21 B

TESTIMONY OF
THE COALITION OF NEW YORK STATE
PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED SFY 2015-2016 HEALTH AND MEDICAID BUDGET

SUBMITTED BY ANTHONY FIORI

TO THE

JOINT LEGISLATIVE BUDGET COMMITTEE ON

HEALTH AND MEDICAID

FEBRUARY 2, 2015

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 one million New Yorkers enrolled in coverage through the Marketplace; nearly two-thirds 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

[1] New York State of Health, 2014 Open Enrollment Report (June 2014). http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf

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

integral role of plans in the long-term sustainability of DSRIP. In fact, the savings associated with expanding managed care have 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 four 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 2014, plans spent a great deal of resources working with the State to launch 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). This month, plans begin implementing the transition of the long-stay nursing home population and benefit from fee-for-service to managed care. Looking ahead, plans will continue to work with the State to carve in behavioral health services and launch a new line of business, Health and Recovery Plans (HARP), for individuals with significant behavioral health needs. 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. Four Coalition plans offer qualified health plans (QHPs) through the Marketplace and collectively accounted for more than a third (36%) of QHP enrollment during the Marketplace's first 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 makes plans eager to work with the State to develop and implement its Basic Health Program (BHP), which will begin transitional implementation in April and full implementation next January.

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

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 last fall do not.

  Plans are working with the Department 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 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.

- ***Behavioral Health / HARP.*** The Coalition also urges the State to develop rates under the behavioral health transition in partnership with plans, and to not adopt rates that will achieve short-term savings at the expense of long-term cost containment and quality improvement. We would anticipate that plan members with mental illness and substance use disorders may have unmet needs for primary care and community-based behavioral health services. Plans are already incurring upfront initial costs as they connect members to these services and to needed social supports, such as housing, in addition to the internal investments in behavioral health management capacity and infrastructure. Rates should be sufficient to ensure that plans can make these investments and help members avoid unnecessary use of more costly inpatient services in the future.

Rate timeliness is also increasingly 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. Although updated rates may be issued imminently, the plans are still awaiting rates that were supposed to be issued ten months ago. 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.

An example of such a cost increase includes high-cost drugs and treatments like *Sovaldi* and *Harvoni*, both of which are used to treat Hepatitis C. Plans have been covering the costs of these drugs for more than 15 months, and while their cost is reflected in updated rates, plans have yet to receive the updated rates and therefore have not been paid for such coverage. As previously indicated, this presents significant problems for plans. 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 5% and any excess profits would be reinvested in the quality incentive pools. 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. Moreover, a cap on Medicaid managed care plan 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 and HARP, which expand coverage to the State's neediest. Not-for-profit plans are *not* distributing profits to shareholders. In addition, because provider-sponsored health plans seek to return savings from their operational efficiencies to their hospital sponsors, such a cap would constrain these plans' reinvestment in the not-for-profit and public health care system. 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.

The Basic Health Program

The Coalition commends the Governor for vesting rate setting authority for the BHP with the Commissioner of Health in his Executive Budget. For several reasons, Coalition plans continue to advocate for the BHP rates to be set by the Department of Health, in a way that leverages the existing Medicaid managed care rate setting process. First, the BHP is a government program-like insurance product, and rates should be set accordingly. The State has built into its BHP many Medicaid-like features and more than half of the population eligible for coverage through the BHP would be eligible for federally-matched Medicaid but for their immigration status. (These individuals, called the Aliessa population, will be transitioning directly from Medicaid to the BHP in April.)

Second, as recognized and affirmed by the Executive Budget, State statute vests authorization of the BHP with the Commissioner of Health. Rate setting should be no different. Given the safety-net nature of the BHP and that authority for its development and administration rests exclusively with the Department of Health, it would be inconsistent with State policy for rates to be set elsewhere.

Third, it is in the State's financial interest to have the Department of Health set the BHP's rates as it does with Medicaid. Federal funding will only cover only a portion of BHP costs; the balance will be supported through State dollars. Cost control in the BHP will be critical to the State achieving targeted savings related to transitioning the Aliessa population, and to the longer-term sustainability of the program. The State can ensure optimal control over BHP costs by directly administering premium rate setting through the Department of Health.

Outstanding Issues Related to the Marketplace

The Coalition also 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.*** One such issue relates to the ongoing delay in 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. Plans must devote substantial resources to tasks like issuing multiple member ID cards per member (due to requirements that 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.

  The Department of Health has recently stated that PCP selection functionality will not be implemented until 2016. Consequently, it has proposed a temporary fix, which involves including a link on the Marketplace to plans' online provider directories alongside a "free fill" field for consumers to enter their selected PCP's name during enrollment. While the Coalition appreciates the Department's efforts to address this critical issue, the proposed temporary fix—which itself will require substantial resources to administer—does not diminish the need for PCP selection functionality on New York State of Health as soon as possible.

- ***Medicaid Renewals on the NY State of Health.*** For years, the New York City (NYC) Human Resources Administration (HRA) has managed ACCESS NYC, a website to help consumers determine eligibility, apply for, and renew public benefit programs; many NYC plans also use this site to effectuate their Medicaid renewals. HRA recently announced that the Medicaid online renewal function of ACCESS NY will no longer be available, because consumers are expected to begin to renew on New York State of Health "at some point in 2016." This gap of almost a year (at the very least) in Medicaid online renewal functionality is problematic for consumers and plans alike—it puts at risk the continuity of care for thousands of Medicaid beneficiaries in NYC and will require plans to develop new renewal processes. Coalition plans are in the process of working with both New York State of Health and HRA leadership to ensure renewals are not disrupted, but assistance and support from the Legislature may be necessary given the implications of this issue for thousands of New Yorkers.

- ***Issuer Assessment.*** The Governor's Executive Budget proposes establishing an assessment on all accident and health insurers to fund the ongoing operations of the New York State of Health. Under the Governor's proposal, all accident and health insurers

would pay a share of the New York State of Health's costs based on the insurer's pro rata share of premiums for all commercial health insurance coverage offered in the individual, small group, and large group markets, regardless of whether the coverage is offered on or off the Marketplace. (Premiums related to Medicaid, Medicare, Child Health Plus, or the BHP would not be included for the purposes of determining the insurer's pro rata share of the Marketplace's costs.) We join our colleagues in the Health Plan Association in urging a different approach.

As the Committee may be aware, New York has a long history of high insurance rates, though the Marketplace has helped ease these rates in recent years. Unfortunately, the proposed assessment will add greater burden on plans and, ultimately, their members and may have the effect of driving up the cost of coverage across the State. The Coalition requests that the Legislature consider reallocating funds within the Health Care Reform Act (HCRA) pools to fund Marketplace operation.

The Role of Managed Care Plans in Delivery System Reform

The State is embarking on a robust initiative to reform its delivery system through the Delivery System Reform Incentive Payment (DSRIP) Program, which begins officially this April and for which substantial planning and development have 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 quality metrics that will eventually affect provider payment. Perhaps most importantly, plans are eager to engage in discussions on value-based purchasing with both the State and the provider community. 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	Bronx, Kings, New York, Queens and Richmond counties	
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 54 additional counties[1]	New York City and 39 additional counties[2]
Healthfirst	Hospitals 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
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester counties	
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York, and Queens counties	Bronx, Kings, New York, and Queens counties
The Monroe Plan for Medical Care	Independent plan with a contract with Excellus BlueCross BlueShield to manage Medicaid, Family Health Plus, and Child Health Plus products	Broome, Cayuga, Clinton, Essex, Franklin, Herkimer, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Orleans, Otsego, Seneca, Tompkins, Wayne, and Yates counties	
VNSNY CHOICE	Visiting Nurse Service of New York	New York City	

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

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

[3] Beth Israel Medical Center, 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 Hospital, New York City Health and Hospitals Corporation, New York Downtown Hospital, North Shore – LIJ Health System, the NuHealth System, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Hospital, and SUNY Downstate Medical Center.