Coalition of New York State Public Health Plans

7 TIMES SQUARE
NEW YORK, NEW YORK
10036

Affinity Health Plan

Amida Care

Fidelis Care New York

Healthfirst

Hudson Health Plan

MetroPlus Health Plan

The Monroe Plan for Medical Care

VNSNY CHOICE

PHP Coalition Lobby Day
March 11, 2015

KEY ISSUES

- **Rate Adequacy and Timeliness:** The Coalition urges the enactment of the enclosed legislation to strengthen provisions relating to the adequacy and timeliness of plan rates.
- **Implementation of FIDA:** The Coalition requests the Legislature to work with the Department of Health to address key operational and benefit design issues necessary to ensure FIDA's success.
- **Copayments on Medicaid Managed Care Beneficiaries:** The Coalition urges the Legislature to reject the imposition of copayments on Medicaid managed care beneficiaries.
- **Supplemental Rebates for Drugs Provided to Medicaid Managed Care Beneficiaries:** The Coalition recommends the State limit its negotiation of supplemental rebates with manufacturers to HIV and Hepatitis C drug classes.
- **The Basic Health Program:** The Coalition supports the Executive Budget proposal to vest rate setting authority for the Basic Health Program with the Commissioner of Health.
- **Limits to Medicaid Managed Care Profits:** The Coalition urges the Legislature to oppose imposition of a cap on Medicaid managed care plan profits, especially those of not-for-profit, provider-sponsored plans.
- **Value-Based Payments in DSRIP:** The Coalition urges the State to prioritize flexibility in the design and implementation of payment reform—over the course of DSRIP and beyond.

***Overview of the PHP Coalition*:** The Coalition is an association of eight health plans that serve New York's public health insurance programs across the State, including its Medicaid managed care and Child Health Plus programs. Current Coalition plan membership is more than 3 million, approximately two-thirds of all New York public health insurance enrollees.

- All Coalition plans are public and not-for-profit organizations that partner with providers in their communities.
- Coalition plans have been in the market for more than 20 years and remain in the market to fulfill a mission—not to generate value for shareholders.
- Coalition plans are based in the communities where they serve as critical employers and providers of health insurance coverage.

Importantly, Coalition plans provide financial support to local providers by reinvesting any surpluses in the health care delivery system that serves low-income New Yorkers.

DESCRIPTION OF KEY ISSUES

The PHP Coalition supports the following proposals and is committed to helping leverage these opportunities to the benefit of all New Yorkers:

- **Rate Adequacy and Timeliness:** Sufficient rates are a critical prerequisite to effective, appropriate delivery and management of care. Plans have urged the Department of Health and its actuaries to ensure that rates accurately reflect the true costs of the populations and benefits covered. This issue is increasingly important to plans as the State begins implementation of major new programs, including its Fully Integrated Duals Advantage (FIDA) initiative for New Yorkers who are eligible for both Medicare and Medicaid and have long-term care needs, and its behavioral health transition and Health and Recovery Plans (HARP) for Medicaid beneficiaries with significant behavioral health needs.

    - **FIDA.** The dual-eligible population is among the most complex and vulnerable in the Medicaid program. FIDA rates must reflect this complexity. Unfortunately, the FIDA rates released by the Department last fall fail to do so and are inadequate—particularly given the program's robust requirements related to care management and interdisciplinary provider teams. Plans are working with the Department to address this critical issue, but strengthening provisions regarding rate adequacy will help ensure that rates are set appropriately going forward.

    - **Behavioral Health/HARP.** The Coalition urges the State to develop rates under this transition in partnership with plans and to not adopt rates that will achieve short-term savings at the expense of long-term cost containment and quality. Members with mental illness and substance use disorders may have unmet needs for primary care and community-based services. Moreover, plans are already incurring upfront costs as they connect members to these services and to needed social supports, like housing, in addition to internal investments in behavioral health management infrastructure. Rates must be sufficient to ensure that plans can make these investments and help members avoid unnecessary use of more costly inpatient services in the future.

  Rate timeliness is also increasingly an issue for plans. The issuance of rates has been consistently delayed, which has had a significant effect on plans' ability to create budgets and manage operations. These delays are compounded by retroactive rate adjustments that risk plans' fiscal stability and potentially challenge their capacity to provide adequate care for their members. While we appreciate the best efforts of a heavily-burdened Department staff and understand that some responsibility lies with the Centers for Medicare and Medicaid (CMS), we would urge that every effort be made to ensure that premiums are established prospectively. *Coalition plans, therefore, recommend that the Social Services Law be amended to reflect the language in the enclosed draft provisions, which will enhance transparency in the rate process, strengthen provisions relating to the adequacy of rates and incentivize the State to expedite the issuance of rates on a timely basis.* [See "Proposed Revisions to Social Services Law Section 364-J."]

- **Implementation of FIDA:** The launch of FIDA has been slow, with many potential FIDA members delaying their decision to join and close to 30,000 opting out of the program entirely. Coalition plans are committed to the success of the program, but a number of issues hamper enrollment and plans' ability to grow the program. In addition to insufficient rates for FIDA plans, potential FIDA members have been confused by the notices from the Department and concerned about the benefits package, and providers have experienced new administrative requirements without a corresponding increase in their rates. *The*

Coalition, therefore, requests that the Legislature work with the Department of Health to address these operational and benefit design issues to enhance the success of the FIDA program.

- **Copayments for Medicaid Managed Care Beneficiaries:** The Executive Budget proposes removing existing copayment exemptions for Medicaid managed care beneficiaries whose family income is between 100 and 138% of the federal poverty level. Under this proposal, Medicaid beneficiaries who fall into this income range and are not part of certain exemption categories (such as children under 21 and pregnant women) would become subject to copayments required under fee-for-service Medicaid. This would affect hundreds of thousands of New Yorkers—including populations eligible for the Basic Health Program—and could potentially disrupt their care. Moreover, implementation of such cost-sharing would cause substantial administrative burden to the State, plans and providers. For example, federal statute requires that cost-sharing be tracked quarterly to ensure it does not exceed 5% of the individual or family's income; this means that for every patient visit, a provider must assess whether the 5% cap has been met to determine whether or not to charge a copay. The implications of this requirement alone are significant.

  According to the Executive Budget, the imposition of copayments on Medicaid managed care beneficiaries is necessary to conform to Affordable Care Act requirements. To address this, the State could seek a waiver of the federal comparability requirements or eliminate copayments in fee-for-service Medicaid. *The Coalition urges the Legislature to reject the imposition of copayments on Medicaid managed care beneficiaries and support the Department of Health in obtaining a cost-sharing comparability waiver or eliminating Medicaid copayments altogether.*

- **Supplemental Rebates for Drugs Provided to Medicaid Managed Care Beneficiaries:** The Executive Budget proposes giving the State authority to negotiate with manufacturers supplemental rebates for drugs provided to Medicaid managed care beneficiaries. Considered together with a new supplemental rebate agreement between the Department of Health and manufacturers, this means manufacturers would be allowed to decline payment of supplemental rebates to the State when plans do not agree to the same formulary placement and prior authorization rules used by the State. This policy will lead to an increase in costs related to procuring drugs for both the State and plans and will restrict plans' ability to manage the pharmacy benefit. *As such, the Coalition urges the State to limit this policy to only HIV and Hepatitis C drug classes by amending the Social Services Law to reflect the language in the enclosed draft provisions.* [See "Proposed Revisions to Social Services Law Section 367-A."]

- **Rate Setting Authority for the Basic Health Program:** The Coalition supports the Executive Budget proposal to vest rate setting authority for the Basic Health Program (BHP) with the Commissioner of Health. For several key reasons, BHP rates should be set by the Department of Health in a way that leverages the existing Medicaid managed care rate setting process.

  - *The BHP is a government program-like insurance product; its rates should be set accordingly.* The State has built into its BHP many Medicaid-like features and more than half of the BHP-eligible population would be eligible for federally-matched Medicaid but for their immigration status.

  - *As recognized and affirmed by the Executive Budget, State statute vests authorization of the BHP with the Commissioner of Health—rate setting should be no different.* Given the safety-net nature of the BHP and that authority for its development and administration rests exclusively with the Department of Health, it would be inconsistent with State policy for rates to be set elsewhere.

  - *Finally, it is in the State's financial interest to have the Department of Health set the BHP's rates as it does with Medicaid.* Federal funding will only cover only a portion of BHP costs; the balance must be

supported by State dollars. Cost control in the BHP will be critical to the State achieving targeted savings and to the longer-term sustainability of the program. The State can ensure optimal control over BHP costs by directly administering premium rate setting through the Department of Health.

- **Limits to Medicaid Managed Care Profits:** The Executive Budget proposes implementing a cap on the profits of Medicaid managed care plans. As currently proposed, plan profits would be limited to no more than 5% and any excess profits would be reinvested in the quality incentive pools. Such a policy could have the unintended and noticeably self-defeating consequence of negatively impacting the plans with highest quality scores that receive quality incentive bonuses. *The Coalition urges the Legislature to reject the imposition of a cap on Medicaid managed care plan profits—especially those of not-for-profit, provider-sponsored plans.*

    - A cap on Medicaid managed care plan profits could disproportionately harm not-for-profit plans and affect coverage across the state. Not-for-profit plans often utilize excess revenue to develop products for new State programs like FIDA and HARP, which expand coverage to the State's neediest. They do not distribute profits to shareholders.

    - In addition, plan surpluses can fluctuate greatly from year to year and across Medicaid product lines, so excess revenue during one year or for one product is often used to smooth swings in profitability over time or across products.

    - Finally, such a cap would constrain provider-sponsored plans' reinvestment in the not-for-profit and public health care system.

  As an alternative, the Coalition would recommend an approach that involves a "simple" medical loss ratio (MLR) requirement, similar to what other states have adopted (e.g., an MLR of 85%). Such an approach would not involve an administrative screen, which can complicate implementation and penalize efficient plans, and would remove from the MLR calculation the quality incentive payments received by plans, to continue incentivizing high quality. Finally, it would reinvest plan revenue not meeting the MLR requirement into the quality incentive pools, consistent with the Executive Budget's proposal.

- **Value-Based Payments in DSRIP:** The Executive Budget proposes broad statutory authority for the Department of Health to enter into value-based payments directly with providers and performing provider systems and to permit plans to enter into value-based payments with these providers. The Coalition plans see real value in shifting provider payment models from fee-for-service to value-based approaches, but the transition must be deliberate and well planned as the impact on providers and consumers is significant.

    - Flexibility throughout the process is key. For many providers, adjusting to these new payment mechanisms will be difficult; for others, some form of value-based arrangement may already be in place. Plans and providers *must* be afforded the flexibility necessary to meet value-based purchasing standards over the course of DSRIP and beyond. Such flexibility should ensure that existing value-based arrangements are not disrupted.

    - In addition, while some not-for-profit, provider-sponsored plans already have value-based relationships with providers, many have not have developed the robust payment models or infrastructure necessary for widespread deployment of value-based arrangements. Given that most Medicaid managed care beneficiaries are enrolled in these plans, the State must recognize the need for infrastructure development at the plan level to effectuate its payment reform vision. Further, given the increased administrative costs related to implementing and managing value-based arrangements, the administrative portion of the plan premium must be adjusted.

The Coalition asks the Legislature to work with the Department, plans, and other stakeholders to ensure that flexibility and consideration for plan investment in infrastructure are prioritized in the design and implementation of payment reform.

❖ **Outstanding Issues Related to the Marketplace:** The Coalition commends the State for engaging diverse stakeholders and balancing multiple important points of view in the continued implementation and operation of the State's Marketplace. However, while New York State of Health (NYSOH) remains one of the country's most successful Marketplaces, there are a number of important policy and operational issues that require the attention of the Legislature.

- **HIV Special Needs Plans (SNPs).** For new Medicaid beneficiaries living with HIV/AIDS, SNPs are not available as a plan option on NYSOH. Unfortunately, the "workaround" option that was created to enroll applicants in SNPs through the Marketplace is both cumbersome and incomplete. The effect is hindered access to coverage for a population in serious need of care. *The Coalition urges the Legislature to prioritize the addition of SNPs to the Marketplace as quickly as possible.*

- **Primary Care Provider (PCP) Selection Functionality.** Currently, consumers shopping on the Marketplace are unable to select a PCP when they enroll in a plan, requiring them to call their plan, separately log into their plan's member portal, or mail a paper form after their coverage has been effectuated. The lack of PCP selection functionality at the point of enrollment places significant burden on both consumers and plans. Despite this, the Department has stated that PCP selection functionality will not be implemented until 2016—a delay from the originally promised date of early 2015. *The Coalition urges the Legislature to join with us in requesting that the NYSOH prioritize this issue, given the implications for both consumers and plans.*

- **Medicaid Renewals in New York City.** For years, the NYC Human Resources Administration (HRA) has managed ACCESS NYC, a website to help consumers determine eligibility, apply for, and renew public benefit programs; many NYC plans also use this site to effectuate their Medicaid renewals. HRA recently announced that the Medicaid online renewal function of ACCESS NY will no longer be available in 2015 because consumers are expected to begin to renew on NYSOH "at some point in 2016." This gap in Medicaid online renewal functionality is problematic for consumers and plans alike, putting at risk the continuity of care for thousands of Medicaid beneficiaries in NYC and requiring plans to develop new renewal processes. *Coalition plans are working with NYSOH and HRA to prevent disruption of renewals and would welcome support from the Legislature in urging the State and City agencies to address these issues.*

- **Issuer Assessment.** The Executive Budget proposes establishing an assessment on all accident and health insurers to fund the ongoing operations of the NYSOH. Under this proposal, insurers would pay a share of the NYSOH's costs based on the insurer's pro rata share of premiums for all commercial health insurance coverage offered in the individual, small group, and large group markets, regardless of whether the coverage is offered on or off the Marketplace. The Coalition urges the State to take a different approach. The proposed assessment would result in driving up the cost of coverage across the State. *The Coalition requests that the Legislature consider reallocating funds within the Health Care Reform Act pools to fund NYSOH operation.*

For more information, please contact Anthony Fiori (afiori@manatt.com, 212-790-4582) or James Lytle (jlytle@manatt.com, 518-431-6700).