of hospitals that are competing. Whether competition is a good idea depends on the type of care you're talking about. For a Medicaid sub-population that is living on the street, with severe mental illness, competition makes no sense.

"So one of the key things that I like a lot about what's happening in New York is it's starting to look at healthcare in terms of the function the system needs to fulfil. They're saying: 'OK, how are we doing with our chronic care, how are we doing with our maternity care, how are we doing with our hip replacements?' Following the patient's needs across organisational boundaries.

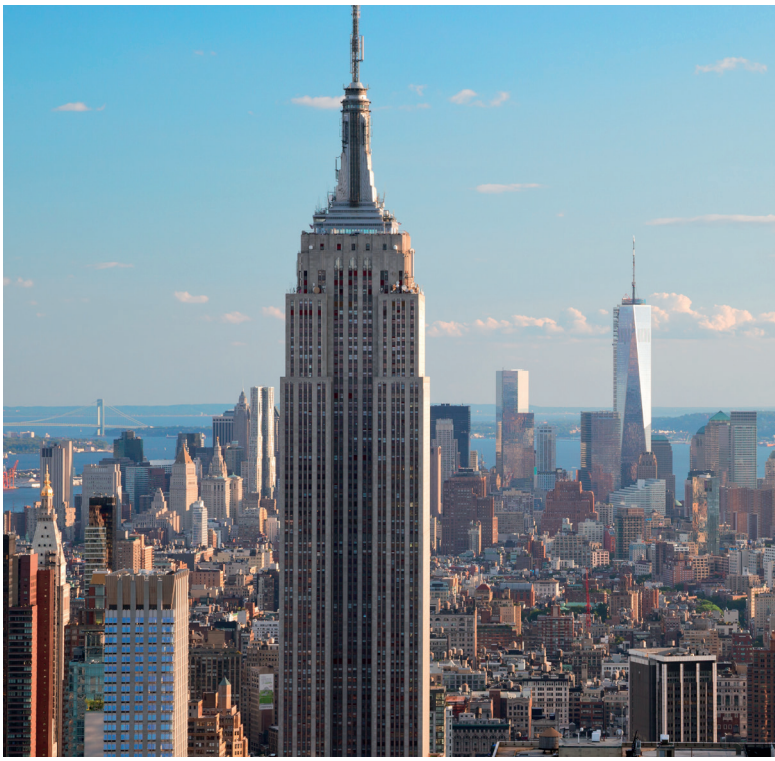
"Health plans will ask providers: who wants to take on the responsibility for the outcomes and the costs of care for the chronically ill? Who wants to contract maternity care? If the hospital plays a big role in the ensuing group of providers that stands up to this challenge, that's great, and if the hospital does not, that's also great. But don't take the existing organisations as the starting point."

What lessons have been learnt during the project that are relevant to the UK?

"The way money is being paid out is what drives the behaviour of providers. Providers will try to do everything they can for the patient. But when you ask providers to do the best for the patient and it means that's going to be financially disadvantaging them, then you're asking people and organisations to be saints.

"I think sometimes in the UK, that is a bit pushed aside, as if that's not something you can easily say. We have all these discussions about whether money motivates, or should motivate, professionals to deliver care. The key point is any organisation in any part of the economy will want to survive financially. So if you don't change the financial incentives, things are not going to change.

"The Medicaid director is making clear we're going to reward outcomes, we're not going to reward volumes. And saying that is easy, but doing that is quite complicated. But the moment you start to make clear what you mean by that, then the people who need to wake up wake up. Because then the chief executives, chief financial officers, realise this is not just about today, tomorrow, this is about whether I'm going to be alive in five years and if so how."



If you were embarking on the project again, what might you do differently?

"Put the frontline clinical staff much more centre stage from the very beginning. So you would say these are the outcomes we're going to want, all of us, and then you leave it much more to the innovation capability of staff on the frontline to shape the path ahead.

"When doctors and nurses hear the words 'financial incentive', they're just going to think they're going to cut this, they're going to cut that. When people hear the top of the NHS say we've got this great idea, we're going to transform things, everybody just reads: 'OK, cutting costs.'

"So you have to engage the frontline staff in the vision: how to fix a broken system. Because if anyone knows it's broken, it's them. Ultimately, these doctors and nurses and frontline workers want the same thing – they want to have less of these avoidable complications and more control over their patients' outcomes. That is the golden combination."

For more on what the NHS can learn from New York, see KPMG's report New Care Models: Learning from New York State's Medicaid reforms.

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