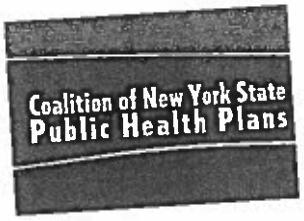

NYS Coalition of
MLTC and
PACE Plans

TESTIMONY OF

THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS AND

THE NEW YORK STATE COALITION OF MANAGED LONG TERM CARE AND PACE PLANS

ON THE NEW YORK HEALTH ACT

SUBMITTED TO THE

JOINT SENATE AND ASSEMBLY STANDING COMMITTEES ON HEALTH

MAY 28, 2019

Introduction

Members of the Joint Senate and Assembly Standing Committees on Health: Thank you very much for the opportunity to testify on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition") and the New York State Coalition of Managed Long Term Care and Programs of All-Inclusive Care for the Elderly Plans ("MLTC/PACE Coalition").

Background on the PHP Coalition

Established in 1995, the PHP Coalition has been and remains a forceful advocate for expanding coverage through its representation of New York's public program-focused health plans and their members. The PHP Coalition represents nine health plans serving more than 4 million individuals in New York's Medicaid Managed Care, HIV Special Needs Plan (HIV SNP), Child Health Plus (CHP), Health and Recovery Plan (HARP), Essential Plan (EP) and Qualified Health Plan (QHP) programs—approximately 70% of all of adults and children enrolled in these programs across the State. PHP Coalition plans specialize in delivering high-quality services to populations that have traditionally faced significant barriers to health care, and we are proud of the role the Coalition has played to support the State's efforts to expand coverage to every New Yorker. Our member health plans have consistently received high marks in quality of care and member satisfaction and are fully engaged in focusing on value-based payment to enhance health care outcomes and in addressing the social determinants of health that impact our enrollees.

Background on the MLTC/PACE Coalition

The MLTC/PACE Coalition represents 15 provider-sponsored, not-for-profit managed care plans that serve elderly or disabled Medicaid beneficiaries. MLTC plans provide the full array of long-term care services, ranging from personal care to nursing home care, for a fixed per-member-per-month payment through a variety of different products. The majority of members are enrolled in "partial cap" MLTC; however, the Coalition plans also offer fully integrated products—including PACE, Medicaid Advantage Plus (MAP), and Fully Integrated Duals Advantage (FIDA)—that provide both Medicaid and Medicare benefits to members that are eligible for both programs. While the partial cap plans are not responsible for providing coverage of physician, hospital or other services, which patients typically access through their Medicare coverage, for the vast majority of MLTC enrollees, they oversee and coordinate all aspects of members' care through intensive care management, regardless of payer. These plans provide access to quality long-term care at a fraction of the cost of institutional care, while also achieving high rates of patient and family satisfaction.

Today's Testimony

The Coalitions appreciate the opportunity to comment on the New York Health Act (NYHA) and would like to convey today two main points:

- **The critical role that Coalition plans have played in transforming health care for the most vulnerable New Yorkers** by championing and implementing the steady expansion of coverage and dramatically improving the quality of health care provided to New Yorkers, for example through increased care coordination and management, innovative approaches to health care delivery, and the provision of non-traditional services that address the social determinants of health; and

- **The array of cost-effective policy alternatives available to New York** to continue this State's efforts to reach universal health coverage and build on the already historic achievement in assuring coverage to 95% of New Yorkers.

The members of the Coalitions serve some of the neediest New Yorkers—the poorest, sickest and hardest to reach—and in doing so, they, like the Legislature, are deeply committed to the goals of increasing access to high quality care and moving toward universal coverage. The Coalition is, however, deeply concerned about both the extraordinary fiscal consequences of the NYHA—not only the *significant* new tax burden placed on New Yorkers, but the risk that it might crowd out State spending on a host of other issues that impact our members' health and well-being—and the unintended consequences of the immense disruption to the current coverage landscape that would result from replacing every New Yorkers' current coverage with the new State-run health benefit.

Coalition plans support the underlying goals of the New York Health Act but oppose the Act's proposed means to attaining those goals. There are far less disruptive, more cost-effective, and more financially and operationally feasible ways to achieve these goals.

Implementing the NYHA would be exceedingly challenging, even if we had a cooperative partner in Washington. Given the role and responsibility of the federal government for Medicare, Medicaid, CHP and Affordable Care Act (ACA) coverage, trying to enact the NYHA under current circumstances would prove to be extremely risky and even reckless.

While the Coalitions support NYHA's fundamental objectives, we respectfully request that the Legislature consider a set of <u>less disruptive</u>, <u>more cost-effective</u>, and <u>more financially and operationally feasible</u> proposals to increase the affordability of coverage and care and expand coverage to the currently uninsured. Plans also recognize that many opportunities exist to reduce the administrative burden currently felt by consumers and providers, and are committed to working with the Legislature, the Executive and other stakeholders to streamline the delivery of coverage and care to New Yorkers, reduce this administrative burden, and ensure that healthcare coverage is as accessible and as responsive as possible.

Plans' Role in Advancing Health Care Delivery in New York

The NYHA would eliminate traditional health insurance coverage and public health coverage programs and replace them with single-payer health coverage run by the State. As proposed, it ignores the critical role that plans have played over the last several decades in effecting positive change in New York's health care delivery system. We should remember what the Medicaid program was like before New York began to transform coverage through managed care: while a Medicaid card theoretically entitled beneficiaries access to an array of health care services, recipients were often unable to access the care they needed in a timely manner, quality was much lower, and the trajectory of costs was unsustainable, among other things. The annual cost containment strategy in the fee-for-service era focused on reducing eligibility and limiting benefits.

Since the mid-1980s, plans have been at the forefront of efforts to improve the quality of care and reduce per capita costs in the State's public programs. In 2011, the Medicaid Redesign Team reaffirmed Medicaid managed care as the vehicle to achieving the State's goals: "measurable improvement in

health outcomes, sustainable cost control and a more efficient administrative structure."[1] Further, New York's Delivery System Reform Incentive Payment (DSRIP) Program recognized the integral role of plans in the long-term sustainability of DSRIP through strategies like value-based purchasing; in fact, the savings associated with expanding managed care *enabled* 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, plans have been—and continue to be—a critical and effective partner to the State in improving the delivery and costs of health care in New York.**

Over the last several years, plans have enrolled new, more complex populations, offered a more comprehensive array of services and developed original products that rely heavily on patient-centered care management and service integration to implement new State programs and serve broader populations of New Yorkers. For example, PHP Coalition plans have implemented the State's program for individuals with significant behavioral health needs, HARP, and now cover 75% of the State's HARP enrollees. Looking ahead, plans in both Coalitions look forward to continuing to work with the State to "carve in" additional services and populations. **The continued shift of more complex populations and services into managed care is testament to plans' collective success in providing high-quality care to members at lower costs.**

In addition to their significant Medicaid redesign efforts, PHP Coalition plans have worked closely with multiple State agencies to support the continued success of the New York State of Health ("NYSOH") Marketplace. On the Marketplace, seven PHP Coalition plans offer EP coverage and five offer QHP coverage, collectively accounting for 66% and 74% of the statewide markets, respectively. PHP 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. Beyond serving the majority of the State's Medicaid and CHP enrollees, **Coalition plans are committed to providing New Yorkers with a *continuum of coverage*, to minimize disruption in care when income or other circumstances change.**

While partnering with the State on these transitions and programs, plans continue to adopt innovative care delivery approaches. Coalition plans are connecting more consumers to care via telehealth, providing critical services like medication adherence, empowering members to take control of their health through comprehensive care management and education, and employing emerging strategies to address social determinants of health, such as housing and food. That they are doing this in unique and localized ways, based on the needs and circumstances of their enrollees and communities, is further evidence of the value of Coalition plans. Plans are leveraging State and taxpayer dollars to generate *value* for the consumer. For these and other reasons, members in Medicaid managed care plans are more satisfied with their benefits than those enrolled in traditional Medicaid fee-for-service programs.[2] **Given their experience delivering high-value, integrated and innovative coverage and care to residents, plans should continue to be key players in New York's health care delivery system.**

> ***Members in Medicaid managed care plans are more satisfied with their benefits than those enrolled in traditional, State-run fee-for-service programs.***[2]

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

[2] *See* AHIP, "Achieving State Medicaid Goals through Managed Care" (October 2018).

Increasing the Affordability of Coverage and Care and Expanding Coverage to the Uninsured

As the public program-focused plans that have led the State's efforts in serving lower-income New Yorkers, Coalition plans appreciate the goals of NYHA to increase the affordability of coverage and care and move toward universal coverage. Today, approximately 1.2 million New Yorkers, roughly five percent of the population, are without health insurance.[3] While the number of uninsured New Yorkers is at an historic low, the consequences for those New Yorkers are unacceptably dire. Moreover, affordability is one of the greatest barriers. Even New Yorkers with coverage—subsidized or otherwise—face high deductibles and coinsurance that prevent them for sufficiently accessing care. Many delay or forgo medical attention, which all too often results in poor health outcomes and more expensive treatment.

There are, however, a number of opportunities available to New York policymakers to increase affordability and expand coverage that are *far* less disruptive and costly than what NYHA proposes. For example, New York could:

- ***Implement State Supplemental Premium Tax Credits.*** One-third of New York's uninsured population is eligible to purchase coverage on the State's Marketplace, and the majority of this group has incomes below 400% of the federal poverty level (FPL). To improve affordability for New Yorkers who are currently priced out of the market or otherwise struggle to access coverage and care because of costs, New York could provide State-funded tax credits to individuals at certain income levels (e.g., between 200% and 400% of the FPL). These credits would be *in addition to* federal tax credits for those who are eligible to receive them today. Depending on their design and level of funding, these tax credits could do much to improve affordability for hundreds of thousands of New Yorkers across the State.
- ***Allow for Age-Adjusted Community Rating in the Commercial Market.*** The State could also amend its current community rating policies to allow for age-adjustments to reduce the cost of coverage for younger populations that often struggle with the cost of coverage, given their health care needs. Such a policy change would need to be paired with State-funded subsidies for older New Yorkers, to keep the cost of their coverage affordable, but could have major impacts on reducing the cost of coverage available in the private market.
- ***Pursue a State Individual Mandate.*** Another one-third of the uninsured population in New York is made up individuals who are, in fact, eligible for Medicaid or Child Health Plus. To address this and the population eligible for Marketplace coverage, New York could follow the lead of states around the country in adopting its own mandate for all residents to purchase or enroll in coverage, now that the federal mandate has been repealed. Such a mandate could help increase coverage and reduce costs further.
- ***Expand the Essential Plan (EP) to Low-Income Undocumented Immigrants.*** The last third of New York's uninsured population include undocumented immigrants, three-quarters of whom are lower income (i.e., have incomes below 200% of the FPL). Because of their immigration status, these individuals are currently excluded from Medicaid and other public or subsidized coverage programs, like the EP. New York could expand the EP program, or some other coverage program, to include undocumented individuals so that they have access to much-needed, comprehensive

[3] Urban Institute Modeling, HIPSM-NY 2018. The Urban Institute estimates that 1.3 million residents will be uninsured by 2020, due to the repeal of the federal individual mandate.

coverage and care. The State could open up coverage broadly (e.g., to all undocumented immigrants) or more narrowly (e.g., to young adult "dreamers" or adults at certain income levels).

- ***Simplify Eligibility and Enrollment Processes to Help Individuals Currently Eligible for Public Coverage Obtain and Retain Coverage.*** As noted above, about a third of the uninsured population is currently eligible for—but not enrolled in—Medicaid or Child Health Plus coverage. Despite plan, State and other stakeholder efforts, these individuals are often unaware that they are eligible for public coverage or unable to successfully navigate the often-complicated eligibility, enrollment and renewal processes. To maintain and build on New York's coverage gains over the last several years, the State should evaluate its eligibility and enrollment processes across the coverage continuum with the overarching goal of streamlining these functions to facilitate timely and sustained enrollment for all eligible individuals.

Reforming Managed Care to Reduce Administrative Burdens for Consumers, Providers and Other Stakeholders

Another of the NYHA's goals is to reduce the administrative burden experienced across the health care system. The Coalitions recognize that the administrative complexity of today's health care system can lead to inefficiencies and unnecessary hurdles and headaches for consumers, providers and other stakeholders. Plans and providers have a number of systems, policies, and processes in place intended to ensure that the right care is delivered to the right person at the right time; however, the lack of standardization and alignment among such elements often results in high administrative burden and inefficiencies throughout the delivery system.

Plans are open to partnering with the Legislature, the Executive and key stakeholders on developing and adopting reforms that would reduce the administrative burden, eliminate system-wide inefficiencies, and generate cost savings. For example, such reforms could include: centralization of the provider credentialing process; standardization of protocols and procedures related to preauthorization and documentation requirements; and expanded adoption of electronic transactions for key activities, such as eligibility and benefit verification, claims remittance and prior authorization. Coalition plans recognize that taking such steps could lead to significant efficiencies in the delivery of care, save time, and reduce costs—outcomes that would benefit all New Yorkers.

Conclusion

We thank you again for the opportunity to provide testimony on the New York Health Act, the critical role that plans play in today's health care delivery system, and alternative approaches to achieving the Act's underlying goals. The Coalitions applaud your continuing efforts to enhance health care access, affordability and quality, and look forward to continued partnership with the Legislature to ensure that a strong and sustainable health care system is in place to serve all New Yorkers.

Appendix I: Members of the Coalition of New York State Public Health Plans

Plan	Product Lines Offered	Counties Served
Affinity Health Plan	Mainstream Medicaid Managed Care (MMC), HARP, CHP, EP	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester counties
Amida Care	HIV Special Needs Plan (SNP)	New York City
EmblemHealth	MMC, HARP, CHP, EP, QHP	*MMC, HARP, CHP*: New York City and Nassau, Suffolk, and Westchester counties *EP and QHP*: New York City and Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Nassau, New York City, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, and Westchester counties
Fidelis Care	MMC, HARP, CHP, EP, QHP	Every county in the State (for most product lines)
Healthfirst	MMC, HARP, CHP, EP, QHP	New York City and Nassau, Suffolk, and Westchester counties
MetroPlus Health Plan	MMC, HARP, CHP, HIV SNP, QHP, EP	New York City
MVP Health Care	MMC, HARP, CHP, EP, QHP	*Public Insurance Programs*: Albany, Columbia, Dutchess, Genesee, Greene, Jefferson, Lewis, Livingston, Monroe, Oneida, Ontario, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, Washington, and Westchester counties *EP and QHP*: 50 counties in the State
YourCare Health Plan	MMC, HARP, CHP, EP	Allegany, Cattaraugus, Chautauqua, Erie, Monroe, Ontario and Wyoming counties
VNSNY Choice	HIV SNP	New York City

Appendix II: Members of the New York State Coalition of MLTC and PACE Plans[4]

Plan	Product Lines Offered	Counties Served
ArchCare Senior Life	Partial Capitation MLTC, PACE	*MLTC*: New York City, Putnam, Westchester; *PACE*: New York City

[4] Note: Many of the MLTC/PACE Coalition members also offer Medicare Advantage plans, though these plans are not listed in this table.

Appendix II, cont.

Plan	Product Lines Offered	Counties Served
Elant Choice (Evercare)	Partial Capitation MLTC	Dutchess, Orange, Rockland
ElderServe Health (RiverSpring Health Plans)	Partial Capitation MLTC, FIDA	New York City, Nassau, Suffolk, Westchester
Fallon Health Weinberg	Partial Capitation MLTC, PACE	Erie, Niagara
Fidelis Care at Home	Partial Capitation MLTC, MAP, FIDA	New York City and 57 additional counties[5]
Hamaspik Choice	Partial Capitation MLTC	Dutchess, Putnam, Orange, Rockland, Sullivan, Ulster
HomeFirst/Elderplan	Partial Capitation MLTC, MAP, FIDA	New York City, Dutchess, Nassau, Niagara, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster, Westchester
Independence Care System	Partial Capitation MLTC, FIDA	New York City
MetroPlus Health Plan	Partial Capitation MLTC, FIDA	New York City
Montefiore Diamond Care	Partial Capitation MLTC	New York City, Westchester
Nascentia Health	Partial Capitation MLTC	Albany and 46 additional counties[6]
Senior Health Partners/Healthfirst	Partial Capitation MLTC, FIDA, MAP	New York City, Nassau, Westchester
Senior Network Health	Partial Capitation MLTC	Herkimer, Oneida
VillageCareMAX	Partial Capitation MLTC, MAP	New York City
VNSNY Choice	Partial Capitation MLTC, MAP, FIDA	New York City and 28 additional counties[7]

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

[6] Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, Yates

[7] Albany, Columbia, Delaware, Dutchess, Erie, Fulton, Greene, Herkimer, Madison, Monroe, Montgomery, Nassau, Onondaga, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington, Westchester