Submitted Testimony

TESTIMONY OF
THE COALITION OF NEW YORK STATE
PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED SFY 2016-2017 HEALTH AND MEDICAID BUDGET

SUBMITTED TO THE
JOINT LEGISLATIVE FISCAL COMMITTEES
HEALTH AND MEDICAID

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Introduction

Members of the Joint Legislative Budget Committee: Thank you very much for the opportunity to testify on behalf of the Coalition of New York State Public Health Plans (PHP Coalition). Established in 1995, the Coalition is an important voice for New York's non-profit, publicly-focused health plans and their members. The Coalition currently represents eight plans serving more than 3 million individuals—approximately two-thirds of all of adults and children enrolled in New York's Medicaid managed care and Child Health Plus programs. All Coalition plans are sponsored by or affiliated with public and not-for-profit hospitals, community health centers and physicians. Coalition plans have decades of experience delivering high-quality services to populations that have traditionally faced significant barriers to health care, and they consistently receive high marks in quality of care and member satisfaction.

Today, the Coalition would like to comment on plans' partnership with the State to achieve the Medicaid Redesign Team's goal of "care management for all" and to further the success achieved thus far by New York State of Health, the State's Health Insurance Marketplace. Last year, close to two million New Yorkers enrolled in coverage through the Marketplace; more than three-fourths of them enrolled in Medicaid or Child Health Plus.[1] That trend continues through this year's open enrollment period, as hundreds of thousands more receive coverage. In recent years, we have been heartened by the extent to which healthcare provider and consumer organizations have joined with us in advocating for policies that enhance the delivery of Medicaid managed care. We respectfully request that the Executive and the Legislature consider strategies that will enable plans to achieve the aims of the Medicaid Redesign Team and continue to assure quality healthcare to their more than 3 million members.

Coalition Partnership with the State

The foundation of plans' partnership with the State is made up of shared and deeply rooted values and goals. Coalition plans serve some of the neediest New Yorkers—the poorest, sickest and hardest to reach—and in doing so, they, like the State, face myriad challenges. To effectively address these challenges, plans have worked closely with the State to improve the way care is delivered and to do so for an increasing number of residents.

For decades, plans have been effecting positive change in New York's health care delivery system. Both before and since Governor Cuomo's 2011 formation of the Medicaid Redesign Team (MRT), plans have played a critical role in efforts to improve the quality of care and reduce per capita costs in the State's public programs. This is exemplified by the MRT's embrace of Medicaid managed care as the vehicle to achieving the Governor's stated goals: "measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."[2] It is further demonstrated by the Special Terms and Conditions of New York's Delivery System Reform Incentive Payment (DSRIP) Program, which recognize the integral role of plans in the long-term sustainability of DSRIP. In fact, the savings associated

[1] New York State of Health, 2015 Open Enrollment Report (July 2015). http://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf

[2] State of New York, Executive Order #5 (January 2011). http://www.governor.ny.gov/executiveorder/5

with expanding managed care allowed the State to negotiate over $8 billion in new investment in its delivery system. It is clear that in the midst of such redesign and reform, managed care plans are a critical partner in the delivery of health care in New York.

Over the last five years, Medicaid managed care plans have enrolled new, more complex populations, offered a comprehensive array of services to their members, and developed original products to implement new State programs. For example, in 2015, plans spent a great deal of resources working with the State to launch and enroll individuals into the Fully Integrated Duals Advantage (FIDA) program to coordinate the delivery of care to individuals with long-term care needs who are dually enrolled in Medicare and Medicaid (dual eligibles). Plans continued implementing the transition of the long-stay nursing home population and benefit from fee-for-service to managed care. Plans also launched the new line of business, Health and Recovery Plans (HARP) for individuals with significant behavioral health needs. Looking ahead, plans will continue to work with the State to carve in additional services and populations such as those individuals in the NHTD and TBI waiver programs. These are just a few examples of the trend to shift more complex and vulnerable populations and services into managed care; they serve as evidence of the success that plans have had in providing high-quality care to members at lower costs to the State.

In addition to their significant Medicaid redesign efforts, plans have worked closely with multiple State agencies to support the continued success of New York State of Health. Five Coalition plans offer qualified health plans (QHPs) through the Marketplace and collectively accounted for nearly half (48%) of QHP enrollment during the Marketplace's second year. Coalition plans bring to the Marketplace a unique perspective that stems from a longstanding mission and operational focus on public programs for the neediest, lowest income residents. Coalition plans are pleased to offer affordable QHP coverage options to New Yorkers who are ineligible for Medicaid coverage but still in need of financial support. In serving the majority of the State's Medicaid and Child Health Plus beneficiaries, Coalition plans are committed to providing New Yorkers with a continuum of coverage, to minimize disruption in care when income or other circumstances change. Such commitment drove plans to work with the State to develop and implement its Basic Health Program (BHP) – the Essential Plan – which began transitional implementation in April 2015 and was fully implemented just recently. Plans worked closely with the State to design and develop an affordable, comprehensive product under a tight timeline and facilitate the transition of hundreds of thousands of eligible New Yorkers from Medicaid and QHP coverage into the Essential Plan. Plans will continue to support New Yorkers' enrollment into this important coverage option.

These new programs and transitions present tremendous opportunity to improve health outcomes and quality of life for hundreds of thousands of New Yorkers across the State. They may, however, be hindered by misguided policy and implementation decisions or lacking operational systems and processes. Indeed, past experiences have shed light on areas where policy refinements may allow future transitions—and ongoing implementation of existing ones—to even better meet New Yorkers' health needs.

The Importance of Rate Adequacy and Timeliness

With over half of the Medicaid budget now allocated to health plans, the Coalition urges the Joint Legislative Budget Committee to be attentive to the issue of rate adequacy. Sufficient rates are a critical prerequisite to effective, appropriate delivery and management of care. Plans have urged the Department of Health to continue to work with them to monitor expenses and ensure that rates accurately reflect the true costs of the populations and benefits covered. This issue is increasingly important to plans as the State begins and continues implementation of major new programs, such as FIDA and HARP, this year and next.

- ***Fully Integrated Duals Advantage (FIDA).*** The dual eligible population is among the most complex and vulnerable in the Medicaid program, with needs that span the primary and acute care, long-term care, behavioral health, and social service systems. FIDA rates must reflect this complexity. Unfortunately, the FIDA rates released by the Department of Health and CMS for the first year of the demonstrate fall short.

  Plans have been working with the Department and CMS to address this critical issue, but assistance and support from the Legislature may be necessary given what is at stake. At their current level, the rates are underfunding long-term care and pharmacy services, which hurts both providers and the dual eligible members being served. Without rates sufficient enough to support the full range of services necessary, as well as the administrative functions required to effectively manage them, plans may find participation in the program untenable. In sum, such inadequate rate setting could cripple a program that is just getting off the ground.

- ***Pharmacy Costs.*** Without question, the fastest growing cost center for Medicaid managed care is the pharmacy benefit. Both the introduction of higher cost drugs and the expansion of policies such as "prescriber prevails" drive additional costs to the plans and ultimately the State. Higher cost drugs, both brand and generic, are driving costs up, faster than medical inflation. Unfortunately, the adjustments made by the Department to the plans' rates to reflect these added costs fall short of covering the added expense. As described below, the Budget proposes some important cost containment initiatives for the pharmacy program that the Coalition strongly endorses, including restricting the "provider prevails" policy, which may help slow the growth of these costs—but even those changes, if enacted, won't obviate the need to update plan rates to keep pace with the extraordinary increases in pharmacy costs.

- ***OMIG/Plan Fiscal Integrity.*** The Department intends to make an arbitrary $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 plans 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 implement this initiative and a host of details remain unclear. 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 actually

duplicate or discourage current fraud and recovery efforts, and so that it fits with the objectives of managed care.

Moreover it should be noted that all of the Medicaid managed care plans have robust fraud, waste and abuse programs already in operation that operate to identify fraud before any payment is made—a far more effective way to avoid fraud, given the extreme difficulty in recouping fraudulently obtained funds once they are disbursed. Plan-identified instances of fraud have led to referrals to the Office of the Medicaid Inspector General (OMIG) and to prosecutions by the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and federal prosecutors. These are extremely important cooperative efforts but it should be noted that to the extent there are recoveries, these are not turned over to the plans.

- ***OSC Audit Findings.*** As a result of the State Comptroller's Audit of the Medicaid managed care program which has not been made public, 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 once it is made public.

Rate timeliness continues to be an issue for plans. The issuance of rates has been consistently delayed, which has had a significant effect on plans' ability to create budgets and manage operations. These delays are compounded by retroactive rate adjustments that risk plans' fiscal stability and potentially challenge their capacity to provide adequate care for their members. While we appreciate the best efforts of a heavily-burdened Department of Health staff and understand that some responsibility lies with the Centers for Medicare and Medicaid (CMS), we would urge that every effort be made to ensure that premiums are established *prospectively*, especially when new significant cost increases are being mandated on plans. The Department has made progress in this regard with the "45 day rule" which allows the State to begin paying the rates 45 days after submission to CMS. But, even with this rule, many rate packages are still delayed.

In addition to rate adequacy, the Coalition urges the Joint Legislative Budget Committee to prioritize the issue of rate timeliness for Medicaid managed care plans. The importance of these issues cannot be understated, as adequate and timely rates for plans means adequate and timely reimbursement for providers and more accessible and high-quality care for Medicaid beneficiaries.

Limits to Medicaid Managed Care Profits

Through administrative action, the Executive Budget proposes implementing a cap on the profits of Medicaid managed care plans. As currently proposed, plan profits would be limited to no more than 3.5%. Such a policy could have the unintended and noticeably self-defeating

consequence of negatively impacting the plans with highest quality scores that receive quality incentive bonuses. For not-for-profit provider-sponsored plans, the accumulation of some surplus is their only means of reinvesting in new technologies, developing new state programs for the State's neediest, like FIDA and HARP, and returning savings from their operational efficiencies to their not-for-profit health care provider sponsors. In recent experience, plans have experienced positive financial results in one year, followed by steep losses in the next—making the imposition of a cap on a single year experience particularly arbitrary. The Coalition, therefore, urges the Executive to reconsider the proposed cap and recommends that the Legislature preclude its imposition.

Pharmacy Proposals

The Executive Budget proposes a host of pharmacy-related provisions which impact Medicaid managed care plans. Most significantly, the Governor proposes to eliminate "prescriber prevails" – a prescriber's right to make a final determination regarding the dispensing of prescription drugs in Medicaid.[3] The Coalition commends the Governor for this effort to strengthen consumer safety and continues to support the elimination of prescriber prevails on all drug classes. While often couched as a consumer protection, prescriber prevails prevents plans from using evidence-based principles to ensure that their members receive the safest, most efficacious, and most cost-effective drugs appropriate to treat their conditions. Plans remain committed to working with prescribers, consumers, and advocates on the development of policies that ensure that all MMC members have appropriate access to medications.

The Executive Budget also authorizes the Department of Health to establish a list of critical prescription drugs and require manufacturers to supply information about said drugs to the State for purposes of setting a ceiling price. Under this provision, the Department may require the manufacturer to pay a rebate to the State if the price paid for the drug (by fee-for-service or managed care) exceeds the ceiling price. The Governor also proposes to establish a cap on the price of generic drugs, which recently have seen dramatic price increases. With the cost of prescription drugs among plans' chief cost drivers and concerns, the Coalition supports the Governor's drug pricing proposals and the State's effort to control drug pricing in fee-for-service and Medicaid managed care. We believe these proposals will ensure patient safety, enhance pharmaceutical price transparency as well as to slow the growth in prescription drug costs.

Nevertheless, as noted above, even if all of these sound proposals are enacted, they will not address the current significant shortfall in plan premiums for the real and unabated cost increases in excess of premium revenue that plans must cover for prescription and office-administered drugs. The Department must recognize the true costs of specialty drugs, and the growing cost in generics, in their payments to plans.

[3] The Governor's proposal eliminates prescriber prevails for all drug classes except atypical anti-psychotics and antidepressants.

New York State of Health Considerations

The Coalition commends the Governor, the Legislature, and New York State of Health leadership for engaging diverse stakeholders and balancing multiple important points of view in the continued implementation and operation of the State's Marketplace. However, while New York State of Health remains one of the country's most successful Marketplaces, there are a number of important operational and policy issues that must be addressed.

- ***PCP Selection Functionality.*** Of highest priority is ensuring the availability of reliable primary care provider (PCP) selection functionality in the New York State of Health online enrollment portal. Currently, consumers shopping on the Marketplace are unable to select a PCP when they enroll in a plan, requiring them to call their plan, separately log into their plan's member portal, or mail a paper form after their coverage has been effectuated. The lack of PCP selection functionality at the point of enrollment places significant burden on both consumers and plans and represents a step backwards from prior Medicaid processes. Plans must devote substantial resources to tasks like issuing multiple member ID cards per member (due to requirements that Medicaid member ID cards be reissued when a PCP is assigned and then selected) and handling members' calls and complaints related to PCP assignment; these resources can and should be devoted to serving members on a variety of other, important issues.

  PCP selection functionality is reliant on the development of the new Provider Network Data System (PNDS), which will collect data needed to evaluate provider networks for all types of plans in New York State. The State is committed to having the new PNDS go live in September and we urge the State to ensure that PCP selection functionality will be available to consumers on the New York State of Health online portal at the same time. Most importantly, the NYSOH should not under any circumstances begin processing Medicaid eligibility recertifications through the Exchange until this problem is fixed. If PCP selection is not functional and fully tested prior to recertification on the Exchange, millions of Medicaid members face the prospect of having their PCPs stripped from their enrollment records. No MCO will be able to restore these through manual means.

- ***Drop in Medicaid Enrollment.*** Starting in the last quarter of 2015, plans have also seen significant declines in Medicaid managed care membership. These drops are not customary, cannot be accounted for by the transition of some Medicaid members to the Essential Plan, and are being experienced by all plans – leading to concerns that there is a broader issue with state systems and roster files and that Medicaid eligible consumers are being disenrolled inappropriately. Coalition plans have raised this issues with State staff to determine the root cause and ensure that consumers are not negatively impacted but may require Legislative intervention to resolve this significant issue expeditiously. The Department must prioritize fixing these glitches that affect coverage.

- ***Reconciliation of Plans' Membership and Capitation Payments.*** Another key issue relating to New York State of Health operations involves non-payment of capitation for members on plan rosters. Last year, plans discovered they were not being paid for members who appear on their rosters and for whom they are providing services. To date,

this issue has cost plans tens of millions of dollars. The Coalition continues to push the New York State of Health to prioritize reconciliation of plans' membership and capitation payments and urges that every effort be made to ensure reconciliation is completed as quickly as possible.

With the New York State of Health as the enrollment backbone for the coverage of over 2 million New Yorkers, it is important that the State prioritizes continued remediation, improvement and enhancement of Marketplace technical functionality to ensure that the more than five million New Yorkers who rely on Medicaid do not suffer unintentional disruption in coverage, or face virtually insurmountable barriers to accessing coverage efficiently. Moving forward, the Coalition will continue to its commitment to improving New York State of Health operational and eligibility and enrollment processes in order to best serve New Yorkers who utilize the portal to gain and renew health coverage.

The Role of Managed Care Plans in Delivery System Reform

The State has embarked on a robust initiative to reform its delivery system through the Delivery System Reform Incentive Payment (DSRIP) Program, which officially began last April and for which substantial implementation has already occurred throughout the State. As part of these efforts, the State must recognize the important role plans have played in New York's Medicaid redesign and will continue to play under DSRIP. By nature, the plans are partners with the State and are eager to support these reform efforts and the emerging performing provider systems (PPSs). At the same time, the State is relying on the plans to innovate payment relationships with providers, the details of which are still under development.

In the coming months and years, plans intend to work closely with the State, DSRIP providers, and other key stakeholders to ensure that reform is both effective and sustainable. For example, Coalition plans are currently investigating methods for streamlining certain aspects of the program, including the exchange of data among plans and PPSs, patient care management, and the development of protocols that govern the interaction among the plans and the PPSs. Perhaps most importantly, plans are eager to engage in discussions on value-based purchasing directly with the provider community. Over the past year, plans have been active participants in the State-led discussions around VBP. Now, the time has come to implement, which should largely be left to the plans and their provider partners to negotiate. As previously mentioned, in designing the DSRIP program, the State and CMS recognized the critical role of plans in its long-term sustainability and plans look forward to stepping up to the task. Payment and delivery system reform cannot happen without a high functioning health plan infrastructure—something New York has spent years building with much success.

Conclusion

Thank you again for the opportunity to provide testimony on these critical issues. The Coalition welcomes the Committee's interest in them. Coalition plans look forward to continued partnership with the Legislature to ensure that a strong and sustainable health care system is in place to not only serve the growing number of New Yorkers that rely on it but also to reflect and enrich the collective vitality of the State.

MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

PLAN	AFFILIATED ORGANIZATIONS	PUBLIC INSURANCE PROGRAM SERVICE AREAS	NYSOH SERVICE AREAS
Affinity Health Plan	Primary care provider organizations with representation on the Board of Directors from Morris Heights Health Center, Charles B. Wang Health Center, Urban Health Plan, and Institute for Family Health	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester counties	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester counties
Amida Care	HIV Special Needs Plan founded and sponsored by Bright Point Health, Community Healthcare Network, Harlem United, Housing Works, Acacia Network, St. Mary's Episcopal, and VillageCare	New York City	
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic health care providers	New York City and 57 additional counties[1]	New York City and 50 additional counties[2]
Healthfirst	Health systems in all counties in which the plan operates[3]	New York City and Nassau and Suffolk counties	New York City and Nassau and Suffolk counties
MVP Health Care		Albany, Dutchess, Genesee, Jefferson, Livingston, Monroe, Ontario, Orange, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren and Westchester counties	New York, Queens and 41 additional counties[4]
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York, and Queens counties	Bronx, Kings, New York, and Queens counties
YourCare Health Plan, Inc.	Monroe Plan for Medical Care	Allegany, Cattaraugus, Chautauqua and Erie counties	
VNSNY CHOICE	Visiting Nurse Service of New York	-Bronx, Kings, New York and Queens counties	

[1] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Ostego, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, St Lawrence, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Wyoming and Yates counties.

[2] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Jefferson, Lewis, Livingston, Madison, Monroe, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Putnam, Rensselaer, Rockland, Saint Lawrence, Saratoga, Schenectady, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Warren, Washington, Wayne, Westchester, Wyoming and Yates counties.

[3] Bronx-Lebanon Hospital Center, The Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Health System, New York City Health and Hospitals Corporation, North Shore – LIJ Health System, the NuHealth System, St. Barnabas Hospital, St. John's Episcopal Hospital, Stony Brook University Hospital, and SUNY Downstate Medical Center.

[4] Albany, Cayuga, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Oneida, Onondaga, Ontario, Orange, Orleans, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Seneca, St. Lawrence, Sullivan, Ulster, Warren, Washington, Westchester and Wyoming counties.