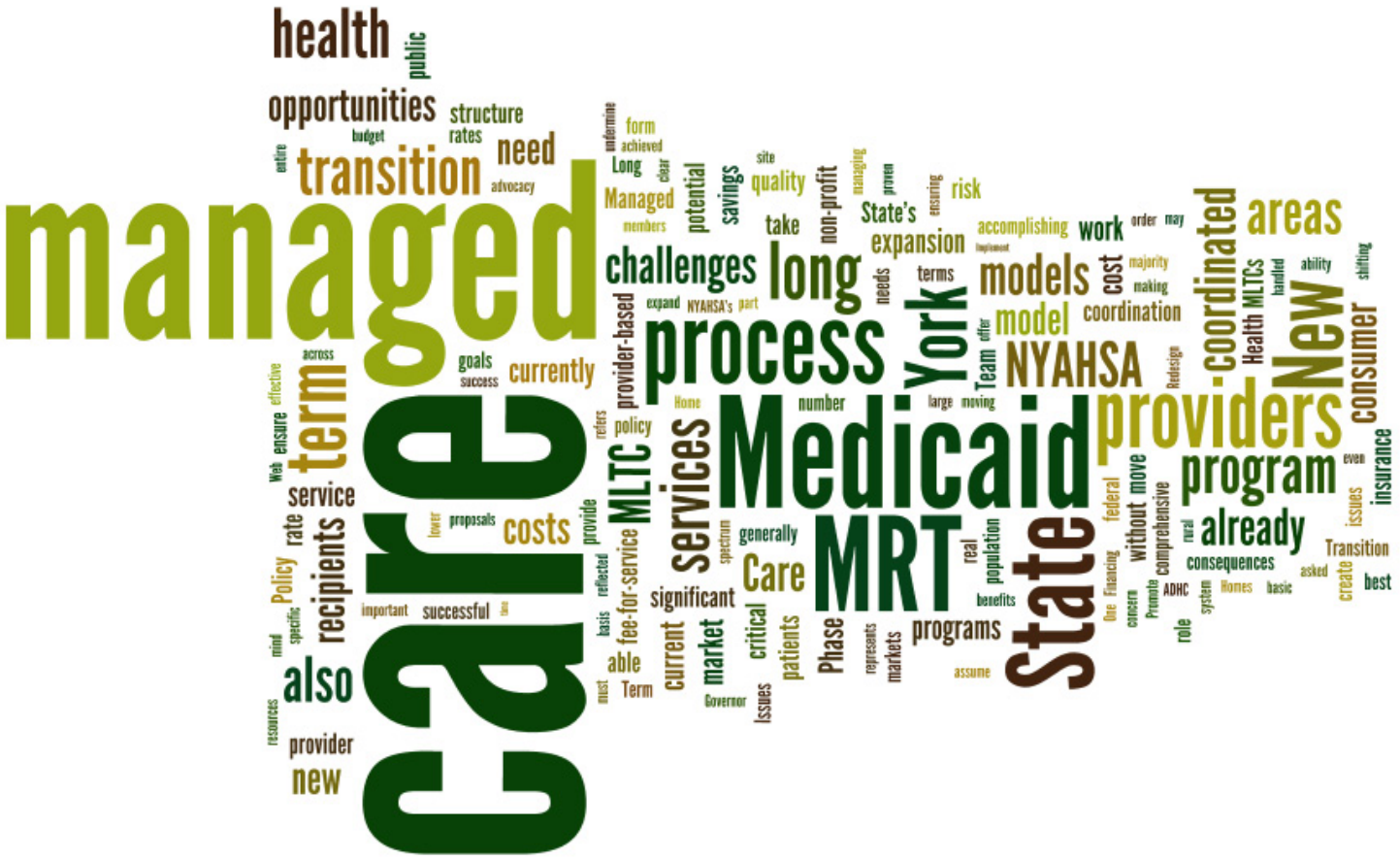

.....Issue Brief: The Expanded Role of Managed Long Term Care

The New York Association of Homes & Services for the Aging
August 15, 2011

Executive Summary

As a result of the sweeping changes coming out of the recent Medicaid Redesign Team process, the New York Medicaid program is moving towards a comprehensive managed care model. As currently envisioned, the expansion of managed long term care would result in the vast majority of Medicaid recipients receiving the majority of care through some form of a coordinated care model. As an association representing the complete spectrum of long term care providers currently offering services in New York, NYAHSA supports the expansion of coordinated care models for long term care, as a means of both enhancing services and controlling costs. The process of accomplishing this transition represents significant challenges and opportunities. This issue brief focuses on the transition from the managed care provider perspective. Our goal is to highlight the specific challenges confronting the managed care provider and offer our recommendations on how best to confront those challenges and create the best opportunity for successful implementation. The challenges are broken down into the areas of Transition, Financing, and Policy Issues. In each area we seek to identify specific concerns and offer our recommendations on how to address them and minimize potential problems.

Presented by:
The NYAHSA PACE/MLTC Cabinet
August 15, 2011

.....I. Introduction

The New York State fiscal year 2011-12 budget marks a dramatic turning point in our Medicaid program. While historically, the State has attempted a variety of strategy to expand the role of various managed care and care coordination models for the Medicaid program, managed care has always operated side-by-side with traditional fee-for-service systems. The work of the Medicaid Redesign Team (MRT) as incorporated into the State budget lays the groundwork for moving covering almost all Medicaid recipients under some form of managed care.

This represents both significant opportunities and challenges for NYAHSA's provider-based, non-profit managed long term care providers. This paper reviews the work of the MRT and defines the critical opportunities and challenges, and thereby defining NYAHSA's advocacy positions.

...II. Review of MRT Proposals/Goals

The details of the MRT can be found by clicking here. The MRT Web site features the following quote from our Governor:

> "It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."
>
> - Gov. Andrew M. Cuomo, January 5, 2011

Also from the MRT Web site:

> The Medicaid Redesign Team has been tasked by Governor Cuomo to find ways to reduce costs and increase quality and efficiency in the Medicaid program for the upcoming 2011-12 Fiscal Year. As part of its work, the Team is seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas.

New York Medicaid spends more than $53 billion annually to provide health care to more than 4.7 million people in need. In effect, Medicaid is the largest health insurance program in New York State. The costs are borne by state, county and federal taxpayers. The Team will undertake the most comprehensive examination of New York Medicaid since its inception.

In Phase 1, the MRT developed a package of reform proposals that achieved the Governor's Medicaid budget target, introduced significant structural reforms that will bend the Medicaid cost curve, and achieved the savings without any cuts to eligibility. Additional information on Phase 1 results can be found in the MRT's June 2011 Progress Report (PDF, 932KB, 35pg.)

In Phase 2, the MRT has been directed to create a coordinated plan to ensure that the program can function within a multi-year spending limit and improve program quality. The MRT has been subdivided into nine work groups, each with a specific charge. Work group membership will allow for even more stakeholder involvement.

As we enter into Phase 2 of the process, we now have enough basic understanding of the State's goals and process that we can offer our analysis of the critical issues as they impact on managed long term care providers. Timing here is critical. One lesson taken from Phase 1 of the process is that the State intends to move very quickly through this process, and it is also reasonable to assume that much of the groundwork underlying the State's process has already been completed "behind the scenes."

One major concern stems from the impression that the State is establishing very aggressive timeframes for accomplishing this transition. Representatives of the Department of Health (DOH) have publicly stated that the migration of all Medicaid recipients into managed care will be accomplished with three years. This ambitious overall timeframe is also reflected in the individual MRT proposals. Most notable is MRT # 90 which will require that all Medicaid recipients over the age of 21 and receiving more than 120 of home and community based services will be required to enroll in managed care, effective April 1, 2012. Starting in New York City, the State intends a very rapid expansion to other geographic areas as they hope to expand the number of available managed care programs.

As detailed in NYAHSA Doc. ID # n00005021, there are no fewer than seven MRT proposals that in one form or another touch on managed care:

1. MRT # 70 Expand current statewide Patient Centered Medical Homes (PCMH)
2. MRT # 89 Implement Health Home for High Cost, High Need Enrollees
3. MRT # 90 Mandatory Enrollment in MLTC Plans/Health Home Conversion
4. MRT # 101 Develop Initiatives to Integrate and Manage Care for Dual Eligibles
5. MRT # 217 Create an Office for the Development of Patient-centered Primary Care Initiatives
6. MRT # 243 Explore Models to Implement Accountable Care Organizations (ACOs)
7. MRT # 1427 Allow consumer direction in MLTC; provide regulatory framework for CDPAP

The State's basic goals can be summarized as:

1. Moving away from a fee-for-service system and covering all Medicaid recipients under capitation;
2. Controlling costs and the eliminating inherent exposure to the State of having to pay for services on a fee-for-service basis;
3. Administrative simplification. The managed care providers essentially take over the rate setting and insurance aspects of running the Medicaid program for the vast majority of "down stream" providers;
4. Reducing utilization, especially institutionalization, through the coordination of care, and in turn reducing costs; and
5. Improving quality and consumer satisfaction through coordination of care.

In order to respond to this rapidly changing environment, the NYAHSA PACE/MLTC Cabinet believes that we also need to pursue an aggressive timeframe of getting our message and advocacy out to all stakeholders. We also need to be able to influence the MRT process during Phase 2.

...Brief Definitions and Acronyms

While health care providers are generally accustomed to dealing with unique terms of art and their acronyms, the managed care world can present a challenge to even the most seasoned health care professional who has not dealt with managed care in the past. Some of the basics:

	PACE Program of All-inclusive Care for the Elderly	**MLTC** Managed Long Term Care	**I-SNP (excluding MAP)** Medicare Advantage	**I-SNP + MAP** Medicare Advantage **AND** Medicaid Advantage Plus
Description	Covers all Medicare, Medicaid, and Home care services	Covers only Medicaid Home care services	Covers only Medicare services	Covers all Medicare, Medicaid, and Home care services
Benefits	Inpatient, Outpatient, Professional, Home Care, Nursing, Transportation	Home Care, Nursing, Transportation	Inpatient, Outpatient, Professional	Inpatient, Outpatient, Professional, Home Care, Nursing, Transportation
Eligible Persons	55 year old + ▪ Medicaid Only ▪ Medicare and Medicaid ▪ Medicare +Direct pay	18 year old + ▪ Medicaid Only ▪ Medicare and Medicaid	Any age ▪ Medicare and Medicaid ▪ Medicare	18 year old + ▪ Medicare and Medicaid ▪ Need for institution level care (like PACE)

Source: Medicaid Reform: A Call to Serve a presentation by Dr. Joseph Healy

You may also refer to the DOH Web site for a comprehensive listing of managed care programs and models available in New York by clicking here. PACE, MLTC, MAP, and SNP will be the main acronyms used in this discussion and are generically referred to as managed long term care. Other important references include: 1.) the Long Term Home Health Care Program (LTHHCP); and 2.) Adult Day Health Care (ADHC).

It also important to keep in mind the distinction between managed Medicaid and managed long term care. Managed Medicaid generally services a younger population, including welfare recipients and working poor who cannot afford to purchase insurance in the open market. MLTC generally services a Medicare/ Medicaid dually eligible population of frail seniors and disabled individuals.

.....IV. The Role of Managed Long Term Care in New York

To understand the historical role of MLTC in New York and why managed care is being looked to as a critical tool in accomplishing the Governor's goal of fundamentally restructuring the State's Medicaid program, please refer to the attached NYAHSA study, entitled *A Statistical Profile of the Efficacy of Managed Long Term Care in New York State (PACE & MMLTC).*

With approximately 34,000 Medicaid recipients currently enrolled in some form of MLTC, that number would have to increase approximately tenfold for the entire long term care population to be covered. The State is anticipating that the same benefits currently seen under managed care will scale up across the entire population of long term care patients. These benefits, as outlined in the NYAHSA paper, include lower per person costs, controls on utilization, slower growth in costs per person if not an actual reduction, better coordinated care, increased consumer satisfaction, and lower rates of institutionalization.

In addition, the State sees benefits in terms of its own operations. Paying a single fee to the managed care provider greatly reduces their administrative burden. In other words, the State gets itself out of the claims processing business. The capitated payment also insulates the State from risk associated with paying on a fee-for-service basis. They are also likely to be looking to simplify the service structure by reducing the variety of programs.

The managed care structure also creates opportunities for the State to take advantage of enhanced federal payments like the 90 percent match on health homes and the consolidation of programs under what is generally referred to as a mega waiver.

.....V. MRT – The Opportunities

For MLTC providers who position themselves appropriately, the potential opportunities in this process are enormous, but not without risk. (NYAHSA also recognizes that to a certain degree the opportunities for managed care create risks for other provider models.)

Among the opportunities are:

1. Growth and expansion for existing providers in an environment in which the managed care provider is favored to receive referrals;

2. Opportunity for new entrants as the total number of programs is expanded from 50 to 75 slots or "medallions;"

3. The ability to move into new markets where there has traditionally been low managed care penetration, e.g., nursing homes and assisted living;

4. The ability to move into geographic areas where there has traditionally been low managed care penetration, specifically non-urban upstate areas;

5. The migration of medical services away from other models to managed care, e.g., medical-model ADHC medical services shifting to managed care; and

6. Finally, the ability for managed care providers to truly demonstrate the savings they can create. Managed care providers have been somewhat stymied in their efforts to expand, despite making a powerful case for the value they bring.

The last item may be the most significant of all. This trend toward managing risk and coordinated care models is occurring across the spectrum, with many federal initiatives under health care reform falling

under this category. If managed care can truly deliver on the prospect of higher quality, coordinated care at lower cost, then managed care becomes the future of health care.

.....VI. MRT – The Challenges

With the opportunities in mind, the current MRT process represents some real challenges, and even threats. These challenges can be broken down into three basic areas 1.) Transition, 2.) Financing, and 3.) Policy Issues.

Transition refers to how the current process of moving patients from their current care models to managed care is handled, and what unintended consequences are likely to arise. For example, the recently enacted caps on certified home health agency (CHHA) payments and the anticipated shifting of patients into managed care has already created a situation where some CHHAs are rushing to transfer patients in numbers that cannot be reasonably handled by the MLTCs.

The State needs to recognize that this transition needs to be handled properly and with a certain degree of circumspection, or the whole process could be undermined. Key to managing the transition are:

1. Anticipating that there will be unintended consequences or unexpected complications and partnering with providers to manage these situations as they arise;

2. Minimizing the disruption to individual consumers and taking all the steps necessary to avoid transfer trauma and service interruptions;

3. Respecting the individual's already established choice or preference in the auto assignment process;

4. Managing expectations, especially where the managed care model is not able to provide the same level of extensive service as the fee-for-service model (Note: it will be inevitable that if overutilization of services is to be controlled through coordination of care then some consumers will have to adapt to what may be a real or perceived reduction in service.);

5. Ensuring an objective and timely fair hearing process that does not undermine the integrity of the managed care model;

6. Minimizing the need to fall back on auto-enrollment and ensuring whenever possible that the consumer is able to make a choice in selecting plans; and

7. Ensuring soundness in the rate setting process in order to avoid adverse selection.

The potential negative consequences in not managing these transition issues properly are such that they could undermine the entire process.

Financing refers to ensuring that the rate structure supports the new risk profile that managed care providers are being asked to assume. It is already clear from the early shifting of patients from CHHAs to managed care that the MLTCs are being asked to take on significantly larger exposure, and this must be reflected in the rates. It is also clear that MLTCs will not be able to sustain the two-year lag in rate adjustments currently built into the system. Here again, unless the State is flexible and willing to make adjustments in their process, this could undermine the success of this initiative.

The major issues under financing are:

1. Ensure actuarial soundness of rates that are ad-

justed in real time to reflect the increasing risk that MLTCs are being asked to assume;

2. The new wage parity or living wage requirement must be reflected in current rates;

3. Current providers, with experience and connections in the market, need an opportunity to develop the necessary economies of scale needed for successful expansion. The current provider-based, non-profit models of managed care have a long term commitment to service and making this process successful. One concern is that large, publicly-traded insurance companies can sell the fact that they are able to take a chance and move into the market with large capitalization resources, but if they find they are not making the profit margins needed to satisfy investors they will simply pull up stakes and abandon the market, thus de-stabilizing it;

4. New entrants into the market cannot be allowed to "cherry pick" the more desirable urban markets while shunning the less lucrative rural markets. This relates in part to the concern raised in number 3 above. A system must be devised to that all players take on their fair share of more and less desirable markets;

5. There have to be strict controls and consumer protections for marketing. Recent experience on the Medicare Advantage and Part D side demonstrates the negative consequences of unscrupulous salespersons signing up new members for the sake of a fast commission, without putting the interests of the patient/consumer first; and

6. With regard to offering new medallions, priority should be given to existing coordinated care models that are seeking to transition to managed care. In particular, the LTHHCP and Adult Day Health Care (ADHC) programs already fill an important niche and have already proven themselves an effective coordination model. In this regard, we believe that there needs to be flexibility in allowing LTHHCPs and ADHCs that cannot transition to a full managed care model to continue to play a role.

Policy Issues refers to many areas that have already been touched on above, but need to be recast in terms of what constitutes effective public policy. We know that cost concerns are driving a good part of this transition. But looking at short term cost savings without considering the long term policy goals constitutes the proverbial "penny wise and pound foolish" approach.

Here again, there has to be a smooth, adaptable transition process that builds on the expertise and foundation of MLTC and coordinated care providers who already have a proven track record of accomplishing the goals the State is pursuing.

The State's policy objectives can only be achieved by a model that is patient-centered, actuarially sound, and committed to the New York consumer. Here again, New York-based, provider-based, non-profit managed care and coordinated care providers are best suited to ensuring the long term success of this program.

For example, this initiative is not going to be successful unless rural areas are adequately covered, and it will be the non-profit, provider-based models that are willing to move into these areas, and not the for-profit publics. There is no need for expansion in the NYC metro area. This is a natural marketplace for MLTC and this market is already saturated. The key will be to have the State work in partnership with providers to cover the rural areas.

Finally, there has to be a process to ensure integrated services for dual eligibles. As far as MLTC is con-

cerned the key to success with the long term patient is the integration of Medicare and Medicaid; this holds the potential for significant cost savings to the State, particularly is a shared savings context with the federal government.

.....VII. Critical Issues and NYAHSA Advocacy

With these critical issues of Transition, Finance, and Policy in mind, it becomes clear what NYAHSA's advocacy role needs to be:

1. Promote a smooth transition that minimizes disruption to the consumer and places value on those non-profit, provider-based MLTCs with a proven track record of controlling costs and providing high quality, patient-centered service;

2. Promote adequacy of the rate structure and ensure that it is sensitive on a real time basis to the new challenges confronting providers; and

3. Promote a sound public health and public policy foundation for the changes.

.....Conclusion

NYAHSA and its members stand ready to provide support and resources as the State sets a new course towards comprehensive, coordinated care for our Medicaid recipients. NYAHSA members are uniquely positioned in terms of bringing expertise and resources from across the complete spectrum of long term care services to the table. The coming transition will not be without its stumbling blocks. All stakeholders need to work together in order to minimize potential problem areas, and ensure the best outcome for our frail seniors and other vulnerable populations currently dependent on the Medicaid program for vital services.

We invite additional stakeholder input on this issue brief. For more information, please contact:

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