



**Public Hearing on
Medicaid Transition to Care
Management for Long Term Care
Testimony Presented By:
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Fri., Dec. 7, 2012**

Presented to:
Assembly Committee on Health
Richard N. Gottfried, Chair

Assembly Committee on Oversight, Analysis and Investigation
Andrew Hevesi, Chair

**250 Broadway, 19th Floor
Assembly Hearing Room
New York, NY**

Introduction

LeadingAge New York appreciates this opportunity to testify before the Assembly Committees on Health and Oversight, Analysis and Investigation on the matter of Medicaid transition to care management for Long Term Care (LTC).

My name is James W. Clyne, Jr., and I am the president and CEO of LeadingAge New York. Founded in 1961 and formerly known as NYAHS, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs and Managed Long Term Care (MLTC) plans.

LeadingAge New York's 500+ members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives us a unique understanding of the impact of Medicaid redesign and other initiatives on the entire LTC system.

Overall Perspective on the Current Transition

LeadingAge New York has advocated for many years for the reform and redesign of the state's Medicaid program, and we embrace the major themes of Medicaid redesign – expanding care management; recalibrating Medicaid benefits; revisiting reimbursement systems and incentives; promoting personal responsibility; eliminating government barriers; empowering patients; and aligning with federal policy objectives.

The shift to care management for the vast majority of Medicaid recipients is one of the main tools the state is using to effect these changes. As implementation of mandatory enrollment into MLTC plans has actually begun, we now have some degree of experience with the process to identify the critical issues as they impact the full spectrum of LTC and senior services.

The Pace of Change

Our fundamental concern at this time is that of the speed and degree of predictability of the changes the state is seeking to implement. These changes may have unintended consequences and prove counterproductive to the long term positive goals of Medicaid redesign.

The state has established what are seen as very aggressive timeframes for accomplishing the transition to care management for the LTC population. Department of Health (DOH) officials have publicly stated that the migration of all Medicaid recipients into managed care plans will be accomplished within three years. This ambitious overall timeframe is also reflected in the individual Medicaid Redesign Team (MRT) proposals. Most notably, MRT #90 requires that all Medicaid recipients aged 21+ and receiving more than 120 days of home and community based services will be required to enroll in MLTC plans/care coordination models. The original April 1, 2012 implementation date to begin the transition in New York City was pushed back by four months.

As of April 1, 2012, some 34,000 Medicaid recipients were enrolled in MLTC plans of various types. To provide perspective on the magnitude of this change, that number will have to increase tenfold for the entire Medicaid LTC population to be covered. The state is anticipating that the same advantages attributed to Medicaid managed care to date will manifest among the entire population of LTC recipients. These advantages include lower per person costs, controls on service utilization, slower growth in per person costs, better coordinated care, lower rates of institutional use and increased consumer satisfaction.

However, this vision fails to account for the fact that a whole new risk pool of frail elderly, chronically ill and disabled enrollees will need to be covered, with care and service needs that may be significantly different from those of either mainstream Medicaid managed care enrollees or the original pool of voluntary MLTC enrollees. Fundamental changes in the underlying service population for MLTC plans will necessitate major investments in infrastructure, resources and ultimately time if the transition is to succeed.

Philosophy of Transition

Clearly, there are budgetary factors for the state that drive much of the current imperative for the planned managed care transition, including the current timeline. The state needs to recognize, however, that this transition needs to be handled properly and with a certain degree of circumspection, or the whole process could be undermined. There is just as much an imperative for predictability and planning on the part of managed care plans and service providers as there is for expediency on the part of the state. The following tenets are key to properly managing the transition:

1. Anticipating that there will be unintended consequences or unexpected complications and partnering with plans and providers across the continuum 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. 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. Inevitably, 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 services;
4. Ensuring an objective fair hearing process that does not undermine the integrity of the managed care model or members' legitimate rights to needed services;
5. Minimizing the need to fall back on auto-enrollment and ensuring whenever possible that the consumer is able to make an informed choice in selecting plans, respecting already established preferences and supporting reasonable continuity of care policies during transition periods;
6. Gathering and monitoring real-time data during the transition on service delivery, cost, quality and enrollee satisfaction, and using such data to make warranted adjustments;
7. Ensuring soundness in the MLTC rate setting process from an adequacy and timeliness perspective in order to avoid adverse selection and financial issues for plans; and
8. Providing flexibility and regulatory relief to allow Long Term Home Health Care Programs (LTHHCPs) and Adult Day Health Care (ADHC) programs that cannot

transition to a full managed care model in order to continue to play a significant role in service delivery.

Preserving Home and Community Based Services

The state has at least tacitly recognized the value of preserving the infrastructure of providers that have significant expertise and experience in caring for and coordinating services for frail elderly and disabled recipients in the community. For example, DOH has agreed to allow home health care providers, such as LTHHCPs, to act as subcontractors to MLTC plans to provide care management services. DOH has also expressed conceptual support for enabling ADHC programs to expand the populations they serve and reconfigure their services in order to act as subcontractors of MLTC plans. Finally, the state has also recognized the need to expand the supply of short-term Certified Home Health Agency (CHHA) services.

These ongoing roles for the LTHHCPs, ADHCs and CHHAs are absolutely necessary to the success of this process. LeadingAge New York members have stepped up to the plate in seeking to adapt their care provision and business models. However, the current pace of transition creates serious concerns for many of these providers as to whether they will remain in operation long enough to fulfill their evolving roles. Should many fail before the new system is in place, there is the potential for serious gaps in service. For example, referrals to LTHHCPs have decreased throughout the state – in some cases dramatically – in anticipation of the intended mandatory enrollment in MLTC plans beginning January 1, 2013.

DOH has already published an aggressive timeframe for the transition to mandatory managed care enrollment across the geographic areas of the state. This schedule already leaves little time for established providers to make the necessary adjustments in operations, and to enter into contracts with plans. With that, this timeline could even be accelerated based on a determination by DOH that the necessary managed care network is in place in a given county. Providers already struggling to stay afloat and adapt their operations could suddenly find the rug completely pulled out from under them due to a faster than anticipated move to mandatory enrollment. It is almost impossible for these providers to orderly continue operations and serve

Medicaid recipients under this degree of uncertainty. Home and community based service providers continue to be in a vulnerable situation, and answers to critical policy questions are not forthcoming.

LeadingAge New York emphasizes again that the potential negative consequences of not managing these transition issues properly are such that they could undermine the entire process. The availability of an array of high quality home and community based services is absolutely critical to the success of the managed care model. Leading Age New York believes that the speed and unpredictability with which the state is seeking to implement major change raises a cautionary note over how the transition process could evolve, and what it could mean for services in the community.

Facility-Based Providers at Risk

Notwithstanding the additional emphasis that MLTC places on the use of home and community based services, there will always remain a critical need for facility-based services of the type offered by nursing homes and assisted living programs for recipients who cannot be safely and appropriately served in home and community based settings.

These services entail significant investments in fixed assets and labor intensive operations. The state has issued little if any guidance on when or how the Medicaid recipients living in these facilities are to be transitioned to managed care, and how the providers are to adapt their operations.

The nursing home provider typically has a large fixed investment in its physical plant, with financing that is predicated on a reliable stream of Medicaid capital reimbursement. For over 30 years, the state's policy has been to reimburse the capital associated with nursing home care based on actual (i.e., "historical") costs, subject to certain limitations. This policy, which has been controlled through the Certificate of Need process, has encouraged providers to maintain safe, up-to-date physical facilities and adopt more resident-centered models of care, while assuring mortgage lenders, bondholders and insurers of a loan repayment source. If this model is abandoned and nursing home capital costs are subsumed in the rates negotiated between

Medicaid managed care plans and facilities, it could have a significant chilling effect on facility updates and on lenders' willingness to finance needed nursing home capital projects.

In addition to the capital piece, the general issue of rate adequacy for many financially vulnerable nursing homes is left unanswered. The state is operating under the assumption that the current Medicaid rate is the benchmark for negotiating managed care contract rates, but this could still leave providers facing serious reductions in reimbursement and downward pressure on rates that could create "a race to the bottom." The current total Per Member Per Month (PMPM) premiums paid to Medicaid managed care plans cover barely half the cost of keeping an enrollee in the nursing home for a month. To date, mandatory MLTC enrollment has only targeted home care recipients. As current nursing home residents are targeted for mandatory enrollment, the importance of properly financing the nursing home benefit in Medicaid managed care will become more paramount. Nursing home residents have never constituted a significant portion of the MLTC enrolled population. This piece of the transition has to be carefully analyzed and the shift of dollars from the nursing home fee-for-service program to MLTC coverage managed properly, so that neither the nursing homes nor the MLTCs are exposed to massive losses during and after the transition.

Another significant impact of the transition to managed care may be the case-mix (i.e., resident care needs) implications. For over two decades, the state has had a policy of reimbursing nursing homes in part based on the case-mix of their residents, creating an incentive for nursing homes to care for more debilitated individuals, thus keeping them out of more expensive acute care beds. There is no provision in the current MLTC framework to account for these case-mix differences, and in fact with downward pressure on overall rates, nursing homes could be discouraged from accepting residents with more complex care needs, potentially causing a backlog of these patients in hospitals and other adverse outcomes.

Additionally, many of the practical rules for how the Medicaid eligibility of nursing home residents would be affected by mandatory managed care enrollment have yet to be worked out. These include the processing of Medicaid applications and spend down to eligibility, the ongoing financial responsibilities of the resident (i.e., the Net Available Monthly Income and Medicare

co-insurance coverage) and provisions for ensuring that community spouses are not impoverished.

These concerns are also relevant for assisted living programs and Adult Care Facilities (ACFs), whose provision of services may overlap with managed care services. The managed care providers are in general eager to pursue relationships with assisted living and ACFs as an important option for providing services while ensuring a stable housing situation. However, current state regulations and policies actually prevent them from doing so, and the state has yet to begin to define the role of assisted living programs in a managed care dominated environment.

Housing with Services

The best managed care service available is useless if the individual does not have a safe, affordable place to live. LeadingAge New York commends the state for acknowledging that there needs to be an expansion of affordable housing as the foundation for delivering home and community based services that keep people out of institutions, and for proposing initiatives in this direction. While congregate senior housing is an ideal location for low-income seniors to remain independent and receive supportive services, there is a severe and growing shortage of this much needed resource, especially in downstate communities. In addition, much of the current infrastructure needs rehabilitation and would benefit from co-location of supportive services.

Here again, the MLTC provisions are being pushed in advance of ensuring the necessary foundation for the success of those services. LeadingAge New York believes that the expansion of MLTC should be developed in coordination with an investment in expanded supportive housing for the LTC recipients targeted for enrollment.

The Information Challenge

The new world of managed care will be data-driven. To date, providing funding for technology applications in LTC service settings (e.g., electronic medical records, telehealth and remote monitoring capabilities) has not been a priority of either the federal or state governments.

However, as the state pursues its goals of containing Medicaid costs, ensuring that the care of every Medicaid recipient is coordinated across settings and serving more individuals in community settings, added investments in technology in LTC facilities and community-based programs are essential.

LeadingAge New York cautions that the current pace of change may widen the gap between the current technology infrastructure in LTC settings and the infrastructure needed in the future.

Opportunities and Challenges for MLTC Plans

For MLTC plans that position themselves appropriately, the potential opportunities associated with this transition are significant, but not without risk. Among the opportunities are the following:

1. Growth and expansion for existing plans in a mandatory enrollment environment;
2. Opportunity for new entrants as the total number of programs is expanded;
3. Ability to enroll populations (e.g., nursing home and assisted living program residents) for which there has traditionally been low MLTC penetration;
4. Ability to move into geographic areas where there has traditionally been low MLTC penetration;
5. Ability to subcontract service delivery and care coordination using a “best of breed” approach; and
6. Ability to truly demonstrate what MLTC plans can accomplish in an environment more conducive to expansion.

The last item noted above may be the most significant of all. This trend towards capitation 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, better population health and reduced cost, then it will become an essential building block of the future health care and LTC delivery system.

LeadingAge New York believes that our not-for-profit, provider-based MLTC members are the best suited to fulfill the needs of New York’s elderly and disabled Medicaid population, building upon a strong foundation of LTC and senior services expertise and experience.

Mandatory enrollment and rapid expansion of MLTC capacity brings with it some significant challenges to plan sponsors; among them are:

1. The need to ensure actuarially sound rates that are adjusted in real time to reflect the increasing risk that MLTCs are being asked to assume, and/or to make prospective adjustments based on trends. MLTC plans will not be able to sustain the two-year lag in rate adjustments currently built into the system, and the financial consequences of not addressing this issue could greatly undermine the success of this initiative;
2. The need to address the currently unfunded home care worker living wage requirement. The costs of compliance with this requirement should be incorporated in the PMPM premiums paid to MLTC plans.
3. The ability of current MLTC plans to develop the economies of scale necessary for successful expansion. The current provider-based, not-for-profit models of managed care have a long term commitment to serving their enrollees and communities, and making this process successful. One concern is that large, publicly-traded insurance companies can sell the fact that they are able to enter the market with large financial capitalization, but if they find they are not making the profit margins needed to satisfy investors, they can just as readily pull up stakes and abandon the market; and
4. The concern about new entrants into the market being 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 three above. A system must be devised so that all players take on their fair share of more and less desirable markets.

The state's future plans for addressing the dual eligible (i.e., Medicare and Medicaid) population present both opportunities and challenges to managed care providers. LeadingAge New York generally supports the current state initiative to fully integrate services and payment mechanisms for dual eligibles, known as the Demonstration Proposal to Integrate Care for Dual Eligible Individuals. This proposal includes the Fully-Integrated Duals Advantage (FIDA) program, which would target those individuals who are required to enroll in MLTC plans. The state intends to move forward with the dual demonstration program starting next year, pending federal waiver approval and to initiate FIDA in 2014. We believe, however, that in order for this plan to work, there needs to be solid foundation of experience in a mandatory MLTC environment for the dual eligibles targeted for the FIDA initiative.

MLTC providers are expected to participate in FIDA, while still unsure as to how the current transition is progressing. Here again, providers are being asked to figure it out as we go along, when what is needed is a firm plan. MLTCs want to support the state's efforts, but find it difficult to commit when there are few details to the plan.

LeadingAge New York Recommendations

In the context of the above comments, LeadingAge New York respectfully submits the following recommendations as we move forward with the current transition:

1. ***The pace of transition needs to be moderated and providers and Medicaid recipients alike need definitive timelines for planning and adapting to change.*** Current providers need to be able to plan operations and adapt based on a clear set of rules. There are simply too many unknowns at this time, for both the traditional providers in an area and the MLTC plans that are seeking to expand. In particular, upstate LTHHCPs need to be able to reconfigure their operations to support the MLTC transition, but need a specific and reasonable timeline around which to plan and operate. As of today, CMS has yet to approve the LTHHCP waiver amendment to allow for the mandatory enrollment of LTHHCP participants beginning January 1, 2013.

The MLTCs also need to be able to ramp up operations efficiently, without developing excess capacity too early, which may then have to be taken off line. For example, MLTC plans have reported hiring staff in anticipation of current DOH timelines, only to then have to let staff go in response to delays. And of course, none of this cost is being reflected in current rates being paid to MLTCs.

This, along with the operational uncertainties confronting other providers, demands that DOH implement a concrete timeline for transition, and allow providers to exercise necessary reliance on that timeline.

2. ***The state needs to approve the “hybrid option,”*** so that adult day services, currently so vital to so many seniors, can best be adapted to effectively serve MLTC enrollees. Draft regulations have already been prepared, but remain under review while providers make difficult decisions to close or downsize needed ADHC services.
3. ***The state needs to ensure that auto-enrollment and disenrollment processes are working smoothly and effectively.*** Our MLTC members are reporting significant problems with the current auto-enrollment process and the clearinghouse for auto-enrollment. There should be a thorough review of the auto-enrollment and auto-assignment process to ensure that it is working as smoothly as possible before there is any acceleration in current timelines.

This review needs to include an assessment of reports that individuals are being inappropriately discharged from LTHHCPs, creating significant problems for providers and consumers alike. Communications around the disenrollment process need to be improved, with individuals reportedly being disenrolled from a MLTC plan without the plan’s knowledge. These communication problems can in turn lead to issues with ensuring continuity of care and the proper development of care plans for individuals.

4. ***Before any major segment of the current under-care fee-for-service population is transitioned, DOH needs to provide concrete guidance on how that population is to be covered and how providers are to be reimbursed.*** This is critically important, for

example, for both the nursing home and assisted living program populations. Although there is no set deadline for transitioning the majority of these consumers, guidance is needed sooner rather than later since community-based MLTC enrollees will soon increasingly need facility-based care. Payment mechanisms on both sides need to be adequate to ensure that neither is disadvantaged during the transition.

5. *The state needs to acknowledge that the Home Care Worker Wage Parity law represents an unfunded mandate on MLTC plans and home care providers.* The compliance costs must be incorporated in Medicaid fee-for-service and capitated rates of payment.

6. *Investment is needed in senior housing with services.* MLTC will always essentially be a home and community based model of service delivery. That model cannot work unless the foundation of senior housing is in place as the platform from which that service can be delivered.

Conclusion

For the vulnerable seniors and disabled persons served by LeadingAge New York members, there is a special understanding that managing the health care of the individual may be the single most important factor that determines the ultimate quality of life for that person. The decisions around a frail elder's care are inextricably integrated with decisions about almost every aspect of life for that person. This is an area where we simply cannot afford any unintended consequences – we have a sacred trust here. This is the most important argument to be made for ensuring that we manage this transition as thoughtfully as possible. The decisions made here do not just impact the state's budget projections or a provider's bottom line; they impact vulnerable individuals in the most intimate and vital aspects of their lives. We have to get this process right, and we cannot afford to be figuring this out as we go along.

LeadingAge New York and our members across the spectrum of LTC and senior services continue to support the fundamental goals of Medicaid redesign. There are problems emerging in

the transition process, driven in large measure by the speed at which change is happening. When providers and consumers alike are expressing the same concerns regarding confusion in the system, it is time to sit up and take notice. LeadingAge New York strongly recommends that this process be implemented at a more considered and predictable pace. And while the drive to increase enrollment numbers continues unabated, other critical issues are languishing for lack of attention, including: (1) rate issues for nursing home services; (2) future integration of assisted living program services in managed care; (3) the hybrid option for ADHC; and (4) the resolution of issues surrounding LTHHCP services. The state must seek out the correct balance between the pace of enrollment and the resolution of these other critical issues.

On behalf of LeadingAge New York and its membership, thank you for the opportunity to testify today. LeadingAge New York remains available to work with the state as this process unfolds.