

Medicaid Redesign Initiatives

New York State has embarked on a major redesign of the Medicaid program, as previously discussed with CMS. Changes affecting the State's waiver programs are intended to streamline and maximize enrollment in managed care programs to simplify the program, improve quality of care and reduce costs. A summary of enrollment changes affecting the State's Section 1115 waiver programs is below.

Governor Cuomo commissioned the Medicaid Redesign Team (MRT) to implement cost savings initiatives while maintaining the provision of needed care. The MRT was composed of twenty-seven (27) health care industry leaders including providers, union leaders, consumer advocates and members of the legislature. The MRT voted to implement seventy-nine (79) proposals which focus on program changes and implementation of new initiatives. All proposals are available on the State's website at http://health.ny.gov/health_care/medicaid/redesign/. Legislative changes were enacted in the State's 2011-2012 budget allowing the State to proceed with obtaining the necessary approvals to implement the various proposals. The State requests that CMS approve the following changes to the State's 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2.

A. Expand Medicaid Managed Care Enrollment of Non Dual eligibles

The State's overall goal is to expand enrollment in the Medicaid managed care program by requiring many of the high need populations which were previously exempted or excluded to enroll in a managed care plan. We believe that the Medicaid managed care program is a better model of care for these populations since managed care plans provide an organized system of care, an accountable entity, and the ability to coordinate and manage care. We propose a phased-in approach to managed care enrollment for new populations over the next three years.

New York State's track record of providing high quality care, effective enrollment education and efficient methods of ensuring continuity of care provided a strong foundation for enrollment of the SSI and SPMI/SED populations beginning in 2006. Quality of care data, including enrollee satisfaction measures, indicate that these vulnerable populations are receiving better quality care and are highly satisfied with their providers and health plans. The State is confident that managed care enrollment will likewise benefit new populations and that any disruptions in care will be minimal. New York State currently has in statute a transitional care requirement that attempts to minimize disruption for people new to managed care. The statute requires managed care plans to allow patients to continue seeing their provider for a 60 day period after enrollment if they are in an ongoing course of treatment and the provider does not participate in any plan. Also, the law requires managed care plans to allow all women in their second trimester of pregnancy to continue to see their provider through post-partum care. New York's transitional care policies, as well as the continuation of a 6 month limited chronic illness exemption will promote a smooth transition into managed care and minimize any disruption in care.

We propose adding a new section to the Special Terms & Conditions (STCs) of both waivers authorizing the State to enroll new populations when program features are in place. A chart is added to the STCs identifying the newly eligible populations and existing charts identifying excluded and exempt individuals are modified to reflect the requested changes.¹ A copy of the most recent draft of the PP and F-SHRP STCs, marked to show the proposed changes, is attached. We request CMS approve the phase in of the additional populations at this time. In preparation for enrolling any new population into mandatory managed care, the State will seek input from the advocacy community, work with the managed care industry to ensure appropriate providers are available, and will educate recipients and providers prior to implementation. The State will notify CMS when we expect to begin enrollment of new populations.

The State also proposes to streamline the enrollment process by standardizing the period during which a beneficiary (all populations) may select a plan. New applicants will be required to indicate their choice of plan at the time of application for Medical Assistance (MA), and if they do not choose a plan, they will be auto-assigned using the existing process. Persons already in receipt of MA will have 30 days from the day the local district or State indicates to choose a plan. If they do not choose a plan within that 30 day window, they will be auto-assigned. Pregnant women will be required to choose a plan when they apply for presumptive eligibility and will be auto-assigned after 30 days if they fail to do so. We believe these initiatives promote and encourage managed care enrollment and the selection of a primary care provider and a medical home. In the case of pregnant women, expedited enrollment promotes early entry into prenatal care leading to improved birth outcomes. All efforts will be made by the local districts and the State to inform and educate beneficiaries concerning their options and rights through training, community outreach, and the State's enrollment broker.

B. Pharmacy “Carve-in” and Other Benefit Changes

The Medicaid redesign statute includes a proposal to carve the pharmacy benefit back into the Medicaid managed care and FHPlus programs. Prescription drugs are already identified as a benefit so no change was necessary to the PP STCs. Personal care services will become a responsibility of the MMC plans in year 1 and nursing facility care in year 2. Both of these services are already listed in the STCs.

C. Mandatory Enrollment Medicaid Eligibles in Managed Long Term Care

Background

Medicaid spending for long term care services continues to grow at a significant rate while the total number of Medicaid recipients receiving long term care services has remained

¹ On the new and revised charts we combined some categories, (e.g., working disabled, foster care and HCBS or CAH people and people with similar characteristics) and removed populations that were included in another category or were no longer necessary (e.g., persons in the Restricted Recipient program) because program features are in place at this time.

flat. Between 2003 and 2009, Medicaid long term care expenditures increased by 26.4% from \$9.8 billion to \$12.4 annually while there was only a .1% change in the number of recipients. The average cost of services per recipient has increased from \$30,769 in 2003 to \$38,839 in 2009.

Between 2003 and 2009 Managed Long Term Care Plans increased enrollment by 175% while successfully controlling the escalation in costs. In fact, during that period the MLTC cost per recipient actually decreased by 0.3%. In 2010 the Department began the phase-in of a risk model for rate setting for partially-capitated and PACE plans that will increase the plans accountability and better match payments to the impairment levels of their members.

There are a large number of programs in the community. This diversity of programs has led to confusion and discontinuity for consumers. These programs are not necessarily required to consider the linkage between the services it provides and the more global needs of its recipients. In addition, each distinct program adds complexity and administrative costs to New York State and county government for oversight and management.

Proposal Overview

As a result, the State will require the transition and enrollment of people who meet the following criteria into Managed Long Term Care (MLTC) plans or other care coordination models approved by the Commissioner of Health:

- Age 21 and older;
- Eligible for Medicare and Medicaid; and
- In need of community-based long term care services for more than 120 days.

Three models of MLTC now operate in New York – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. Partially capitated plans are expected to be the primary type of plan these individuals will enroll in because there is no requirement for concurrent Medicare enrollment. However, where available and when additional plan-specific enrollment criteria are met, people will have an option to select PACE or MAP as well.

- PACE and MAP fully integrate both Medicare and Medicaid capitation and services. Both serve people who are nursing home certifiable, which must be established as a condition of enrollment. PACE may enroll people who are age 55 and older; MAP enrolls people who are 18 and older. These plans include all primary, acute, behavioral and long term care services in the benefit package and provide care coordination. PACE is provided by 7 plans statewide currently serving approximately 3,450 participants; MAP is provided by 8 plans and has nearly 700 members.
- The partially-capitated plans currently serve people who are nursing home certifiable. The benefit package includes community-based long term care services, nursing home care and many ancillary services. These plans are responsible for care managing the balance of the services the member needs including transitions into and out of hospitals

and physician care. There are 14 partially capitated plans serving nearly 29,000 members.

All three models operate as Managed Care Organizations, certified under Article 44 of NYS Public Health Law, and subject to periodic survey and ongoing monitoring by the Department of Health. As PACE and MAP are integrated Medicaid/Medicare models, they are also subject to applicable federal regulations and additional CMS oversight and audit. Inherent in each model are extensive patient rights, driven by applicable State and federal regulations that afford member protections and provide options to complain or appeal decisions involving service delivery.

MLTC plans are responsible for assessing members and developing, implementing and monitoring a plan of care that meets the physical, social and environmental needs of the members inclusive of all medically necessary home care services (including personal care) and custodial nursing home care. Members and care givers will have a single entity to which they can raise concerns and make requests. The plan is at risk financially and therefore has an incentive to implement a plan of care that meets the member's needs in the least restrictive setting to improve health or prevent further decline or acute illness.

Members have shown a high degree of satisfaction with their MLTC plans. In a 2007 satisfaction survey conducted by IPRO, 87% of respondents rated their MLTCP as "good" or "excellent" and 91% said they would recommend the MLTCP to others.

MLTCPs currently serve members with a high level of impairment. Department analysis of the severity of those receiving long term care services (using similar data items on the MDS, OASIS and SAAM) found the MLTCs serving a population that is less impaired than people in nursing homes but more impaired than those served by the LTHHCPs and CHHAs. As such the MLTCPs would be well able to serve the extended population of those eligibles currently in other programs.

Beginning in April 2012 in New York City, where MLTC capacity is adequate, individuals who need community based long term care services for more than 120 days will be required to enroll in MLTC plans or other care coordination models specified by the Commissioner of Health. Those who must enroll would include those currently served in community based long term care programs as well as people who are new to long term care.

Mandatory enrollment will expand throughout the rest of the State as MLTC plans or other care coordinated models become available. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office of People with Developmental Disabilities would be exempted from mandatory enrollment in a MLTC program until the State develops appropriate program features for these populations. Individuals enrolled in the programs above are already in programs that have a high level of care management for long term care services.

Partially capitated plans will expand their target population beyond those who are nursing home eligible to include all dually-eligible people in need of long-term community based services. Non-dually eligible disabled adults who meet these criteria will have the option of joining a MLTCP in lieu of an MMC plan. Necessary changes will be made to permit Consumer Directed Personal Assistance Program services to be made available through the MTLC plans.

New York City has the greatest concentration of plans and members at present. Ten partially capitated plans serve approximately 27,000 members, 7 MAPs serve 450, and 2 PACEs serve 2,400. Therefore, we believe there is sufficient capacity in NYC to implement this initiative.

Mandatory enrollment would begin in New York City and be phased-in throughout the rest of the State as plan capacity is developed. Dual eligibles who are current users will be provided a notice before reassessment that they have 30 days to choose a plan and will be provided with information and assistance about specific plans in their service area. This information will include a description of the types of plans and programs available, to promote an informed choice. If the individual does not make a choice, he/she will be auto-assigned to a partially capitated plan. It is expected that approximately 2,000 people per month will transition to MLTC or other care coordination models during a 36 month phase-in period. Enrollees will have the ability to disenroll from one plan and join another if dissatisfied. New users in need of community based long term care will be provided with similar information and have a choice of the types of plans and programs available. If they do not make a choice, they will be auto-assigned to a partially capitated program.

The mandatory program will not be implemented in other districts until there is adequate capacity, (2 plans non-rural districts, 1 plan rural districts) and the State will give CMS 90 days notice with budget neutrality prior to expanding implementation in additional districts.

Plans will be required to ensure continuity of worker for members who are currently receiving services by contracting with members' current home care service providers to avoid any disruption in care to this vulnerable population.

Prior to implementation, the Department will utilize the Enrollment Broker to improve consumer knowledge and understanding about MLTC toward increased voluntary enrollment as well as to streamline the administrative process for joining a plan. The current level of consumer education will be maintained. All MLTCPs must currently provide interested parties with information about the plan, such as member handbooks and provider network listing. These requirements are now in place to ensure informed choice and the voluntary nature of enrollment.

Budget Neutrality Fiscal Impact

Mandatory enrollment of eligible individuals into MLTC from open-ended fee-for-service is expected to control costs through care management. Anticipated savings will be offset by the initial implementation and administration of the program.

Managed long term care plans are paid a Medicaid monthly capitation rate for the covered benefit package, and the plans assume the full risk of providing health care and care management services for their enrollees.

New without waiver PMPMs will be requested for the following MEGs: MLTC – Dual Community Based 21 - 64, MLTC – Dual Community Based 65+, MLTC – Non Dual Community Based 21 -64, MLTC – Non Dual Community Based 65+, MLTC - Dual Nursing Home and MLTC – Non Dual Nursing Home.

Public Notice Process for these amendments

On January 5, 2011 Governor Cuomo issued an executive order to create a new Medicaid Redesign Team to find ways to reduce costs and increase quality and efficiency in the Medicaid program. The Team was asked to give the Governor recommendations by March 1 for consideration in the budget process. The Team included 25 voting members appointed by the Governor including:

- State officers or state employees with relevant expertise.
- Two members of the New York State Assembly, one recommended by the Speaker of the Assembly and one recommended by the Minority Leader of the Assembly.
- Two members of the New York State Senate, one recommended by the Temporary President of the Senate and one recommended by the Minority Leader of the Senate.
- Leaders with expertise in the healthcare industry.
- Leaders with expertise in the healthcare insurance industry.
- Business and consumer leaders.
- A list of the members is available on the MRT website at http://health.ny.gov/health_care/medicaid/redesign/

New York State Medicaid Director Jason Helgeson served as the Team's executive director and the state Budget Director served as a non-voting member.

On January 7, 2011 the Governor announced the members of the Medicaid Redesign Team. The Team held regional meetings throughout the State during January and February. At a February 24th meeting open to the public the team considered a package of recommendations. The recommendations are based on ideas submitted by stakeholders and suggestions and feedback from the Redesign Team. The Team voted to present these recommendations to the Governor by a vote of 20 members in favor and four abstentions and three members absent. There were no votes in opposition.

On February 24 the Team provided the Governor with the recommendations. The recommendations met the Governor's spending target for the 2011 – 2012 budget. The report included the 79 recommendations approved by the Team to redesign and restructure

the Medicaid program. These recommendations were incorporated in the legislative proposals to enact the 2011 – 2012 budget.

Throughout this process materials were posted on the Medicaid Redesign website for review and comment by interested parties. All stakeholders are aware of the proposals and have had the ability to comment. The proposals affecting the waivers include:

- Proposal# 1458 “Care Management and Benefit Expansion, Access to Services and Consumer Rights,” which recommends expanding enrollment to populations previously exempt or excluded, adding personal care and nursing home care into the managed care benefit package, reducing the time period to enroll in managed care and enhancing and maintaining consumer protections;
- Proposal # 11 “Bundle Pharmacy into MMC,” that proposes to include pharmacy services in the benefit package;
- Proposal #number 90 “Mandatory Enrollment in MLTC,” which proposes to transition persons over 21 who meet the criteria into Managed Long Term Care Plans. There are two other proposals that are necessary to implement mandatory enrollment in MLTC;
 - Proposal number 141 “Accelerate State Assumption of Medicaid Program Authorization” (this takes the local district out of a pre enrollment approval for MLTCPs); and
 - Proposal #1427 “Allow consumer direction in MLTC”.

Additionally, the State published a public notice describing the changes to the waivers and giving interested parties 30 days to submit comments was published in the State Register on April 27, 2011.