Managed Long Term Care Budget Requests

Overview: The Governor's budget proposes $51.45 million in cuts related to Managed Long Term Care (MLTC) plans. These cuts will further depress already inadequate MLTC rates. Instead of cutting the funding for MLTC, the State should add funds to MLTC rates in order to align them with the costs associated with serving recently-enrolled populations, implementing wage mandates, new benefits, and a steady stream of new policies. ***LeadingAge New York (LANY) urges the legislature to: (i) restore $ 51.45 million to the MLTC program; (ii) enact legislation to ensure that all quality pool funds withheld from plan premiums are re-distributed; (iii) enact legislation directing DOH to create a nursing home rate cell to reduce the financial uncertainty associated with growing MLTC enrollment of nursing home residents; and (iv) require DOH to meet specified financial review criteria related to plan financial health prior to adopting any new administrative reductions in MLTC funding.***

Why MLTC rate adequacy is important to the entire long term care continuum: With managed care enrollment of long term care beneficiaries mandated statewide, and more than 187,000 Medicaid long-term care beneficiaries already enrolled in various types of MLTC plans, the overwhelming majority of Medicaid revenue payable to long term care providers is derived from reimbursement by MLTC and other Medicaid managed care plans. To ensure beneficiary access to high-quality services and promote the fiscal health of both providers and plans, MLTC rates must be adequate to cover the costs of delivering services.

The impact of inadequate reimbursement: The MLTC rate setting methodology, specifically for the nursing home population, has resulted in underpayment that is placing financial pressures on MLTC plans and providers and has the potential to destabilize plans and disrupt care for the individuals they serve.

- Based on 2015 annual managed care cost reports, half of established MLTC plans had negative premium margins. [1]
- Enrollment of nursing home residents is progressing much faster than anticipated, and the amounts reflected in MLTC rates for nursing home care fail to cover the cost of paying the benchmark rates plans are required to pay. The rate setting methodology does not keep pace with rapidly changing levels of nursing home membership, as more nursing home members enroll or transfer from one plan to another, nor does it reflect the risk associated with these members. As a result, the current methodology creates incentives for plans to contract with nursing homes based on price rather than quality or consumer preference and contract with fewer providers. As plans narrow networks, members shift from one plan to another, creating confusion for members and providers.
- With mandatory managed care enrollment of most long term care beneficiaries, along with minimum wage, wage parity and Fair Labor Standards Act mandates, and the impending roll-out of the Community First Choice Option benefits, the expenses of delivering care are outpacing premium revenue.

[1] Source: 2015 Q4 Medicaid Managed Care Operating Reports (MMCORs). MCCORs typically include premium revenues received, rather than premium amounts owed under proposed rates. "Established MLTC plans" are those that report annual revenue in excess of $4 Million. They enroll over 70 percent of MLTC beneficiaries.

Restore $51.45 million in cuts affecting MLTC plans:

- **Diversion of MLTC Quality Funds Withheld from Rates:** This proposal would reduce MLTC quality payments by an estimated $30 million -- from $150 to $120 million. Because the quality payments are not a "bonus," but are funded through a 2% premium withhold, this provision represents a funding cut which may be even greater than $30 million as enrollment grows (i.e., the state will withhold 2% of premium revenue, which may yield more than $150 million, but will only pay out $120 million in quality incentives). This proposal is contrary to the state's goal of moving towards quality-based reimbursement and value-based payment arrangements, and should be rejected.
- **MLTC Transportation Carve-Out:** The legislature should once again ensure access to this essential service by rejecting this cut and retaining transportation in the MLTC benefit package.
- **Nursing Home Level of Care Eligibility Requirement:** The Governor proposes to save $5.5M ($15.2M full annual) by excluding individuals from MLTC enrollment who do not meet the clinical criteria that define nursing home level of care (NHLOC). Individuals who require long term care, but do not meet the NHLOC standard, would be served on a fee-for-service basis. While this cut will affect few MLTC members, it does represent a reduction in funding for the MLTC program. These savings should be restored and reinvested in the MLTC program.
- **MLTC Marketing Ban:** This cut would prohibit MLTC plans from engaging in marketing activities in order to limit the rate of enrollment growth. Although the ban itself would have limited impact on MLTC, the $6 million savings ($24 million in SFY 2018-19) represents a further depletion of dollars in the MLTC program. We urge the Legislature to restore the funds and reinvest them in MLTC.
- **Implementation of a "Plan Fining Mechanism" by DLTC.** This additional fining authority would yield $2 million in all funds savings in SFY 2017-18. While we do not oppose additional fines to the extent that they are necessary and are implemented fairly, we urge the Legislature to restore the savings associated with this measure and reinvest them in MLTC.

The following provisions should be adopted to help ensure stability for MLTC plans, enrollees, and providers:

- **Require the Creation of a Distinct Nursing Home Rate Cell for MLTC Plans and Include Nursing Home Members in MLTC Risk Scores:** Mainstream Medicaid managed care plans are paid for nursing home enrollees based on a separate rate cell. By contrast, MLTC plans are paid a blended premium for both community and nursing home members. Further, MLTC rates do not reflect the level of acuity or risk associated with the nursing home members they serve. This has led to a lack of transparency in nursing home funding and an inability of rates to keep up with rising nursing home resident enrollment. Faced with inadequate payments for the nursing home benefit and growing numbers of nursing home members, MLTC plans are experiencing mounting financial pressures. Some MLTC plans have reduced their provider networks, and are under pressure to select network providers simply based on price, rather than quality or consumer preference. This will, in turn, adversely affect member choice, provider stability, and compromise state efforts to establish value-based payment arrangements among plans and providers. ***Our request: Ensure that MLTC plans are paid based on a separate, adequate rate cell for nursing home members and that nursing home members are reflected in plan risk score calculations.***
- **Require Consideration of MLTC Plan Financial Stability Prior to Adoption of any Premium Reductions:** The Department of Health's (DOH) ability to reduce MLTC rates and increase MLTC plan responsibilities and covered benefits with little oversight or input has created an unpredictable funding environment for plans. DOH should be required to analyze the impact of administrative funding reductions on plan financial health prior to proposing or implementing such provisions. ***Our request: Require that DOH establish a process to review the impact of administrative funding reduction proposals on plan finances prior to adoption.***
- **Support the TBI/NHTD Carve Out of Medicaid Managed Care:** A.2442 (Gottfried)/S.1870 (Hannon) would allow individuals with traumatic brain injuries (TBI) or who qualify for nursing home diversion and transition (NHTD) Medicaid waiver services to continue to receive such services outside of managed care programs. There are no cost savings associated with moving TBI/NHTD into managed care. Given the significant programmatic changes absorbed by Medicaid Managed Care and Managed Long Term Care plans in recent years, the interests of all stakeholders would be best served by focusing on current populations and benefits. ***Our request: Support this legislation.***