WHITE PAPER AND FISCAL ANALYSIS

The following whitepaper and fiscal analysis have been developed to detail the policy and fiscal impact relating to S.7800 (Rivera)/A.8470 (Paulin), legislation that would repeal and replace the State's Managed Long-Term Care (MLTC) Program with "managed" Fee-for-Service (FFS) home care.

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I. Executive Summary

- **The Managed Long-Term Care ("MLTC") partial capitation program is popular among consumers and delivers high quality care.**
    - 90% of enrollees rate their plan as good or excellent.
    - The 2023 AARP Long Term Services and Supports Scorecard ranks New York 6th in performance across all states.

- **The MLTC program has effectively controlled the growth of Medicaid spending.** While overall spending has increased, the annual cost for MLTC has risen by less than 7% (in total) on a per member basis despite:
    1) Increased acuity (service needs) of aging population and transition of nursing home population to MLTC,
    2) Increased utilization of Consumer Directed Personal Assistance Services (CDPAS), and
    3) Historic minimum wage increases in 2016, 2022, and 2023 and other worker recruitment investments driving costs across MLTC and Fee-For-Service (FFS).

- **MLTC ensures appropriate and efficient care management across a comprehensive set of Medicaid and Medicare benefits.**
    - Proposed care coordination entities (CCEs) that would replace MLTCs are untested or do not exist.
    - The health home model of care management that could replace MLTCs as CCEs is expensive and lacks consumer support.

- **MLTC generates significant revenue, <u>including $1 billion per year in federal support for home care workers</u>, that cannot be replaced under a FFS model.**
    - Premium tax revenue ($129 million).
    - Federal participation in direct Wage Parity costs ($854 million).
    - Federal participation in the QIVAPP program ($79 million).

- **MLTC is key to the State's managed care strategy across all major Medicaid and LTC populations, including more robust and integrated care for dual eligibles.**

- **MLTC offers DOH the ability to achieve savings through programmatic flexibility that is unavailable under a FFS model.**
    - Various policies and Executive Budget actions have increased MLTC requirements while reducing MLTC and overall Medicaid expenditures, which would be impossible to achieve under a FFS model, including:
        - Increasing the medical loss ratio (MLR) from 86% to 89%.

- Developing MLTC rates at the low end of the range of actuarially soundness as determined by DOH's third party actuary.
- Mandating plan consolidation, and other cost savings measures.

- **Repealing the MLTC Partial Capitation Program and returning to FFS would cost the State conservatively between <u>$3.07 to $4.67 billion annually</u>.**

    - Savings proposed by advocates of S.7800/A.8470 are illusory, based on incomplete or erroneous data and assumptions, and will not accrue.

Additional Costs of Repealing MLTC	**Est. Fiscal**
County Administration	$50M
Direct Care Management Expenses	$1,096M
Lack of FFS Cost Containment	$700M – $2.24B
Loss of premium tax revenue	$129M
Loss of FFP for Wage Parity	$854M
Loss of DOH population management control across managed care product lines	$60M – $120M
Recent MLTC Budget Actions	$186M
Total	**$3.07B to $4.67B**

II. Background

New York State oversees a number of Managed Long Term Care (MLTC) products lines serving Medicaid members who demonstrate a need for long term care services, including the MLTC Partial Capitation program, Medicaid Advantage Plus (MAP), and the Program for All-Inclusive Care for the Elderly (PACE). Of these, the MLTC Partial Capitation program is the most popular, with a current enrollment of nearly 300,000 members statewide.

MLTC Partial Capitation plans provide long term care services (e.g., home health care, adult day care, and short-term nursing home care) as well as ancillary health and ambulatory services (e.g., dentistry, optometry, eyeglasses, medical equipment) for eligible members that require more than 120 days of community based long term care services (CBLTCS). These plans, which receive a premium payment from the State for included Medicaid benefit package services, are available to both dual-eligible individuals (i.e., persons in receipt of both Medicare and Medicaid) and non-duals who are at least 18 years old. Such plans are also responsible for members' care coordination across a comprehensive set of benefits, including services provided through FFS Medicaid, Medicare (FFS or Medicare Advantage), and other programs. Members continue to use FFS Medicaid or Medicare coverage for primary care, hospital, behavioral health, and certain other services.

On August 31, 2012, The Department of Health (DOH) received written approval from the Centers for Medicare and Medicaid Services (CMS) under the State's 1115 Demonstration waiver to move forward with mandatory enrollment into MLTC plans for all dual-eligible individuals aged 21 or older and in need of CBLTCS for more than 120 days.[1]

The adoption of mandatory enrollment was not without context. For decades, State and Local governments and regulators grappled with ways to provide New York's generous home care benefit while managing its costs. In the early 1990s, reacting to court decisions that overturned certain Medicaid authorization policies for home health services, the State passed a series of laws intended to curb home health care costs.[2] Under these laws, the State and local districts were directed to implement standardized assessment processes to determine need and cost-effectiveness of home care services in comparison to institutional care, and to authorize service accordingly. For a variety of reasons, these efforts were never fully adopted. But understanding this history reveals that the pressure to contain home care costs is not new to Managed Care or foreign to FFS.

The advocates' proposal (as embodied in S.7800/A.8470) to return to a FFS model for home care delivery does not address these pressures, and would instead be extremely damaging to both the quality and fiscal soundness of the State's long term care program.

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[1] https://www.health.ny.gov/health_care/managed_care/mltc/aboutmltc.htm

[2] Section 22 of Chapter 165 of the Laws of 1991; Section 165 of Chapter 41 and Sections 68 and 70 of Chapter 42 of the laws of 1992; Section 41 of Chapter 59 of the Laws of 1993 (adding and amending SSL 367-j and 367-o [REPEALED]).

A. Moving to Mandatory MLTC

In 2011, prior to the implementation of the State's mandatory managed care program, DOH reported that approximately 34,000 Medicaid members were enrolled across 16 MLTC plans (including the Partial Cap and PACE product lines). At the time, the State was spending approximately $36,039 per recipient per year for MLTC and $38,839 for all long-term care recipients.[3] The decision to embark on mandatory MLTC was data driven. In the preceding period from 2003-2009 spending per recipient for MLTC had declined by 0.3% as comparted to overall LTC spending per recipient, which had increased by 26%. Additionally, data indicated that Managed Care models produced improved outcomes for the populations served. Managed care plans exceeded national HEDIS benchmarks on 44 of 46 quality measures, and performance had improved over time in virtually all quality measures.[4]

The State understood that it was facing a demographic shift, and as its population aged, many more people would begin to utilize LTC services. Given the comparative ability of MLTC to contain costs of these services while improving quality, the State reached the decision in the form of Medicaid Redesign Team Initiative #90 to move to a managed care model for the LTC population. Doing so would allow the State to manage the increasing costs of these benefits while its population aged into them.

Today, there are now more than 280,000 Medicaid members enrolled in MLTC Partial plans,[5] with more than 330,000 across all MLTC products.

Despite the considerable growth in the population it serves, and the transition of thousands of nursing home residents into MLTC increasing the average acuity of members (from 16.6 in 2014[6] to 18.44 in 2022[7]), the annual cost for MLTC has risen less than 7% (in total) on a per member basis since 2009.[8] During the same period of time, utilization of the Consumer Director Personal Assistance Program (CDPAP) has increased exponentially, and the minimum wage for home care workers has effectively doubled.[9] Without the efficiencies realized through the MLTC program, the effects of these cost pressures would likely be much greater. Had costs for this population continued to rise at the rates experienced for other LTC sectors, the State may have faced considerably more difficult policy decisions over the last decade.

These figures demonstrate the fiscal success MLTC has had in bending the cost curve of providing CBLTCS to the State's aging and disabled population, while simultaneously allowing

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[3] https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-01-13_redesign_team_presentation.pdf (DOH calculated using approx. $1.2B total state spending divided by 33,826 plan enrollees) pg 38 of report

[4] https://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-02-09_redesign_team_presentation.pdf

[5] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[6] https://www.leadingageny.org/linkservid/760F2CD5-AB85-8AB3-2B0705BF4C774418/showMeta/0/

[7] https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2022.pdf

[8] Based on a comparison of the blended rates for MLTC partial capitation rate for FY 23-24 compared to annual MLTC per member costs reported by DOH for 2009 and accounting for changes for the CPI-U medical care services major expenditure category published by the U.S. Bureau of Labor Statistics using unadjusted December annual comparisons published from December 2010 through December 2023 (available at https://www.bls.gov/bls/news-release/cpi.htm).

[9] Chapter 54 of the Laws of 2016, Chapter 56 of the laws of 2022, and Chapter 56 of the Laws of 2023.

the State to invest in its workforce by enacting historic minimum wage increases **three times**, in 2016, 2022 and again in 2023.[10] Without the MLTC program, it is questionable whether recent minimum wage increases could have been afforded purely with state general fund resources.

B. Program Quality and Consumer Support

The MLTC program is not simply a fiscal success story. The program maintains strong consumer support and rates well as compared to other state's program.

MLTC plans are measured on multiple quality measures each year, with data made publicly available. In DOH's 2022 Managed Long-Term Care Report, the most recent available, MLTC plans received high marks in keeping members healthy. This included high flu (75%) and pneumococcal (76%) vaccination rates and preventing injuries due to falls (91%).[11] Additionally, from 2019 to 2021, the share of enrollees receiving care at home rose from 88.6% to 96%, helping members avoid nursing home placement.[12] **In the same survey, 90% percent of respondents rated their health plan as good or excellent and 86% rated the helpfulness of the plan in managing their illnesses as good or excellent.[13]**

The State's survey aligns with AARP's comprehensive 2023 Long Term Services and Supports (LTSS) Scorecard, which ranks New York 6th in the Nation in LTSS performance, and the top performer when comparted to other large population states.[14]

Key to these high scores, is the fact that MLTC plans provide more than just personal care or consumer directed care. Through coordinated and tailored care management, MLTC plans assist in coordinating a comprehensive range of services and supports to meet the unique needs of each member, helping to keep vulnerable individuals healthy and living in their communities. This includes linking enrollees with services and supports outside of the MLTC benefit package, through comprehensive care management of the enrollee's entire needs.

Enrollees have trusted – and often longstanding – relationships with their MLTC care managers. These relationships have formed over the last decade or more, as MLTC Plans made significant investments to ensure members receive the care they need, while boosting the quality of care provided. The proposed legislation would eliminate those investments and infrastructure, and massively disrupt the relationships formed between enrollees and MLTC care managers.

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[10] Id.

[11] https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2022.pdf

[12] mltc_satisfaction_survey_summary_report_2021.pdf (ny.gov) (available at https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_satisfaction_survey_summary_report_2021.pdf)

[13] https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2022.pdf

[14] https://ltsschoices.aarp.org/sites/default/files/documents/doi/ltss-scorecard-2023-innovation-and-opportunity.doi.10.26419-2Fppi.00203.001.pdf

III. The Proposed Legislation (S.7800/A.8470)

A. Repealing and Replacing New York's Managed Long Term Care Program

The proposed legislation (S.7800/A.8470) repeals Section 4403-f of the Public Health Law, eliminating the State's MLTC Partial Capitation Program, which coordinates a comprehensive set of Medicaid and Medicare benefits for nearly 300,000 members. In its place, members would be required to receive services through a FFS model with services coordinated through a care coordination entity (CCE), which may be a health home.[15]

The proposed legislation fails to confront the reality of the scope of benefits and the cost trends discussed above. It also ignores the fact that, for decades, the county-administered FFS program has included payment for case management activities intended to manage the provision of home care services and promote linkages with other programs and services.[16] FFS case management has never demonstrated success in coordinating care across health, social, and community care systems for individuals in need of CBLTCS.[17] While care management is far from a new concept, the proposal relies on a system whereby the State historically has been unable to develop an efficient and effective care management system outside of managed care or niche waiver programs.

B. Health Homes are Not a Viable Care Management Alternative to MLTC.

As an example, the legislation would allow health homes to be a CCE that would manage care for the MLTC population. However, despite being implemented around the same time as mandatory MLTC, the State's Health Home program has significantly underperformed expectations. Health homes programs in multiple states have lagged behind other models of care management in both efficiency and effectiveness.

In New York, less than half of those eligible to enroll in a Health Home have done so, citing the cumbersomeness of having to work with yet another organization (or multiple interconnected organizations) in addition to their plan and provider. This decentralized approach inhibits effective care management and has resulted in Health Home reimbursement rates that are significantly higher than the care management costs experienced under MLTC for populations with similar acuity levels.[18]

The FY 24 budget acknowledged these issues, reducing funding to the program by $30 million. Despite last year's initiative, the Executive continues to grapple with the program's issues, seeking major restructuring and cuts, with an associated savings of $125 million. Given its current challenges and proposed downsizing, it is unrealistic to suggest that the health home program could handle managing care for nearly 300,000 vulnerable MLTC enrollees.

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[15] Or through a MAP or PACE plan. However, these products are only available to enrollees who require a nursing home level of care, which is a higher eligibility threshold than applies to the current MLTC Partial Capitation program.

[16] 18 NYCRR 505.14(c)

[17] See 10 NYCRR 763.6 and 766.3

[18] Health Home rate codes indicate significantly higher costs as compared to care management plan costs reported to DOH. See https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

C. The Advocates' Fiscal Analysis is Flawed.

Proponents of this legislation have suggested that it would yield savings of between $29.8 billion and $35.3 billion over a 10-year period. The savings are derived entirely from the elimination of the administrative portion of the MLTC premium, which the proponents erroneously believe is unnecessary for care management and other managed care services. For several reasons, this is not a credible assessment of savings.

First, since a plans administrative fee includes any potential margin, the proponents "double count" any potential savings by indicating savings from both the elimination of administrative costs and, separately, margin. Moreover, the proponents' projections use misleading data to misrepresent the reality of MLTC plan profit margins. Specifically, during the COVID pandemic, state and federal rules required that MLTC plans maintain membership by prohibiting plans from disenrolling individuals who were not using services.[19] This requirement artificially inflated profits to 5.5%. However, the State recouped the vast majority of these funds through its Medical Loss Ratio (MLR) policy, which places a cap on total "administrative" payments from which plans may derive any margin. Additionally, anticipating the effects of reduced utilization due to COVID, the State reduced MLTC premiums by 3.5% in January of 2021, retroactive to April 1, 2020, to include the entire fiscal year. The reduction was for the entire premium – medical, pharmacy, and administrative costs – which the proponent's fiscal analysis also fails to reflect.

In reality, plan margins were approximately 1% for this period, eliminating almost all of the "savings" identified by advocates.

The advocates' methodology also fails to consider how DOH utilizes MLTC plans to control long-term care spending and set actuarily sound rates. MLTC plans are partially capitated; however, that term is misleading. Medicaid MLTCs are partially capitated plans, primarily because these plans do not include any Medicare-covered services.[20] And although MLTC plans do not cover every service under Medicaid, the plans are responsible for several services critical to the health of the MLTC population, including all types of home and community-based care, short-term nursing home care, adult day care, medical transportation, podiatry, audiology, optometry, and dentistry.

The services excluded from MLTC coverage are almost exclusively utilized by discrete populations such as alcohol and substance use services, chronic renal dialysis, or family planning services.[21] Other services not covered under MLTC are covered by other programs and benefits such as Medicaid Fee-For-Service or Medicare (examples include, inpatient hospital services, outpatient hospital services and lab work).

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[19] See MLTC Partial Capitation model contract, Art. V Section P.7.b.ii.A, requiring maintenance of enrollment except in cases on death, residing out of state, or in accordance with DOH direction (available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2023/docs/part_cap_model.pdf), implementing Section 6008 for the Family First Corona Virus Response Act (FFCRA) and subsequent federal legislation.

[20] http://health.wnylc.com/health/glossary/?let=M

[21] https://www.health.ny.gov/health_care/managed_care/mltc/mltc_overview.htm

Partial capitation allows DOH to control aggregate spending by setting plan premiums. The setting of plan premiums must be actuarially sound pursuant to CMS rules; there is, however, a significant amount of flexibility in determining these rates. MLTC rates are subject to what is known as a "rate range" which set a high end and a low end of actuarially sound rates. DOH consistently sets such rates at the low end of the range, putting downward pressure on premiums. DOH is thus able to control costs through its rate setting function and push spending trends in a negative direction. As discussed infra, the flexibility that MLTC plans has afforded DOH has been the primary focal point of cost containment for these services, as personal care services, wage enhancements and CDPAS utilization have each contributed to the dramatic increase in costs over the last several years.

Finally, the bill's proponents fail to acknowledge a realistic analysis for the replacement cost for providing care management and program oversight through this new class of CCEs. Ensuring quality and providing care management for 300,000 high-needs individuals is a labor-intensive activity. The suggestion that this could be done effectively through Health Homes and State and County government **at less than 30 percent** of what plans currently receive to perform all required administrative and oversight functions is simply not credible.

IV. A Realistic Fiscal Analysis of S.7800/A.8470

A. Direct Fiscal Impacts

1. County Administration

To operationalize the proposal, the State would likely need to augment the existing administrative structure of local districts, which have continued to administer home care benefits for populations excluded or exempt. However, local district capabilities and resources have been significantly degraded or diverted over the past 20 years. This "leaning" of local district administrative capabilities was the intended policy outcome of the State's takeover of Medicaid administration and the transition to managed care. It was also justified by the statutory cap on local expenditures, which limits County exposure to Medicaid costs.[22]

In order to reimplement a full scale FFS program, the State would need to rethink the past 20-years of fiscal and administrative policy for this high-cost population and ensure that additional administrative resources were appropriately directed to managing the program.

To reestablish programmatic capabilities and capacity, local districts would have to appropriately staff up to manage the increased home care administration responsibilities, including contracting with providers, utilization review, and overall program management and oversight.

Previously, some of the administration could be contracted out to local providers, which helped to defray state and local costs while ensuring professional expertise. However, modern conflict of interest requirements, will make outsourcing oversight and administration difficult in many regions across the state. Most of the re-established administrative capacity, therefore, would likely require significant additional county or state staff.

Although county needs could vary considerably based on the size and current capacity, a reasonable average estimate of county staffing needs across all 62 counties would include the following:

- On-staff **medical directors** and/or additional professional staff (e.g., **nurses**) to perform initial and periodic utilization review and authorization (1-2).
- Additional **attorney and legal/compliance staff** to manage provider contracting, regulatory compliance, fair hearings, and litigation response (1-2)
- **Additional program staff** to handle general program operations and program integrity responsibilities (1-3).

Assuming an average of four (4) staff per county and $200,000 of salary and benefits impact, county staffing requirements could increase State and Local liabilities by around $50M/year.

2. Direct Care Management Expenses

[22] See page 83 of FY 24 Health Care Briefing Book, comparing the true local costs of Medicaid administration as compared to the local cap (available at https://www.budget.ny.gov/pubs/archive/fy24/ex/book/healthcare.pdf)

Health Home administrative costs are nearly twice those paid to MLTCs. The Health Home Plus (HH+) model, which is tasked with coordinating care and assuring access to services for high need adults with serious behavioral health and substance use challenges, and is most comparable to the model envisioned in the FFS proposal, receives a significantly higher rate compared to MLTC plans.

For example, the HH+ rates range between $790.50 PMPM (Upstate) and $843.20 PMPM (Downstate), which compares to $398.60 PMPM and $434.83 PMPM for MLTC plans, respectively.

MLTC Partial Capitation per member per month (PMPM)				
FY23-24	NYC Area	Mid-Hudson /Northern Metro	Northeast/Western NY	Rest of State
Administrative Expenses Care Management – Community	$200.22 $226.26	$269.32 $165.51	$226.10 $185.03	$230.49 $168.11
Total	$426.48	$434.83	$411.13	$398.60
Health Home Plus/Care Management per member per month (PMPM)				
FY23-24	Upstate: $790.50		Downstate: $843.20	

Whether DOH would use health homes or other entities, these new CCEs would have to be appropriately staffed with case managers. DOH has indicated that Health Home rates include staffing ratio assumptions that vary depending on the complexity of the case. Specifically, DOH's Health Home rate build assumes care management to patient ratios of 1:12, 1:20, and 1:40 for high, medium and low acuity cases, respectively. Also included in the assumptions is a recommended case manager to supervisor ratio of 5 to 1.[23]

Even using DOH's lower acuity staffing assumption of 1:40 and an average of $100k/year[24] for salary and benefits, CCE direct costs for care managers and overhead could easily reach well above $1billion/year. This does not account for additional responsibilities CCEs might be tasked with relating to program performance and oversight, however it is likely DOH would rely heavily on CCEs for functions currently delegated to MLTC plans for various program purposes, such as staffing for Special Investigative Units and other program integrity functions.

Est. Avg. Population Served (2026)	CM to enrollee ratio	Supervisor & admin staff to CM ratio	Average Salary + Benefits (2026)	Admin/ Overhead	Est. CCE Direct Costs per Year
325000	40	5	$100,000	12.5%	$1,096,875,000.00

[23] HH Standards and Requirements for HHs, CMAs, and MCOs (ny.gov) (see p. 21)
[24] Salary: Care Manager in New York City, NY (Dec, 2023) (ziprecruiter.com); Care manager salary in New York, NY (indeed.com); Employer Costs for Employee Compensation - September 2023 (bls.gov)

3. Lack of cost containment in FFS

Prior to the shift to managed care, counties were responsible for a portion of all Medicaid costs incurred by recipients in the county. This resulted in service authorization and program policies that reflected the individual cost consciousness of each County. However, beginning in 2005, local district contributions were capped, and could not rise faster than provided in law.[25] In 2012, the Legislature amended the law further, fully capping county expenditures at their 2014 level. As a result, Counties have no incentive to manage any additional spending above their cap level, which they have hit consistently every year since the cap was instituted.

In 2015, the state's third-party actuary estimated that, based on the plans ability to effectively manage the care, the all-in aggregate impact of moving from FFS to MLTC would mean a reduction of about 33% of costs on a PMPM basis.[26] This savings estimate was incorporated into MLTC plan premiums, and continues today. These were built in savings derived from the cost of these services under FFS. While the magnitude of these savings could be debated, some level of increased service authorization must be anticipated in moving back to FFS, especially considering the counties' current lack of cost exposure and the inclusion of these savings in current MLTC rates. The advocate's FFS proposal, however, does not contemplate the loss of these embedded savings.

Assuming annual spending on personal care and CDPAS services at around $14 billion for FY 2024, if there is only a 5% increase in FFS utilization (as opposed to the 33% built into the MLTC premiums), an additional $700 million/year cost increase to Medicaid would be incurred. Similarly, if *half* of the 33% that the State actuary previously estimated in MLTC premiums is assumed as additional utilization (approx. 16%), the resulting cost increase would be approximately $2.24 billion/year.

B. Revenue Generated through MLTC that Would Fail to Materialize Under a FFS Model.

In addition to the utilization costs outlined above, the proponents' fiscal projections also fail to contemplate the various revenue sources that are incorporated into MLTC plan premiums; revenue sources that would otherwise be unavailable to the State under the contemplated FFS model.

1. Loss of Premium Tax Revenue

New York Tax Law section 1502-a requires health insurers to pay a tax on all "gross direct premiums . . . written on risks located or resident in this state." Insurance Law section 1510 provides that premiums include "all amounts received as consideration for insurance contracts or reinsurance contracts or contracts with health maintenance organizations for health services, other than for annuity contracts, and shall include premium deposits, assessments, policy fees, membership fees, any separate costs assessed upon their policy holders, and every other compensation for such contract."

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[25] Part C of Chapter 58 of the Laws of 2005.
[26] See FY16 MLTC Actuarial Memorandum

The imposition of premium taxes on Medicaid Managed Care organizations are part of a taxing mechanism known as "provider taxes". Provider taxes are utilized by the state to increase federal financial participation. Specifically, New York imposes a 1.75% premium tax on MLTC plans. The state includes the state share of the cost of the premium tax in MLTC plan premiums. The state includes the state share of the 1.75% premium tax from the general fund and claims the federal share (at 50% federal financial participation), match in plan premiums. By drawing down the federal share and including payments in plan premiums, the state incurs additional revenue when the plan pays its premium tax liability. The net gain to the state is .875% of the premium tax (i.e. the 50% federal share of the 1.75% premium tax).

Based on SFY 2019 - 2020 MC MLR Summary Managed Long-Term Care (MLTC) data, total MLTC premium was $14,758,237,406. **New York's net gain on the premium tax from the federal government at .875% was $129,134,577.** The discontinuation of MLTC plans would eliminate the benefit of these provider taxes paid by the federal government to the state.

2. Loss of FFP for Wage Parity

Federal Financial Participation (FFP) is not available to fund the wage parity portion of PCS or CDPAS rates under FFS.

In 2011, the State codified in law (PHL § 3614-c) payment protections for home care workers in New York City, Nassau, Suffolk, and Westchester that were negotiated between various unions and home care agencies. These additional rates of payment, which have been periodically updated throughout the years, must be included in the State's payments to the agencies, and passed through to workers.

As part of the federal approval process, CMS refused to provide reimbursement for a wage parity rate add-on to the FFS rate, ostensibly because it was not related to a necessary cost for such services (i.e., it only applied to the payment of Medicaid services, not private or third-party pay home care services). Today, there continues to be no State Plan Amendment that would allow for federal reimbursement of these costs through FFS.

Fortunately, these labor costs are accounted for in network provider rates negotiated between MLTC plans and providers. As a result, the costs for wage parity are included in MLTC Plan MMCOR reports to DOH, which DOH and its actuary use to develop actuarially sound capitation rates. CMS does not require DOH to remove or discount any amount for wage parity in the process, as doing so would be antithetical to the managed care rate development process. As such, the rates that CMS ultimately approves includes amounts for wage parity, allowing the State to draw down FFP for wage parity costs through the approved MLTC rates.

Moving the nearly 250,000 enrollees in New York City, Nassau, Suffolk, and Westchester to FFS would deprive the State of this significant source of FFP, **calculated to be $854 million for FY 2024.**

	Wage Parity Amount for 2024 (PHL § 3614-c)	Fringe (DOH Actuary figure for NYC Metro)	Fed Share (50% + 6% CFCO)	Estimated Hourly Federal Share for WP	Enrollee Count (DOH Nov 23 Enroll Report)	Enroll. Growth Factor	Avg Hours per year (2023 MMCOR data; NYC Metro)	FFS Auth Increase (2015 State Actuary Assumption x 1/2)	Estimated Annual Fiscal Impact (in 2024)
NYC	$ 2.54	17.46%	56%	$ 1.67	222160	5%	1757	16%	$ 794,322,119.76
NSW	$ 1.67	17.46%	56%	$ 1.10	25592	5%	1757	16%	$ 60,161,377.49
								Total:	**$ 854,483,497.25**

C. The MLTC Program Gives DOH Unparalleled Programmatic and Fiscal Flexibility as Demonstrated by Policy and Executive Budget Actions.

1. Population Management Across Managed Care Product Lines

Many enrollees in MLTC Partial plans meet the basic eligibility and enrollment criteria for other managed care products, including Mainstream, MAP, and PACE. DOH's enrollment and coverage policies have been carefully tuned over the course of more than a decade to ensure that enrollees receive the appropriate access to services and care management to meet their needs. Eliminating MLTC Partial Capitation from the portfolio of plan options will fundamentally upset this carefully tuned balance and would cause a misalignment between the state's fiscal obligations and the care that members receive.

For example, MLTC Partial plans are approved under the 1115 waiver to offer certain "additional" services that are not available through FFS or other non-dual managed care products: home delivered meals, social day care, and social and environmental supports. These services are low-cost alternatives that help meet enrollees social and functional needs and would not otherwise be available to this population. The services also perform an important fiscal gatekeeping function. Mainstream enrollees that want to transfer to MLTC must show that they meet MLTC criteria **and** need one of these "additional" services.[27] As a result, the state lowers its costs by lowering its exposure to higher MLTC premiums.

Under the advocates' proposal, this population would be required to receive services through FFS and the local district/CCE, which will result in a State fiscal impact relative to the Mainstream premium, as these individuals would transition to receive all Medicaid services (including CBLTCS) through FFS.

Assuming even a small population of 5000 individuals across Mainstream managed care, and a relative PMPM increase range of $1000 to $2000, the estimated fiscal impact range would be $60 million to $120 million annually.

[27] See MLTC Policy 14.01 (ny.gov).

2. MLTC Program Flexibility Provides The State with Annual Budget saving Opportunities Without Targeting Core Services.

The efficiency of MLTC as a tool to both improve the member experience and control costs is demonstrated by the various Executive Budget actions taken by DOH since mandatory enrollment was fully implemented in 2014. The most recent Enacted Budget is an example of the manner in which DOH can alter the size and scope of the program, draw savings from reductions in plan administration and premiums, while simultaneously requiring higher performance standards of the MLTC plans.

The FY2023-2024 Enacted Budget included major cost-savings initiatives that could not be implemented in a FFS setting, as well as an investment that went to support wage parity- a program that can only exist in a managed care setting. In FY23-24, DOH:

- Mandated that MLTC plans increase their medical loss ratio (MLR) from 86% to 89%, which led to an estimated state share savings of $55 million, and
- Reformed MLTC performance standards as follows, which led to $52M in estimated state share savings and increased plan requirements:
    - Plans must have a DSNP 3 STARs or higher
    - Plans must not be categorized as a 'poor performer' by CMS or have an excessive volume of NYS penalties or Statements of Deficiency
    - Plans must ensure appropriate network adequacy and demonstrate readiness implement upcoming CMS rules and regulations
    - Plans must demonstrate commitment to quality improvement
    - Plans must demonstrate accessibility and geographic distribution of providers, considering the needs of persons with disabilities and the rural, suburban, urban settings
    - Plans must demonstrate cultural and language competency specific to the population of participants
    - Plans must demonstrate the ability to serve enrollees across the continuum of care
    - Plans must demonstrate VBP readiness and experience.[28]

As explained by DOH, the state savings from MLTC reforms accrue from reductions in the administrative portion of the MLTC premium. These Budget actions put the onus on the plans to deliver better services at lower costs; a paradigm that eluded the State and local governments during the many decades they administered the benefit locally through a FFS model.

Further, the FY23-24 Budget actions invested $158 million across two years in QIVAPP support. This program will pay providers directly, provided they utilize the funds in a manner that secures the benefits of the wage parity law. As explained by the Empire Center:

> "This program [QIVAPP] pays extra money to home-care agencies that meet certain criteria – including offering a minimum level of employee health coverage. Most of the agencies receiving this money have collective bargaining agreements with 1199. Those

[28] https://www.health.ny.gov/health_care/medicaid/redesign/2023/docs/fy2024_enacted_budget_briefing.pdf

agencies would be expected to pass along the extra QIVAPP money to their insurance provider – which would mean more revenue for the, which it urgently needs."[29]

Loss of the MLTC program, on which QIVAPP depends for funding, would mean the loss of more than $79 million per year in additional federal financial participation that goes directly to fund worker benefits and could not be replaced through a State Plan amendment.

The FFS program provides fewer mechanisms for seeking savings or implementing policies. In any given year, the State frequently books tens or even hundreds of millions of dollars in savings from the MLTC program. If savings had to be accrued from the FFS program, with fewer policy options at its disposal, it is likely that the State would have to revisit the scope and generosity of its home care benefit, or significantly reduce rates paid to providers on a more frequent basis.

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[29] https://www.empirecenter.org/publications/1199-seiu-advances-a-divisive-change/