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Testimony to the New York State Legislature Joint Hearing of the Senate Finance and Assembly Ways and Means Committees

THE 2020-2021 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

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I. Medicaid: Reconsider the Global Cap to Minimize Harmful Cuts; Include Consumers in MRT II; Transparency on MLTC Needed to Illuminate Sources of Cost Increases – which is not CDPAP

- **Reconsider Global Cap**

The announced $2.5 billion deficit in Medicaid costs presumes the continued validity of the Global Cap introduced in 2011. This cap is essentially the same as the federal block grants proposed by Republicans in Congress – forcing states to manage their Medicaid programs within a fixed cap regardless of increased need and costs, leading states to cut services or eligibility. New York is proud of embracing the Medicaid expansion under the ACA and of its commitment to providing services for people with disabilities to live at home rather than in nursing homes. The harsh limits of the Global Cap should be revisited to allow for enrollment growth, increased demand for services and costs -- to prevent arbitrary cuts.

- **Medicaid Redesign Team II Must Have Consumer Representation**

Unlike previous years, the Executive Budget does not propose any particular cuts in financial eligibility for Medicaid. Nor does it propose any specific limits in access to Managed Long Term Care (MLTC) or other Medicaid services. Instead, it delegates to a new Medicaid Redesign Team II (MRT II) the job of deciding how to make $2.5 billion in Medicaid cuts. We object to this abdication of the Executive's responsibility and its delegation to powerful interest groups through the MRT for several reasons. First, the Governor just released the list of appointees with not one consumer representatives on the MRT – again it will be chaired by a hospital executive and a labor leader – again a back room deal will be made to fend off well-funded vocal opposition by these powerful political players. Second, to convene an MRT in late January delays any meaningful work by the legislature and interest groups at least until after the 30-day Amendments – if the MRT can even act that quickly to have its recommendations incorporated in the 30-Day Amendments.

The fabled Albany last minute budget deals behind closed doors will be more secret and last minute than ever, shutting out consumer interests, smaller providers and other smaller interest groups.

- **Scapegoating Consumer Directed Personal Assistance program (CDPAP) services for causing growth in MLTC diverts attention from the real causes for increased costs of MLTC – good and bad**

The Governor blames the CDPAP program for driving up spending on MLTC. Let's look at the facts.

1. MLTC plan enrollment is up statewide 12.18% from Dec. 2018 to Dec. 2019. MLTC insurance plans have contracts with the State to provide home care and other long term care services to adults with Medicare and Medicaid. No one "enrolls" in a CDPAP program. They enroll in an MLTC Plan, only after they have been approved as eligible for MLTC by Maximus, the State's contractor for MLTC enrollment that has a nurse conduct an individualized need assessment. There is no indication that the increased enrollment is somehow due to fraud; Maximus would have rejected any potential enrollee who did not meet the functional criteria for enrollment.

2. Any Medicaid recipient found eligible by Maximus to enroll in an MLTC plan in the community must, by definition, need help to perform Activities of Daily Living. The MLTC plan MUST authorize one of these two types of home care services – either Personal Care services, from a traditional Licensed Home Care Services Agency, or CDPAP services, from a Fiscal Intermediary. If there has been an increase in usage of CDPAP services in MLTC plans, then there is presumably less usage of Personal Care services.

3. CDPAP isn't to "blame." CDPAP is essential to fill the gap caused by the well known home care worker shortage, especially outside of big cities, and also saves money by performing skilled tasks for which a nurse would otherwise be needed at higher cost. In 2016, the legislature and Governor together responded to the huge demand by expanding the pool of who can be CDPAP aides to include certain family members. Naturally that increased utilization of CDPAP, but this is meeting a NEED that is determined by a conflict-free assessment by Maximus.

4. MLTC plan enrollment and costs has likely increased due to various factors not related to CDPAP:

a. **Nursing home residents** have been required to enroll or stay in an MLTC plan since 2015, increasing MLTC enrollment by more than 10 percent. In December 2019, CMS approved "carving out" nursing home care from MLTC, which will lead to disenrollment of at least 23,000 MLTC members in early 2020 (figure DOH cited in 2018 for the number of MLTC members in nursing homes, likely higher now).

b. **When nursing home care was added to the MLTC service package, the plans received a significant increase in their rates**. An increase in capitation applies to every MLTC resident, even though it is designed to pay the cost of nursing home care only for the approximately 10% of members in nursing homes. If rates increased, for example, by an average of $500 per member per month, that would total **$1.5 billion/year** in increased rates for the 250,000 MLTC members statewide. If this bump is eliminated, now that nursing home care is no longer the plans' expense, savings should be realized.

c. **MLTC plans market to enroll new members – transparency needed for accountability on where the dollars are spent**. At least in NYC, one sees TV commercials or ads on subways or buses for MLTC plans. Where there is marketing, there is the potential of "cherry picking" -- seeking new members who have minimal needs, which are just enough to pass the Maximus eligibility determination. MLTC plans receive the same rate for low-need members as those with high needs so have an incentive of recruiting and enrolling low-need members.

   Advocates have reported for years that plans routinely avoid enrolling high-need individuals. The problem was severe enough that the legislature passed a bill last year that would auto-enroll people in MLTC plans if they had trouble enrolling in plans despite being found eligible by Maximus. A7578. The Governor vetoed this bill, enabling plans to continue to avoid enrolling high need consumers.

   Is the State monitoring to make sure the plans are using billions of Medicaid dollars properly – providing sufficient home care services for their members, as opposed to using it for administration or profit? Transparency on where the Medicaid dollars for MLTC services go, such as making public the Medical Loss Ratio for each plan, may well expose opportunities for saving state Medicaid dollars. Close monitoring will be even more necessary now that plans are no longer responsible for paying the cost of nursing home care.

   Is state monitoring disproportionate increases in enrollment in some MLTC plans? While MLTC growth statewide was 12% in the last

year, some plans have had much higher growth. Centers Plan for Healthy Living enrollment in NYC increased **22.7%** from Dec. 2018 to Dec 2019 to 34,141 – now the largest plan in NYC. It grew **138% since Mar. 2018**. Integra is the next largest plan in NYC with 22,417 enrolled – a **67%** increase in one year, and a **364% increase since Mar. 2018**, while enrollment growth grew 38% in NYC since 3/2018. Examining the reasons for this disproportional growth may illuminate opportunities for cutting costs. (See attached chart showing enrollment figures by plan for NYC for benchmark dates thru 12/2019).

d. **Home Care Wage Increases -** The Governor acknowledges that part of the increased cost is due to support for minimum wage workers in the health care sector -- a projected $1.8 billion in FY 2021. We applaud New York State for its commitment to paying home care workers a decent wage. New revenue streams must be explored to pay for this long-needed wage enhancement, which is plowed back into local economies all over the state as workers spend their paychecks.

e. **Demographics -** The growing aged population is well documented, and the level of poverty among the aged is higher than other age groups. Not only are baby boomers growing old and beginning to need services, but medical advances keep the elderly living longer – extending the length of time in which they need support services in the home. The cost of their care is rising nationally at a faster rate than for medical care generally.[1]

- **Passing the Cost on to the Counties and New York City is Not the Answer**

The Governor would penalize NYC and other large counties for the fact that many of their residents are poor and need long-term care because of disability and aging. A "carrot or stick" approach may work to change behavior when an entity has actual control over cost. But NYC HRA like other county Medicaid programs have no such control. They solely determine financial eligibility under strict rules set by the state and federal government. Except for a small number of cases, the local counties and

[1] There has been an average 2.87% year-over-year increase in the average CPI-U for Medical Care (US City Average) from 2009-2019. However, the CPI-U component for "Care of invalids and elderly at home" has accelerated much faster than the overall medical care category. From 2017 to 2018, it grew about 1% nationally, but from 2018 to 2019 it grew 2.76%. Again, this suggests that the growth in spending on community-based long term care largely reflects underlying demographic trends on a state and national level, which are unrelated to any inefficiencies in the program.

HRA do not determine eligibility for or authorize home care or other services.[2] That function is performed by MLTC and other Medicaid managed care insurance plans with rates set by state. NYS embraced Medicaid expansion under the ACA and has been committed for 50 years to providing services in the community rather than in nursing homes. If there is fraud, NYC goes after it. But to suggest that the growth in spending is from some wrongdoing or neglect by HRA is simply wrong. Passing this cost on to localities is a regressive tax that should be rejected.

- **If the MRT Revives Past Proposals to Cut Medicaid Eligibility or Services, These Must be Rejected**

We cannot advocate against unspoken proposals. But we suspect the MRT will likely revive some past proposals to cut Medicaid eligibility, which we strongly oppose, such as eliminating "spousal" or "parental" refusal, or reducing the permitted resource allowance for the "community spouse" of an individual permanently placed in a nursing home. Eligibility must be preserved for the most vulnerable New Yorkers. Consumers must have the opportunity to voice opposition to any proposals.

With the growing aging population, many of whom are low-income, we have to expect growing costs for long term care and fund it. Serious attention should be paid to omitting the middleman – the managed care plans – that take billions of Medicaid dollars for administration and profit. The State has not been transparent about exactly how many public dollars are spent on insurance plan administration and profit rather than services – both MLTC and mainstream. This data should all be public for accountability for these public funds.

II. Support Funding for the Managed Care Consumer Assistance Program, the state's community-based consumer assistance program for people with Medicare – and increase funding this year because of increased need.

NYLAG thanks the Governor for including level funding for the Managed Care Consumer Assistance Program, the state's community-based consumer assistance program for people with Medicare. MCCAP is a statewide program that provides essential assistance to low-income seniors and people with disabilities in accessing

[2] See HRA Fact Sheet, Nov. 2019, p. 2, available at https://www1.nyc.gov/assets/hra/downloads/pdf/facts/hra_facts/2019/hra_facts_2019_11.pdf. Out of 207,713 total home care cases in New York City in November 2019, only 2,918 are actually approved and managed by HRA (combining the "home attendant" cases plus housekeeper cases)(CDPAP cases approved by HRA are presumably included in the "home attendant" cases). This compares to 204,795 MLTC cases, for which HRA's sole involvement is approving the initial financial Medicaid eligibility and handling annual renewals of Medicaid eligibility.

health services and reducing their Medicare costs. NYLAG has been a member of the MCCAP network of community-based organizations since the program's inception. Along with the other members of the MCCAP, NYLAG collaborates with the New York State Office for the Aging (NYSOFA) to take referrals of complicated cases and resolve complex Medicare and Medicaid issues for dual eligibles.

NYLAG requests that the Legislature increase funding for MCCAP in 2020-2021 to the amount of $2,767,000, an increase of $1,000,000. Several programs—New York State of Health (NYSoH), MLTC, and Dual Eligible Special Needs Plans (D-SNP)—have added to the complexity of the healthcare landscape for people with Medicare and those dually eligible for Medicare and Medicaid. Thousands of New York residents will need MCCAP agencies to continue serving as trusted on-the-ground resources explaining how such changes affect their Medicare prescription drug and health coverage, and access to healthcare providers.

As a greater number of residents become Medicare-eligible MCCAP services are needed more than ever to help people enroll into valuable cost-saving federal benefits such as the Medicare Savings Program (MSP) and Extra Help. Enrollment for New York Medicare beneficiaries in the MSP is far under the national average. By providing $1 million in additional MCCAP funding, a new initiative could be started that is dedicated to reaching 25,000 more people with Medicare to educate them about the MSP and helping a minimum of 2,000 low-income New Yorkers enroll in MSP and Extra Help benefits. For an investment of $1 million, the state could save elderly and disabled New Yorkers, many of whom live in poverty and on fixed incomes, over $10 million in out-of-pocket expenses each year.

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Thank you for the opportunity to submit this testimony. Please feel free to contact me with any questions.

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NYC - Growth by Plan
Outside NYC - Total Growth

MLTC Plan Growth:

April 2013 to Dec. 2019

plan NYC enrollment only	Apr-13	Mar-18	Dec-18	Dec-19	% increase since 12/18	% increase since 3/2018	% increase since 4/2013	Notes re closed plans
CENTERS PLAN FOR HEALTHY LIVING	149	14,345	27,827	34,141	22.69%	138.00%	22813%	9000 from Centerlight 2016 but 24,000 since then
INTEGRA (Personal Touch)		4,830	13,269	22,417	68.94%	364.12%		↑ 25% Sept to Dec 18 from 7th to 4th largest
VNS CHOICE	19,360	11,376	10,166	16,199	59.34%	42.40%	-16%	4/2019 transition from ICS closing
Senior Whole Health	278	7,373	14,133	14,599	3.30%	98.01%	5151%	
SENIOR HEALTH PARTNERS (HealthFirst)	8,088	12,743	13,933	14,587	4.69%	14.47%	80%	
ELDERSERVE	8,282	10,532	12,520	14,110	12.70%	33.97%	70%	
ELDERPLAN (HomeFirst)	7,572	10,609	11,585	12,794	10.44%	20.60%	69%	
VillageCareMAX	1,687	7,466	11,745	12,389	5.48%	65.94%	634%	
AgeWell New York (Parker Jewish)	363	5,963	6,958	8,515	22.38%	42.80%	2246%	
Fidelis	4,224	7,577	8,347	8,005	-4.10%	5.65%	90%	
HealthPlus/ AMERIGROUP	2,726	4,176	5,856	7,180	22.61%	71.93%	163%	
EXTENDED MLTC		1,867	5,203	6,444	23.85%	245.15%		
Aetna	390	3,145	5,170	6,215	20.21%	97.62%	1494%	
WELLCARE	4,166	4,887	3,905	3,723	-4.66%	-23.82%	-11%	
Archcare MLTC	217	1,714	3,110	3,661	17.72%	113.59%	1587%	
MetroPlus	100	1,460	1,901	2,072	9.00%	41.92%	1972%	
MONTEFIORE HMO		1,069	1,254	1,391	10.93%	30.12%		
ALPHACARE (Magellan)		3,414						transferred to Senior Whole Health
CenterLight	7,566	42						transferred to Centers Plan 11/2016
GUILDNET	10,602	10,594	2,734					Closed Jan. 2019 ↓9% Sept to Oct "18
HHH CHOICES	1,973	0						closed
HIP	649	0						transferred to Guildnet 12/2015
INDEPENDENCE CARE SYSTEMS	4,382	6,504	5,825					txferred to VNS Choice if not select other plan
North Shore LIJ		2,604						transferred to Centers Plan 9/2017
United Health Care	211	1,899	2,900					closed 4/2019
Total NYC - MLTC	**82,985**	**136,189**	**168,341**	**188,442**	11.94%	38.37%	127%	
rest of state	4,810	39,465	55,227	62,301	12.81%	57.86%	1195%	
Total NYS	**87,795**	**175,654**	**223,568**	**250,743**	12.16%	42.75%	186%	

Data from
https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/