Testimony of the New York Health Plan Association

to the

Assembly Standing Committee on Health
on the subject of
Medicaid Program Efficacy and Sustainability

October 26, 2021

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 25 health plans that partner with the state to provide comprehensive health and behavioral health services to more than five million Medicaid managed care enrollees, appreciates the opportunity to present testimony to the Assembly Health Committee on Medicaid program efficacy and sustainability.

The focus of our remarks today will be on managed care. As the State's managed care program has grown, and plans have taken on new benefits, populations, care management and administrative functions, the managed care delivery model has proven its value to Medicaid members and the State. We wholeheartedly support the imperative to address and eliminate longstanding racial and ethnic disparities in the health care delivery system, which were exacerbated by COVID-19. Plans remain committed to working with the State to build a more equitable system, to make additional strategic investments and build on work already being done in their communities to improve the physical, mental and socioeconomic wellbeing of the individuals served by the Medicaid program in measurable ways.

PRESERVING MEDICAID MANAGED CARE

The overwhelming evidence makes clear that eliminating managed care organizations from the Medicaid program would not benefit Medicaid members or the State. Rather, the evidence shows that managed care in Medicaid has improved patient access and health care outcomes while encouraging innovation and promoting the efficient use of State and federal funds. The State should preserve and strengthen its Medicaid managed care program not dismantle it.

For 30 years – since passage of New York's landmark Medicaid Managed Care program in 1992 (Chapter 165 of the Laws of 1991) – health plans have collaborated with the state in the implementation, expansion and continuous improvement of the Medicaid managed care delivery system, working together to increase access and improve quality of care. New York's Medicaid managed care program routinely meets or exceeds the national average on quality measures and patient satisfaction. Since implementation of the recommendations of the first Medicaid Redesign Team (MRT I), managed care has grown to be the primary vehicle to provide comprehensive medical, and behavioral health, pharmacy, long term care and a variety of other benefits to the Medicaid population, who are often the most vulnerable of our residents.

At the same time, plans have helped New York stay within the Medicaid global cap and avoid what would otherwise be punishing across-the-board cuts to beneficiaries and providers. New York State's annual Medicaid spending growth rate has been cut in half—from 13% in 2011 to 6% today. The savings generated enabled the State to request and receive billions of dollars in federal waiver funding to reinvest in the Medicaid program.

Today, more than 5.6 million of New York's Medicaid beneficiaries – 78% of all Medicaid beneficiaries – receive their care through a Medicaid managed care plan – including managed long term care (MLTC) plans. It is with those 5.6 million New Yorkers in mind that we offer our thoughts about Medicaid program efficacy and sustainability.

Assure Adequate Rates

Plans have sustained hundreds of millions of dollars in Medicaid cuts over the past several years, including initiatives for which related cost reductions to the plans never materialized. In the current fiscal year, rates continue to be set at the bottom of the actuarially sound rate range for a third consecutive rating period.

Setting rates at the bottom of the range is financially unsustainable and will inevitably jeopardize access and outcomes for Medicaid members. We are also concerned that the current rates could impede success of the next 1115 waiver proposal, by constricting plans' ability to invest in the development of higher level value-based arrangements, limiting provider willingness to enter risk-sharing arrangements because the financial incentives are insufficient, and jeopardizing the long-term stability of value–based arrangements. Plans are already investing in social determinants of health projects to expand supportive housing, address food insecurity and connect members to other social supports – all of which take time and significant investment to bring to scale, and which could be inhibited by continued low premium rates to plans. Such low rates also limit plans' ability to provide sufficient incentive payments to smaller providers who cannot take on risk, but are willing to work with plans to achieve specific outcome measures. **We urge the State to restore prior year Medicaid reductions and set the rates significantly higher in the actuarial rate range so that plans can continue to invest in members and providers.**

Restore the Quality Pools

New York has been a national leader in delivering high-quality care to its Medicaid beneficiaries – largely as a result of efforts by managed care plans and their provider partners. To monitor managed care performance and improvements to the quality of care, the State implemented a public reporting system in 1994 called the Quality Assessment Reporting Requirements (QARR), which is largely based on measures established by the National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS). The State's quality oversight program has been a model to other states.

The Medicaid Managed Care Quality Incentive Program is an essential funding resource in advancing quality in Medicaid as it rewards managed care plans for the quality of care that they deliver to the 5.6 million New Yorkers covered by Medicaid. The measures incentivized by the quality program are at the core of addressing health disparities experienced by low-

income communities and are essential to New York State's achievement of better health outcomes for underserved populations. Yet, funding for this program has been consistently reduced over time and has been nearly eliminated. The SFY 2020-21 budget cut the mainstream managed care incentive program in half, from $240 million to $120 million, and reduced the MLTC incentive to $103.5 million. The SFY 2021-22 budget further reduced funding.

Massive reductions in quality incentive funding have a direct impact on the delivery system, resulting in corresponding cuts in plan payments to providers, negatively affecting the state's Medicaid quality rankings and stalling statewide efforts to move toward a value-based system, that rewards effective, appropriate care over volume. Without funding for this program, Medicaid members are more likely to fall through the cracks because Medicaid plans and their providers will lose resources as well as a clear incentive to focus on the measures of greatest significance to the population. **We urge the State to fully fund the quality incentive program to enable plans to continue the push toward value-based care.**

Promote Whole-Person Care

We believe that all benefits and populations which are currently in managed care should remain there. With the full complement of medical, behavioral and pharmacy benefits included in the managed care benefit package, plans are better able to coordinate care across the full spectrum of a member's needs – from a "whole person" approach. Likewise, value-based arrangements are more effective when they be can coordinated across the whole spectrum of care. We continue to oppose the currently delayed carve-out of the pharmacy benefit from managed care and to believe that it will actually add significant new costs to the Medicaid program. Further, and more importantly, it will decrease the quality of care for the state's most vulnerable individuals and have a devastating impact on the financial stability of community health centers, hospitals and other safety net providers. **We urge the State not to carve any benefits or populations out of Medicaid managed care – including pharmacy**.

Medicaid Modernization and Innovation

Medicaid managed care has improved access to health care services, including primary care, pediatric care and OB/GYN care. Medicaid plans must maintain robust provider networks to meet the needs of enrollees for all service categories, with strict network adequacy standards overseen by the State as required by federal regulations. Plans and the State routinely monitor provider networks for timely and reasonable geographic access to services, and cover out-of-network services if they are unable to provide timely access. Having a network of providers also allows plans to monitor the quality of care delivered to members and work with providers to improve care. Under the predecessor FFS system, many providers refused to participate with the Medicaid program as a result of inadequate FFS reimbursement, which was based on fee schedules that many providers refused to accept – limiting access to Medicaid enrollees and often forcing them to seek care in the emergency room.

Moreover, plans' use of tools like prior authorization and utilization management are not barriers to care, but instead help to ensure that care is appropriate to meet the member's needs by working with providers to coordinate care. Timely prior authorization is more than just approval or denial of care. It can be an opportunity to implement best practices around alignment of a discharge plan with the ambulatory health care needs and social risk needs of beneficiaries. These are the types of best practices that address equity.

Managed care plans have been working for many years at expanding innovative value-based arrangements in the Medicaid program, including projects to improve care coordination for members with co-occurring behavioral and medical health challenges, including arranging supportive housing; to improve maternal care; to provide members with diabetes with home delivered medically tailored meals to address food insecurity and improve health outcomes – to name only a few examples. We believe that the new 1115 waiver conceptual framework

moves the Medicaid program in the right direction toward modernization and innovation, and builds on work plans have been doing in their communities.

One area where State policy change could allow greater innovation and access is in telehealth. While plans have greatly expanded the types of services available through telehealth and other innovative technologies that support remote care, state restrictions limit the ability to unlock the full potential of this important technology. One approach would be to allow for multi-state licensure for telehealth services. Currently, to be eligible to practice in multiple states, a provider must have a license in each state, either through a reciprocal agreement with another state licensing body or by independently being licensed in other states. Efforts should be undertaken to amend the education law and the public health law to create an interstate licensure program with contiguous states and states in the Northeast region to support telehealth access for specialties with historical provider access issues. By allowing for an expedited pathway to licensure for those who wish to practice across multiple states, this would serve as an important step to improve access to care for all patients regardless of where they live.

GLOBAL CAP

While for several years, the state has been able to keep Medicaid spending growth within the 10-year rolling average of the CPI, it is worthwhile to determine whether different measures are more appropriate to properly reflect enrollment growth as New York State moves toward universal coverage.

CONCLUSION

We recognize that as New York emerges from the pandemic and applies for a new 1115 Medicaid waiver amendment that there are opportunities to improve the Medicaid program by incentivizing innovative value-based care. Plans have worked with the State for 30 years to improve quality, expand access and control costs, with the overarching goal of assuring that

Medicaid members receive all the services they need, in the most appropriate setting and in a coordinated manner to improve health outcomes. At the end of this testimony, we include a short list of real examples that exemplify how Medicaid managed care plans change members' lives for the better each day. HPA and its member plans are proud of the role they continue to play in helping New York improve access to high quality care for Medicaid members. Plans remain committed to working with you and your colleagues on initiatives and strategies to improve care for all Medicaid enrollees.

We thank you for the opportunity to share our views today.

APPENDIX: MEDICAID MANAGED CARE IMPROVING LIVES

Helping Members Understand the Importance of Preventive Care

"Laura" was connected to a Community Advocate at the plan, who helped her understand the importance of regular primary care and select a doctor who she trusts and likes to see. Laura's advocate also worked with her to schedule a routine mammogram and helped ease Laura's fears before the appointment, so she wouldn't cancel it. Building on that trust, the advocate has also helped Laura schedule an eye exam and dental visit, and encouraged her to participate in classes offered by the plan to help members with questions to ask at their doctor's visits, information about their health care coverage, other resources available to them in their neighborhood and other information developed to keep them healthy.

Coordinating Care for Justice Involved Youth

"Curtis" is a young man in rural upstate New York diagnosed with Conduct Disorder and Substance Use Disorder challenges, who needed access to behavioral health supports convenient to him in his community. Working with one of his existing providers, the plan care managers connected him to another provider and helped him understand how their offerings could meet his needs. In addition to behavioral health treatment supports, they have a peer support program that is ideal for youth transitioning into adulthood. This program was identified by Curtis, and those involved in coordinating his care, as a great next step in his care planning that connected him to an evidence based program with the potential to mitigate his risk of future justice system involvement.

Monitoring Patient Prescriptions to Complete Treatment

"James," who's enrolled in a Medicaid Managed Care Plan had been taking medication to treat his Hepatitis C. Due to the high cost of Hepatitis C treatments, this plan has a team of in-house pharmacists that manages all Hepatitis C medications and track new products

entering the market. This allows the plan to have a comprehensive offering of the most optimal and cost-effective therapies. After meeting with his physician, he was prescribed a new medication with excellent cure rates for patients who complete the full course of treatment. One of the plan pharmacists reviewed his prescribed treatment and identified that the physician had prescribed an eight-week course of therapy, which is only half of the recommended 16-week treatment. The plan pharmacist contacted the physician who then adjusted the prescription. James was then contacted to ensure he completed the full course of therapy. Without the access to real-time prescription data and the intense follow up from the in-house team, he would not have completed the full course of treatment, and thus would have wasted tens of thousands of dollars on incomplete treatment that would not have successfully treated his Hepatitis C.

Ensuring Continued Access to Medication Amid the COVID-19 Pandemic

"Aida," is a Medicaid plan member, who is HIV+, has schizophrenia, and a long history of emergency hospital admissions for mental and physical health issues. As a result of the COVID-19 pandemic, her regular physician's office closed, and she could no longer access the necessary monthly injections of an antipsychotic medication. This plan's social work and behavioral health care management teams immediately recognized that a missing injection could have disastrous health outcomes for her, so they worked to arrange for her to pick up the medication at her local pharmacy and for a provider who specializes in medical and psychiatric home care to administer the injections at her home.

Switching Medications

"Maria," is a long-term survivor of HIV who is managing multiple health conditions and has a prior history of substance abuse. She had a heart attack last year and is diagnosed with high cholesterol, high blood pressure, and severe allergies. Her health plan's pharmacy team regularly reaches out to help her manage the multiple daily medications she takes to manage her health and stay well. They reached out to Maria and her provider to switch her

HIV therapy to one with lesser side effects on her liver and kidneys. Recently during the COVID-19 pandemic, she reached out to the team for help accessing fresh food while following the “stay at home” order. The plan was able to connect her to Get Food NYC. Since becoming a member, she enrolled in the plan’s workforce training program and is now a member of her plan’s member advisory board.

Referral to Treatment Adherence Specialists

“Sarah,” a Medicaid plan member is living with HIV and was recently diagnosed with Hepatitis C. Her case was especially complex because she had a heart condition, a high HIV viral load, and a breast cancer diagnosis during her HCV treatment. To complicate matters further, the patient has a history of drifting into and out of care and often missed her appointments. Her plan’s pharmacy team referred her to a treatment adherence specialist to ensure that the plan actively reaches out to her and coordinates with her providers. The first step in her treatment was to reduce her viral load, which was delayed due to her breast cancer diagnosis. Though difficult, the plan was able to help her achieve load suppression and recently confirmed that Sarah has been cured of her Hepatitis C.

Working with a Pharmacist to Provide Additional Case Management Support

“Reggie,” a Medicaid member suffers from debilitating depression. When he began taking antidepressants, he and a plan pharmacist spoke about the symptoms and prognosis of depression, realistic expectations for antidepressants, and side effect management. Reggie and the pharmacist formed a bond through their discussions, and he began to realize the benefits of having a continued support system through this pharmacist. Several months later, during the “New York Pause” as a result of COVID-19, he lost his job and was living with his family to save money, despite ongoing disagreements.

His depression and anxiety steadily increased. He called the pharmacist back several months later and conversations picked up between the two, with weekly scheduled

conversations between Reggie and the pharmacist. These conversations involve positive coping mechanisms, natural management of depression, relationship building with his family, and follow up with his counselor and his patient advocate. At the same time, the pharmacist helped discuss advantages and disadvantages of increasing his prescription strength, streamlining prior authorizations to ensure adherence, and support/encouragement of positive weekly examples of his own self-advocacy.

Behavioral Health Prescription Drug Treatment and Adherence Support

"Joe," a Medicaid plan member, has schizophrenia and was non-adherent to his provider appointments, medications, and case manager appointments. After running and reviewing a non-adherent antipsychotic treatment report, the health plan flagged Joe as needing support/intervention. The health plan staff reached out to his provider and community pharmacy to better understand the situation and obtain updated contact information. The case management team successfully reached out to him and relinked him to his care team.

The health plan continued to face challenges with Joe's adherence given his mistrust of the medications and lack of understanding around the necessity of the treatment for his condition. Recognizing there is a social component of successful adherence, the health plan pharmacist reached out to his mother and discussed options for counseling and motivational interviewing (including the advantages and disadvantages of the medications) to encourage him to adhere to treatment. Through continued involvement, pharmacist aids were able to ensure adherence by regular check-ins, real time connections, and honest and trusting working relationships with family, pharmacy, case managers and counselors.

Reducing Preventable Hospitalizations

"Thomas" was diabetic and engaged in hoarding behavior. Before enrolling in an MLTC plan, he was hospitalized several times each year. To improve his health and address

challenges in his living environment, the plan's care management team worked to gain his trust and as a result, his Nurse Care Manager was able to clear away the clutter in his apartment and create a safe path to the bathroom. More importantly, she learned that Thomas bought all of his food in the bodega located on the ground floor of his apartment building. Given the importance of diet in managing diabetes, she brought a nutritionist to the bodega to meet with Thomas and the bodega owner and staff. The nutritionist went through the store with Mr. T and the Nurse Care Manager and showed them what Thomas should eat and what he should avoid. With the help of his care team and the bodega staff, Thomas was not hospitalized for the next five years.

Maintaining Patients in their Home Environment

"Beatrice" is ambulatory, with severe Alzheimer's disease. Until her sister's death six months ago, she lived with her sister in a railroad-style apartment. Since her sister's death, she spends her days walking the length of her narrow apartment (60 feet up and 60 feet back) in search of her sister. Her home care aide felt she had to walk the halls with Beatrice to keep her safe, but this obligation made it difficult for the aide to do anything else, such as cooking or cleaning; the aide was frustrated. One day Beatrice fell in the middle of the night. When her MLTC plan's Director of Rehabilitation visited, surveyed the apartment and talked to the aide extensively, she learned that Beatrice was often awakened in the middle of the night by noise from the 24-hour deli on the floor below, and she learned about the aide's difficulties. The Nurse Care Manager and the Director spoke with Beatrice's niece and the aide, and, with their approval, bought a baby monitor for the bedroom and the kitchen, so the aide could do her chores and monitor Beatrice's walks. They also purchased a white noise machine, so that Beatrice can sleep through the night, avoiding further falls. The plan's patient-centered care management yielded effective, low-cost solutions to issues that were otherwise likely to result in institutionalization.