Submitted Testimony

Testimony of
The Coalition of New York State Managed Long Term Care and PACE Plans

on the Governor's Proposed 2016-2017 Health and Medicaid Budget

Submitted to the
Joint Legislative Fiscal Committees
Health and Medicaid Budget Hearing

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Introduction

Members of the Joint Legislative Budget Committee: thank you very much for the opportunity to submit this testimony on behalf of the New York State Coalition of MLTC and PACE Plans. The Coalition was formed in 2006 to provide a single voice for not-for-profit, provider-sponsored MLTC and PACE plans. The Coalition now represents 21 plans that provide coverage for the overwhelming majority of the elderly and disabled individuals enrolled in MLTC, PACE, and now FIDA.

MLTC and PACE Background

Since 2004, the number of New Yorkers enrolled in Managed Long Term Care (MLTC) and the Program of All-Inclusive Care for the Elderly (PACE) has increased from approximately 10,000 to nearly 143,000. While the plans are justifiably proud of the growth of the program, they are even more gratified that the program continues to receive very high marks for quality—not only from the Department of Health but, more importantly, from the tens of thousands of frail and elderly New Yorkers that they serve.

MLTC and PACE plans coordinate an array of medical and social services for elderly or disabled Medicaid beneficiaries who require more than a hundred and twenty days of community-based long term care services. These plans provide access to quality long term care at a fraction of the cost of institutional care, while also achieving extraordinarily high rates of patient and family satisfaction.

It should be noted that MLTC plans provide the full array of long term care services for a fixed per member per month payment, covering personal care to nursing home care, and, while the plans are not responsible for physician, hospital or other services, which patients typically access through their Medicare coverage, the plans oversee and coordinate all aspects of their members' care through intensive care management, regardless of the payor. PACE enrollees receive comprehensive health care services and coordination through their plan, including all physician, hospital and pharmacy services. The MLTC initiative has proven to reduce Medicaid expenditures on what had been runaway long term care costs—and has done so by actually improving the quality and coordination of care.

For the most part, the plans in the Coalition have enjoyed a productive and positive partnership with the Department of Health and have sought to secure the Medicaid Redesign Team's vision of achieving higher quality and lower costs through a reliance on managed long term care. We are, generally, supportive of the Governor's budget. Most of the concerns detailed below relate to administrative actions that have been proposed to be taken by the Governor and focus more on the implementation of the MRT objectives—including the timeliness and adequacy of the MLTC and PACE premiums, along with certain issues relating to the oversight and operation of MLTC and PACE plans.

Current Issues

While the rapid transition of over 143,000 elderly and disabled New Yorkers to mandatory enrollment in MLTC and PACE plans has proceeded very successfully, there have been some challenges along the way and there are some urgent issues that will need to be addressed to ensure that plans will continue to be able to provide high quality and coordinated care at a cost that ensures continued savings to the State of New York:

- ***Rate Timeliness and Adequacy.*** The issuance of rates for MLTC and PACE plans has been consistently delayed, which has had a significant effect on the plans' ability to budget, manage their operations, and most importantly pay providers. This delay is, in part, due to the complex structure of the rates, which include adjustments for risk scores, administrative loads, care management, high cost/high need pools, quality withholds, managed care savings assumptions, and a "blend" of the nursing home certifiable and non-NH certifiable populations. These adjustments have, in the aggregate, depressed the rates and created considerable confusion--which in turn has jeopardized the stability of the plans and, in some respects, their provider partners. We have had many discussions with the Department regarding the lateness and inadequacy of the rates, and hope as the rates become more normalized, the timeliness will improve. While we appreciate the best efforts of a heavily-burdened Department staff, we would urge that every effort be made to make sure that premiums are established prospectively and are adequate. We would encourage the legislature to become more engaged in rate setting, and examine funding for managed care closely, particularly as the proportion of the Medicaid budget allocated to managed care continues to grow.

- ***Minimum Wage.*** Compounding issues relating to the adequacy of rates, the plans are also subject to DOH-issued mandates on rates of payments to contracting agencies, requirements for payment of "live-in" aides that were enacted last year, and federal requirements relating to overtime obligations. These issues would be further complicated by the implementation of an increase in the minimum wage as contemplated by the Governor in his budget. The Coalition plans support fair wages for home care aides (and other employees who would now receive this minimum wage) and recognize the obligation of plans to provide sufficient payments to contracted entities to meet their obligations, but the State also has an obligation to ensure that the premiums paid to plans are fully adequate to meet state mandates, including any increase to the minimum wage: an increase that not only increases hourly wages for the lowest paid workers but requires upward adjustments for more experienced staff. It would be disingenuous in the extreme for the State to mandate a higher minimum wage—and then not provide sufficient financial support for State-funded programs to meet it.

- ***MLTC Eligibility.*** The budget proposes to return to limiting enrollment in MLTC plans to those enrollees who require a nursing home level of care. While the Coalition recognizes the need for well-defined eligibility criteria in order to simplify eligibility determinations, we stress that there must be appropriate rate adjustments made as a result of this change to reflect the new case mix that will result from the eligibility change. This change to the eligibility criteria should not justify a disproportionate decrease in rates by the Department: to the contrary, rates will have to increase to reflect the fact that all new enrollees will be nursing home eligible.

- ***Transportation carve-out.*** This budget, like last year's, also proposes to carve-out transportation from the MLTC benefit package and rely on traditional Medicaid transportation services for individuals enrolled in the program—although the proposal this year properly exempts PACE plans from this carve-out. This proposed change would have profound implications on the program models used that have successfully linked enrollees with needed medical services and that provide a host of other informal supports to enrollees, especially in more rural or otherwise underserved areas in New York. MLTC members, unlike most mainstream enrollees, are elderly, frail, chronically ill, and/or disabled, and dependent on transportation for needed medical services. Accordingly, we do not believe the case has been made to justify the carve-out, which could substantially limit plan effectiveness and increase patient dissatisfaction. At a minimum, we would urge limiting any change in transportation services and funding to exempt upstate plans where these services can

make such a significant difference in enhancing access to care, reducing institutional care and increasing patient satisfaction.

- ***OMIG/Plan Fiscal Integrity.*** The Department intends to make a $30 million reduction to plan rates to account for fiscal integrity actions. Essentially, the Department proposes to make a plan specific reduction, through a yet to be identified formula, and then encourage the plan to work with OMIG to come up with these savings in order to improve fiscal integrity in the program. The Department is currently considering how to deal with funds recouped in excess of the plan's target savings, which could result in the plan retaining those funds or at least a portion of the savings, with the remaining savings shared with OMIG. On its face, this is essentially a cut to health plan rates without any real justification. The Coalition has serious questions about whether this initiative is well-conceived and believes that the Department and OMIG need to develop this program carefully so that it doesn't duplicate or discourage current fraud and recovery efforts, and so that it fits with the objectives of managed care. We encourage the Legislature to become more involved in the determination of rates, through both the rate setting process and other actions proposed by the Governor, including this so-called fiscal integrity initiative.

- ***MLTC Benefit Package.*** The Department intends to move behavioral health services, among others, which are currently carved out of managed care benefits, into the MLTC benefit package. While the Coalition supports the inclusion of these services in the MLTC benefit package, the addition of these benefits must be supported by a rate increase to ensure that quality services are provided and affordable. We advocate for the imposition of an enhanced MLTC rate, which would ensure adequate reimbursement for the newly covered services, and urge the Legislature to ensure that an appropriate enhanced rate is enacted—and that adjustments are made in the plans' administrative reimbursement to reflect increased contracting and oversight obligations that the new benefits will impose.

- ***OSC Audit Findings.*** As a result of the State Comptroller's Audit of the Medicaid managed care program, the Department intends to take a series of actions that will impact plan rates, including a requirement that the plans pay for the State's actuary, Mercer, at a cost of roughly $20 million per year. Again, the Coalition believes that more conversation is needed with the Department regarding how these initiatives will impact the adequacy of the rates, and whether it is even appropriate for plans to fund the Mercer contract. We encourage the Legislature to actively participate with both the Coalition and the Department in crafting solutions to address the issues identified in the State Comptroller's audit.

- ***Managed Care Profit Cap.*** Through administrative action, the Executive Budget proposes implementing a cap on the profits of Medicaid managed care plans, including MLTC plans. As currently proposed, plan profits would be limited to 3.5%. Such a policy could have the unintended and noticeably self-defeating consequence of negatively impacting the plans with highest quality scores, which receive quality incentive bonuses on top of their standard PMPM. Moreover, a cap on profits could disproportionately harm not-for-profit plans, like the Coalition plans, and affect coverage across the state. Specifically, these plans often utilize excess revenue to develop products for new State programs like FIDA, which expand coverage to the State's neediest, or investments in new technology to improve care coordination, rather than distributing profits to shareholders. In addition, because provider-sponsored health plans seek to return savings from their operational efficiencies to their provider sponsors, such a cap would constrain these plans' reinvestment in the not-for-profit and public health care system. At a minimum, the proposal will have to be applied to MLTC plans with the recognition that care management expenses are an integral part of the

program and should be considered part of the plans' medical expenditures. The Coalition, therefore, urges the Joint Legislative Budget Committee to support the omission of the cap on Medicaid managed care plan profits—especially those of not-for-profit, provider-sponsored plans—in the Enacted Budget.

- ***PACE Innovation and Flexibility:*** PACE plans currently serve individuals age 55 and older—but recent federal law allows more flexibility that permits enrollment of younger, eligible persons and special populations. In addition, PACE enrollees should be given the opportunity to select their own primary care providers and PACE plans should be able to contract with senior centers and adult day health care programs to serve as PACE centers—and steps should be taken to streamline the process by which PACE plans can open up additional PACE centers.

- ***Implementation of FIDA.*** The Coalition continues to work with the State on the implementation of the Fully Integrated Duals Advantage (FIDA) program for individuals with complex long-term care needs who are enrolled in both Medicare and Medicaid (dual eligibles). The Coalition plans are committed to the continued implementation of the program, and have worked with the Department and CMS to adjust the programmatic and financial components in order to make the program more successful; including a critical increase to the Medicare rates. We also hope to have additional discussions with the Department concerning the long term care components of the rate package. We would ask the legislature to continue to monitor the implementation of this program, as the dual eligible population is among the most complex in the Medicaid program, which also makes them the most vulnerable.

- ***Implementation of Value-Based Payments.*** The Coalition plans recognize that they play an important role in the reform currently taking place in NYS's healthcare delivery system. The plans are already negotiating performance-based payments with providers and entering other risk-based arrangements. Accordingly, the plans have been engaged in discussions through the value-based payment workgroups, and are continuing to explore how this new payment paradigm will be implemented within the confines of long term care while also considering the simultaneous move toward value-based payments within the Medicare program. Plans want to ensure that the requirements of value-based payments can be reconciled with all of the wage-related obligations, which are touched on above, as well as the existing goals and structure of managed long term care. We look forward to working with the department and our provider partners on transitioning to more value-oriented payments.

Conclusion

MLTC and PACE plans have enhanced the quality and the coordination of care for New Yorkers who require long term care services, allowing people to remain in their homes by providing high quality and coordinated care increases their quality of life, while decreasing the state's costs. We welcome your interest in this important program and we appreciate the opportunity to present our testimony.

Any additional questions or comments can be directed to James Lytle at 518-431-6700 or at jlytle@manatt.com.

Appendix A

Coalition Plans	PACE/MAP/MLTC	Enrollment as of 1/1/16
ArchCare	PACE, MLTC	2,425
Catholic Health LIFE	PACE	201
CenterLight Healthcare	PACE, MLTC	8,931
Eddy Senior Care	PACE	174
Elant Choice	MLTC	860
ElderOne	PACE	668
Elderplan	MLTC, MAP	11,477
ElderServe	MLTC	10,643
Fidelis Care at Home	MLTC, MAP	11,393
GuildNet	MLTC, MAP	15,427
Hamaspik Choice	MLTC	1,339
Independence Care System	MLTC	5,729
MetroPlus	MLTC	939
Montefiore	MLTC	691
North Shore LIJ	MLTC	2,585
PACE CNY	PACE	489
Senior Health Partners	MLTC, MAP	16,543
Senior Network Health, LLC	MLTC	493
VillageCareMAX	MLTC	4,974
VNA Homecare Options	MLTC	1,410
VNS Choice	MLTC, MAP	13,642
Total Coalition Members	-	**111,033**
Total MLTC/PACE/MAP Members Statewide	-	**149,436**