TESTIMONY OF

THE COALITION OF NEW YORK STATE

PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED FY 2013-2014 HEALTH AND MEDICAID BUDGET

SUBMITTED BY ANTHONY FIORI

TO THE

JOINT LEGISLATIVE COMMITTEE ON

HEALTH AND MEDICAID

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Introduction

Thank you for the opportunity to provide testimony on behalf of the Coalition of New York State Public Health Plans (PHP Coalition). My name is Anthony Fiori, and I am testifying in my role as representative of the Coalition.

Established in 1995, the Coalition of New York State Public Health Plans is an important voice for New York's non-profit, publicly-focused health plans and the low-income people they serve. The Coalition currently represents ten plans serving 2.8 million individuals, about three-quarters of all of the children and adults enrolled in New York's Medicaid managed care, Family Health Plus, and Child Health Plus programs. Coalition plans offer decades of experience in delivering high quality services to members who often, otherwise, experience significant barriers to accessing health care.

Today, the Coalition would like to comment on how health plans are partnering with the Executive and Legislative leaders to achieve New York's "care management for all" commitment and encourage the Legislature to consider transition strategies for populations that will experience coverage changes during implementation of New York's Health Benefit Exchange.

Reining in Costs While Improving Health Care Quality

Medicaid managed care's partnership with the State grows out of shared and deeply rooted values, goals, and incentives. In New York, plans know that patients who are the poorest, sickest, hardest to reach, and most expensive to treat are not "the problem" with our health care system; instead, they challenge all of us to provide them with access to a health care system that anticipates and meets their profound health needs. Health plans are meeting this challenge and connecting people who would otherwise fall through the cracks with patient-centered, coordinated, and comprehensive care.

Long before Governor Cuomo brought together key healthcare stakeholders to form the New York Medicaid Redesign Team (MRT) in 2011, the Medicaid managed care model had been a catalyst for positive change in New York's health care delivery system. Recognizing this, the MRT embraced Medicaid managed care as the vehicle to achieve the Governor's stated goal: "measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."[1] To meet this goal, the State decided to have Medicaid managed care plans enroll new, more complex populations and provide a more comprehensive Medicaid benefit to their members. Health plans stepped up in 2011 to implement those new policies to drive better outcomes and lower costs. In 2012, plans built on their earlier efforts as the State continued its redesign initiatives, bringing new populations and benefits into Medicaid managed care.

In 2012, some of the most complex and vulnerable populations served by New York's Medicaid program transitioned into Medicaid managed care. Homeless individuals and families,

[1] State of New York, Executive Order #5 (January 2011). http://www.governor.ny.gov/executiveorder/5

low birth weight babies, and participants in the Consumer Directed Personal Assistance Program were among the populations newly served by plans. These transitions are not easy and have required intense planning and coordination among the plans, consumers, the State, and other health care stakeholders. But, despite aggressive timelines, intensive logistical and technical preparations, and major administrative overhauls, implementation has been remarkably smooth with no widespread disruptions for Medicaid beneficiaries.

As their covered populations expanded and diversified, Medicaid managed care plans' benefit packages broadened to encompass a wider array of services in 2012. Building on the carve-in of personal care services in 2011, plans began to cover consumer directed personal care services, expanding the range of options available to plan members with personal care needs. In addition, 2012 saw the transition of dental benefits in some counties and orthodontia into Medicaid managed care. As plans' ability to coordinate and manage care has expanded to new categories of services, they have been better able to simultaneously promote patient-centered care and contain costs.

Although the transition of new benefits and populations into Medicaid managed care has been smooth, on-the-ground experience has pointed to policy refinements that can strengthen program changes. To that end, the Coalition is supportive of the Executive's proposed elimination of "prescriber prevails" for the atypical antipsychotic drug class. Prior to implementation of the policy, there was little evidence of any interference by plans to prevent individuals with mental illness from obtaining appropriate medications. Recognizing that, plans are committed to working with prescribers, consumers and advocates on the development of policies that ensure people with mental illness have appropriate access to medications.

With the responsibilities of plans continuing to grow, the Coalition urges the Legislature to continue to pay close attention to the rates that they receive. Adequate rates are a critical prerequisite to effective, appropriate delivery and management of care. In 2011, plans saw the consequences of overly optimistic assumptions on costs, as they endured significant losses on the pharmacy benefit. Coalition plans are pleased that the State worked with them to address and resolve these insufficient rates last year. However, they urge the Department of Health to continue to work with them to monitor expenses as these and other transitions occur to ensure that rates accurately reflect the true costs of new populations, benefits, and changes in case mix and utilization.

The Coalition also urges the State to collaborate with plans as it finalizes its Fully Integrated Dual Advantage (FIDA) program for individuals with long term care needs enrolled in both Medicare and Medicaid (dual eligibles). These 125,000 dual eligibles account for a substantial share of both Medicare and Medicaid spending in New York. The FIDA program represents a tremendous opportunity to improve outcomes and quality of life for these beneficiaries by centering responsibility for their care in a single accountable entity. It also presents an opportunity to achieve significant operational and financial efficiencies for the State.

Public health plans must play a major role in implementing this new system, as they currently serve over 77,000 (more than 10 percent) dual eligibles through Medicare Advantage Special Needs Plans for the duals. These enrollees are already benefiting from managed care –

better care coordination, robust provider networks, member services support, and quality oversight, among other advantages. Plans' experience and expertise serving dual eligibles can productively inform the development of the FIDA program. The Coalition welcomes the State's engagement with the stakeholder community, as it has already demonstrated through the FIDA work groups organized in 2012. The Department of Health, Legislative and Executive leaders, and plans will need to continue to work collaboratively to make FIDA implementation a success.

Cooperation will also be necessary to ensure success as the State moves forward with the integration of behavioral and physical health benefits. The Coalition thanks the State for embracing Medicaid managed care as the vehicle for improvement in outcomes and coordination of care for individuals with behavioral health needs. Plans recognize the complexity and cost of covering these individuals and are prepared to develop models to appropriately and cost-effectively deliver their care. Access to critical social services, including affordable housing, will be a key part of any model. Going forward, plans will need to be engaged with the State in conversations on the details of integration, including benefit packages, network requirements, coordination with behavioral health organizations and health homes, and the role of full benefit special needs plans. The Coalition looks forward to continuing to work with the State to move this important initiative forward.

As New York outlines ongoing population and benefit integration in the years ahead – particularly around FIDA and moving behavioral health services into Medicaid managed care – health plans stand ready to ensure real, measurable progress to reduce immediate and long-term Medicaid costs while upholding and building on exceptional standards of care.

Implementing New Structures to Expand Access to and Continuity of Care

The Coalition is supportive of the State's efforts over the last year to design and establish a Health Benefit Exchange that improves access to and the cost of coverage in the individual and small group insurance markets. We commend the Governor and Exchange leadership for making significant progress in creating New York's Exchange, engaging many diverse stakeholders and balancing multiple important points of view. The public health plans will continue to work with the State and Legislature to ensure successful operation of the Exchange, particularly for the low-income New Yorkers we serve and who historically have experienced gaps in their insurance coverage. With the implementation of the insurance marketplace and expansion of the State's public insurance programs in 2014, New York has an unprecedented opportunity promote affordable coverage for all New Yorkers, particularly those most likely to experience barriers to coverage because of the cost and complexity of obtaining health insurance.

The Coalition is pleased that, under the Affordable Care Act and the Governor's proposed budget, 76,000 childless adults with incomes between 100 and 133 percent of the federal poverty level (FPL) will be newly covered by Medicaid in 2014 and most New Yorkers with incomes up to 400% of FPL will be eligible for federal tax subsidies to offset the cost of insurance premiums.[2] However, plans are deeply concerned regarding affordability of QHP

[2] Blavin F, LJ Blumberg, M Buettgens, and J Roth. March 2012. The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State. Washington, DC: The Urban Institute. http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/2012-03_urban_institute_report.pdf.

coverage in the Exchange for our lowest-income residents. For this reason, the Executive's proposal to "phase out" the Family Health Plus (FHP) program between 2014 and 2015 is of concern to our plans and their members.

The Executive proposes to end new FHP enrollment in December 2013 and transition current beneficiaries with incomes below 133% FPL to Medicaid and those between 133% and 150% of the FPL to subsidized Exchange coverage. The Executive further proposes to provide "wrap around" financial assistance to those current FHP members with incomes from 133-150 FPL who select a Silver level QHP in order to bridge the cost-sharing "cliff" between FHP and silver QHP coverage. We commend the Executive for offering financial assistance to these low-income individuals, but are deeply troubled that this help is offered only to those who enroll in FHP by December 2013. We anticipate that many other New Yorkers with incomes from 133-150 FPL will apply for insurance affordability programs in 2014 and beyond, including families who experience job loss or other circumstances that lead to a decrease in income. These families will face steep annual premiums and co-payment obligations, with no similar assistance. Further, plans have decades of experience with their Medicaid members transitioning between Medicaid and FHP because of frequent, small changes in income; the Executive's proposal would offer no financial assistance to Medicaid members whose incomes increase to the 133-150 FPL level.

Health plans are concerned that without such assistance these individuals will decide they cannot afford to purchase coverage through the Exchange. The Coalition encourages our Legislative and Executive leaders to consider extending wrap-around financial assistance to all consumers with incomes above new Medicaid eligibility level of 133% up to 150% FPL, regardless of whether they are transitioning from FHP. This proposal would advance the goals of affordable and continuous coverage for lower-income New Yorkers.

As an alternative to the wrap-around financial assistance approach, the PHP Coalition supports the creation of a Basic Health Program (BHP) in New York, a natural progression of the State's current FHP program. A BHP would provide affordable and comprehensive coverage for adults whose incomes fall below 200 percent of FPL by leveraging federal subsidies and government purchasing power. In doing so, New York State would be able to save significant State dollars – estimated between $500 and $800 million – by transitioning from Medicaid certain immigrants, including those residing in the country for less than five years, and thus ineligible for federal matching funds.[3]

Moreover, the BHP improves the continuity of coverage for some of the state's most vulnerable. It would smooth the steep cost-sharing cliff between Medicaid and subsidized QHP coverage in Exchange. A BHP would also provide consistent and stable coverage for low-income families who have family members eligible for Medicaid, CHIP and or subsidized QHP coverage and might otherwise face a "split" in provider networks, policies, procedures, and cost-sharing as adults receive coverage through an Exchange and children remain in Medicaid and/or Child Health Plus. A BHP minimizes the risk of coverage breaks for individuals that can lead to extremely harmful effects on their health and on the entire health care system.

[3] February 2012 Analyses by the Community Service Society of New York and the Urban Institute

The Coalition acknowledges that there are design, implementation, and sustainability options with respect to ensuring that our lowest income residents are able to obtain affordable health insurance coverage in 2014 and beyond. We stand ready to work with the Legislature and Administration in developing solutions like the ones we have described here today so that that all New Yorkers benefit from the implementation of health care reform in our state.

Conclusion

Thank you for the opportunity to provide testimony on these critical issues. Coalition plans look forward to continue our partnership with the Legislature to ensure that a strong and stable health coverage and health care system is in place that not only serves the growing number of New Yorkers that rely on it, but that reflects and enhances the collective vitality of the entire State.

MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

PLAN	AFFILIATED ORGANIZATIONS	SERVICE AREAS
Affinity Health Plan	*Primary care provider organizations with representation on the Board of Directors*: Morris Heights Health Center, Charles B. Wang Health Center, Urban Health Plan, and Institute for Family Health	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester Counties
Amida Care	HIV Special Needs Plan founded and owned by Harlem United, HELP/PSI, Inc., Housing Works, Acacia Network, St. Mary's, and VillageCare	Bronx, Kings, New York, and Richmond Counties
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic healthcare providers	New York City and 54 other counties[1]
Healthfirst	Hospitals in all counties in which the plan operates[2]	New York City and Nassau and Suffolk Counties
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester Counties
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York, and Queens Counties
The Monroe Plan for Medical Care	The Monroe Plan for Medical Care is an independent, not-for-profit managed care organization that has a contract with Excellus BlueCross BlueShield to manage their Medicaid, Family Health Plus, and Child Health Plus products	Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne, and Yates Counties
Neighborhood Health Providers	Brookdale Hospital and Medical Center, Jamaica Hospital Medical Center	New York City and Suffolk County
Total Care (Syracuse PHSP)	Syracuse Community Health Center	Cortland, Onondaga, Oswego, and Tompkins Counties
VNSNY CHOICE	Visiting Nurse Service of New York	New York City

[1] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Ostego, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St Lawrence, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Wyoming Counties.

[2] Beth Israel Medical Center, Bronx-Lebanon Hospital Center, The Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Hospital, New York City Health and Hospitals Corporation, New York Downtown Hospital, North Shore – LIJ Health System, the NuHealth System, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Hospital, and SUNY Downstate Medical Center