LeadingAge New York

PACE / MANAGED LONG TERM CARE

SENIOR HOUSING | ASSISTED LIVING | ADULT CARE FACILITIES | HOME CARE | RETIREMENT COMMUNITIES
ADULT DAY HEALTH CARE | PACE/MLTC | NURSING HOMES | CCRC

Managed Long Term Care Budget Requests

Overview: The Executive Budget proposes $325 million in savings related to Managed Long Term Care (MLTC) in the 2018-19 State Fiscal Year (SFY), growing to $537 million in SFY 2019-20. This represent a disproportionate share of proposed statewide Medicaid savings and includes several provisions with serious consequences that that would be implemented administratively with no legislative review. With a rapidly aging population and workforce shortages in practically every region, the State should be investing in long-term care, rather than depleting it. ***LeadingAge New York urges the legislature to: (i) restore $131.3 of the $325 million savings proposed for the MLTC program; (ii) require reimbursement for administrative activities commensurate with costs and new mandates; (iii) prohibit DOH from setting caps on contracts with network providers without legislative review; (iv) block proposed provider marketing and referral bans that interfere with continuity of care; and (v) support serving permanent nursing home residents outside of managed care.***

MLTC rate adequacy is important to the entire long-term care continuum: Medicaid eligible individuals who need continuous long-term care services are required to enroll into managed care with the majority enrolling into Managed Long Term Care plans. With the exception of some long-term nursing home and Medicaid Assisted Living Program (ALP) residents and participants in certain waiver programs, MLTC plans manage and pay for services provided to the vast majority of the state's most vulnerable individuals. The bulk of Medicaid revenue to long-term care providers is derived from reimbursement by MLTC plans. Medicaid cuts in MLTC premiums, many of which are operating at or below the break-even point, impact providers and destabilize the long-term care delivery system.

Addressing concerns regarding enrollment growth: DOH has expressed concern that the MLTC enrollment is growing more quickly than projected and has proposed several provisions that would limit MLTC program eligibility to those for whom it is most appropriate. We do not object to those proposals that seek to target MLTC enrollment to those who would need it most and would benefit from its intensive care management. Thus, we do *not* oppose :

- **Increased UAS Eligibility Threshold:** Increases the minimum Universal Assessment System (UAS) score required for single capitated plan enrollment from 5 to 9, thereby raising the level of acuity or functional limitations required to qualify.
- **Continuous MLTC Eligibility Requirement:** Requires a member to remain in need of 120 continuous days of community-based long term care services to be eligible for continued MLTC enrollment.
- **Disenrollment of Members not Utilizing Services:** Transfers out of MLTC those members who qualified for MLTC enrollment but who do not utilize community based long term care services for a period of 30 days.
- **Fee-For-Service Medicaid for Long-Stay Nursing Home Residents:** Excludes long-stay nursing home residents from MLTC enrollment after six months of nursing home care, thereby requiring these residents to revert to fee-for-service Medicaid. We support expanding this proposed exclusion from the MLTC benefit package.

The following proposed cuts should be *rejected*:

- **Administrative Rate Reduction:** Further reduces the capped reimbursement for administrative activities for all MLTC plans. The proposal would be implemented administratively, resulting in a rate cut of $37.8 million this year and increasing to $39.7 in SFY 2019-2020. *The current cap already results in underpayment for the extensive administrative activities that plans are required to perform, including administering new state mandates (VBP, minimum wage) and inclusion of new benefits scheduled for this year (CFCO, Waivers, ALP).*

- **Provider Marketing and Referral Ban:** Restricts all community-based long-term care provider marketing activities and prohibits referring providers from becoming the service provider of the referred member. This administrative provision is expected to result in all-funds savings of $9.85 million in the first year, increasing to $20.74 million in SFY 2019-20. *Currently, an independent enrollment broker (CFEEC) assesses potential enrollees for MLTC eligibility, provides information on all MLTC options, and manages the plan selection process. There is no need to prohibit all community-based long-term care providers, from engaging in marketing. Moreover, the referral ban would interfere with consumer choice and continuity of care.*
- **Limit Number of Network LHCSA Providers:** Caps at 10 statewide the number of Licensed Home Care Services Agencies (LHCSAs) with which an MLTC plan is permitted to contract. This administrative provision would become effective Oct. 1, 2018, and result in all-funds savings of $27.42 million in the first year, increasing to $69.38 million in SFY 2019-20. *Most plans contract with many more than ten agencies to ensure access to necessary staff and specialized services (e.g., clinical, cultural, language) to meet the needs of their members. This provision would disrupt access and separate thousands of members from their caregivers.*
- **Social Day Benefit Efficiencies:** Seeks efficiencies by providing guidance and education to plans regarding the effective use of the social adult day benefit. This administrative provision would become effective April 1, 2018, and result in all-funds savings of $56.25 million in the first year, increasing to $78.75 million in SFY 2019-20. *This proposal removes significant funding from the MLTC premium without making any programmatic change that would reduce costs or drive savings. In fact, a likely consequence of attempted social day service reductions would be an increase in higher-cost levels of care (e.g., increased personal care hours) and appeals and fair hearing requests that would also increase administrative burden and cost.*
- **OMIG Fines and Penalties:** Authorizes increased fines for violations of any Medicaid rule or directive, with each violation and each date triggering a separate fine, with fines of up to $100,000 for submission of inaccurate cost report or encounter data. *These fines are unnecessarily harsh.*

<u>The following provisions should be adopted to help ensure stability for MLTC plans and their members:</u>

- **Require administrative reimbursement to reflect administrative expenses:** The administrative burden on MLTC plan continues to grow with requirements to manage additional state mandates (VBP, minimum wage, contract changes) and the scheduled inclusion of new benefits (CFCO, Waivers, ALP). The current cap already results in underpayment for administrative activities that plans are required to provide. DOH should be required to report to the legislature on how administrative reimbursement compares to allowable costs and quantify the administrative cost/savings of every contract and policy change. ***Our request: Require the administrative component of MLTC premiums to align with costs and that DOH quantify and report on the administrative cost for MLTC plans of implementing contract and policy changes.***
- **Prohibit administrative limitations on the number of network providers:** Plans have an inherent incentive to contract with the appropriate number of providers to ensure the needs of their members are met, while minimizing the administrative burden of managing unnecessary contracts. Arbitrary caps on the number of network providers will result in members being separated from care providers with whom they are comfortable and will make out-of-network arrangements more common. Out-of-network arrangements increase costs and can make value based payment arrangements more difficult. ***Our request: Require that any limitations on MLTC provider networks be done through legislation.***
- **Carve out the long-term nursing home benefit from MLTC:** Once a Medicaid beneficiary is permanently placed in a nursing home, there is minimal value-added to having that individual enrolled in a Medicaid-only managed care plan. The opportunity for the individual to return to the community is at the beginning of a nursing home stay and should be supported by intensive care management. ***Our request: Exclude the long-term nursing home benefit from MLTC.***
- **Permit MLTC plans the option to continue providing transportation directly:** The Executive Budget would eliminate transportation from the MLTC benefit package and delegate responsibility for managing Medicaid transportation for MLTC members to the State's transportation management contractor(s) on a fee-for-service basis. This proposal would take effect on Oct. 1, 2018 and provide a $12 million savings. While some plans support the carve out, there are others who operate their own fleet of vehicles and/or utilize transportation as part of overall care management. Plans should have the option to manage the transportation benefit directly. ***Our request: Provide MLTC plans the option to maintain transportation in the MLTC benefit package.***