NYAHSA

Public Hearing Testimony

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Presented to:
Medicaid Redesign Team:
Managed Long Term Care Implementation
and Waiver Redesign Work Group

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Introduction

The New York Association of Homes and Services for the Aging (NYAHSA) appreciates this opportunity to submit testimony to the Medicaid Redesign Team: Managed Long Term Care Implementation and Waiver Redesign Work Group on the opportunities and challenges facing Managed Long Term Care providers in New York.

My name is Patrick Cucinelli, and I am the Senior Director of Public Policy Solutions at the New York Association of Homes and Services for the Aging (NYAHSA), soon to be known as LeadingAge New York. My comments on the opportunities and challenges facing PACE/MLTC providers dovetails with those of my NYAHSA colleague, Ms. Cheryl Udell, who is addressing our specific recommendations on the role of long term home health care providers (LTHHCP) as a coordinated care model. We also work closely with our colleague, Ms. Christine Fitzpatrick of the Adult Day Health Care Council, in support of the vital role of adult day health care programs (ADHC).

Founded in 1961, NYAHSA is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including home care, community services providers, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living, and PACE/MLTC.

NYAHSA's nearly 500 members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives NYAHSA a unique understanding of the impact of the MRT process on the entire long term care (LTC) system.

Overall Perspective on Medicaid Redesign

NYAHSA has advocated for many years for redesigning Medicaid, rather than simply cutting provider rates year after year. NYAHSA embraces 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. We also support individual MRT proposals in each of these areas. The MRT package creates a framework within which consumers, government, providers and other payors can collaborate to advance broader system objectives of containing cost, improving quality and ensuring access.

Care Management of Medicaid Recipients

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 strategies 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 covering almost all Medicaid recipients under some form of managed care.

Opportunities and Challenges

This represents both significant opportunities and challenges for NYAHSA's provider-based, non-profit managed long term care providers. The MRT has 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.

As we enter into actual implementation phases, we now have enough basic understanding of the State's goals and processes that we can offer our analysis of the critical issues as they impact on managed long term care providers. Timing here is critical. Our experience so far tells us that the State intends to move very quickly through this process.

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 within 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 days of home and community based services will be required to enroll in manage 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.

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 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.

For MLTC providers who position themselves appropriately, the potential opportunities in this process are enormous, but not without risk. 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 what they can accomplish. 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 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, coordinated care at lower cost, then managed care will become the future of health care.

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

I.) 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. 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 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 (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);

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

5. 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 respecting already established preferences;

6. Ensuring soundness in the rate setting process in order to avoid adverse selection; and

7. 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 under the new coordinated care model principles.

I emphasize again, the potential negative consequences in not managing these transition issues properly are such that they could undermine the entire process. NYAHSA believes that the urgency with which the State is seeking to implement change raises a cautionary note over how the transition process could evolve.

II.) Financing refers to ensuring that the rate structure supports the expanded role and new risk profile that managed care providers are being asked to assume.

It is 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 exceptions 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 adjusted 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 in the market need an opportunity to develop the economies of scale necessary 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 can just as readily pull up stakes and abandon the market;

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 so 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 managed care and Part D side demonstrates the negative consequences of unscrupulous sales persons 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, LTHHCP and ADHC already fill an important niche and have already proven effective coordination models.

III.) Policy Issues refers to the 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."

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

Application Process

NYAHSA believes that the non-profit, provider-based model is the most effective model for delivering high quality, cost effective care that places the welfare of the patient above profit. As already noted, we also believe that there should be a preference for New York-based providers with a proven track record of commitment to the citizens of our State.

We believe that the application process should focus on the following priorities:

1. The application process should be a deliberative process, which carefully evaluates the full qualifications and track record of each applicant, and avoids a mechanical or "first-come-first-served" approach.

2. The NYC market is already saturated with experienced managed/coordinated care providers with proven capacity to readily expand to meet increased demand.

3. NYAHSA believes that New York-based operators only should be considered. The State Medicaid program is publicly financed with taxpayer dollars and those dollars should stay within New York with New York-based operators who will reinvest those dollars here at home.

4. Slots need to be left available for already established coordinated care operators throughout the state who wish to transition to MLTC, but who may need time to develop business plans based upon the outcome of the current coordinated care model guidelines deliberations.

Conclusion

I want to thank you for the opportunity to present to you and I am honored to be a small part of this process. As always, NYAHSA staff and members stand ready to assist and support the State's efforts at reform and advancing the well-being of and succor to our long term care population.