March 2022

Medicaid Matters New York

Consumer Interests Must Be Central to Medicaid Managed Care:

Coalition Statement on Budget Proposal for Managed Care Procurement

The 2022-23 Executive Budget includes a proposal that would require managed care organizations (MCO) to go through a procurement process to do business with New York's Medicaid program. The proposal specifies criteria the State would use to select the MCOs, and would set the number of managed care plans to no more than five per region.

Whether procurement of MCOs is implemented, any entity administering a Medicaid product in New York must operate as part of a system that prioritizes patients and better health outcomes, while offering full transparency into how plans operate. Otherwise the system is unlikely to provide the care or management people need.

Any discussion of the managed Medicaid system must begin with a long-overdue examination of the managed care model contract. The model contract is the mechanism by which the State sets minimum requirements for what must be included in contracts between the State and plans. This must be coupled with a meaningful overhaul of State processes and a commitment by the State to invest in oversight of the managed care industry. This all must be done with an eye toward ensuring people are afforded every service to which they are entitled and ensuring true accountability for plans that fail to meet the requirements.

Existing State oversight mechanisms (like complaint lines, for instance), statute, regulations, and stipulations set forth in the model contract are seldom employed to properly monitor the system. The Governor's proposal to increase State agency staffing to allow for better monitoring is important, but vastly insufficient, given the current failures of the State's oversight mechanisms. The State must have the will to adequately oversee a system that has, to this point, failed to meet the needs of all New Yorkers enrolled in managed care, most notably those with complex, long-term needs.

Managed care reforms and oversight are needed regardless of whether this procurement proposal moves forward. Medicaid Matters has an unwavering interest in making sure Medicaid Managed Care in New York centers the interests of people and their access to services. To achieve this, New York must:

- Guarantee adequacy of provider networks to ensure timely access to all services, including specialty care; "adequacy" must be defined by accessibility of providers, as well as cultural competency, including language access and disability competency;

- Improve communications to consumers by involving them in the drafting of outreach materials, like new notices and consumer assistance scripts;

- Provide independent individual advocacy assistance services for all people enrolled in managed care;

- Promote compliance with the *Olmstead* decision, which demands services be provided in the most-integrated setting; collect data on institutionalization, including data that compares institutionalization rates in different racial and ethnic groups, and penalize MCOs with high rates of institutionalization;

- Measure and reward person-centeredness;

- Enhance value-based payment requirements for addressing social determinants of health and require MCOs to contract with non-profit community-based organizations that do not bill Medicaid to provide social services (such as housing supports, peer mentoring, food assistance, etc.) for Medicaid enrollees;

- Set minimum MCO requirements for serving specific populations, such as people who are homeless;

- Require MCO decision-making entities to be located in and familiar with the communities they are serving;

- Apply uniform standards across all MCOs by enforcing the terms of the model contract.

If the State moves forward with procurement, consumers and consumer advocates must have a role in shaping the procurement process. In addition, the State must fund community-based organizations that work in marginalized, historically-underserved communities to engage in education and outreach activities to ensure broad understanding of what will change, how the changes may impact people, and what people should do if they experience loss of services as a result of the changes.

Medicaid Matters has extensive experience in advocacy related to Medicaid Managed Care, ramping up in 2011 when the "Care Management for All" initiative was brought before the Medicaid Redesign Team (MRT) for approval. "Care Management for All" was one of the most consequential initiatives to emerge from the MRT, setting a course for mandatory enrollment of people previously exempt or excluded from managed care. In February 2011, Medicaid Matters published a document of principles titled "Managed Care in Medicaid Redesign," laying out considerations for protecting consumers and improving access to services in the context of Medicaid Managed Care. Much of what we presented in 2011 remains relevant today, as the State has made little progress to protect people enrolled in managed care.

Medicaid Matters stands ready to work with the administration and the Legislature to achieve needed and long-overdue improvements to managed care. Consumer advocates welcome the opportunity and urge our involvement – as well as the involvement of consumers themselves – in making sure Medicaid Managed Care provides for the services and care management people need and deserve.

Medicaid Matters New York

Managed Care in Medicaid Redesign
February 2011

It is clear that the state is interested in moving more populations into mandatory Medicaid managed care and reducing the number of services that are excluded, or carved out, of the managed care benefit package. We support efforts to increase care coordination and integration. However, any proposal to increase care management must include the following critical elements if it is to be successful in improving outcomes and reducing costs, particularly for consumers with multiple, high-cost service needs.

Begin with culturally-competent outreach and engagement

Consumers need to be engaged in understanding care management systems. High auto-enrollment rates in Medicaid managed care are red flags for disengaged, confused consumers who will be unlikely to benefit from the coordination a managed care plan can offer. New York needs to engage in an aggressive patient literacy strategy for outreach and education for all Medicaid populations, particularly those with disabilities, in order to ensure that people have the information they need to be knowledgeable about the programs and services available to them and can select among these options based on quality ratings as well as organizational characteristics. It is crucial that appropriate language access be incorporated into whatever community outreach and engagement activities are carried out in order to best reach people.

Provide comprehensive care coordination teams

Currently, care coordination requirements vary from program to program and across providers and plans. New York should require a team approach to care coordination and require adequate training for care managers in order to prevent gaps in care and inappropriate hospitalization and institutionalizations. At the same time, it should be clear to the consumer and to the team as to who is responsible for the person and who will be responsive to the person's questions and needs overall.

Care coordination teams must be required to monitor consumers transitioning between care settings such as from the hospital or skilled nursing facility to the community, as well as during points of transition such as loss of housing or changes in direct care workers. It is during these transitions that people's health and well-being are most at risk.

Care coordination teams must also be required to coordinate care provided within managed care with services that remain carved out of the managed care contract. It is essential that all managed care staff, especially member services staff, are appropriately trained to understand consumers' right to out-of-network services and provide assistance to accessing those services when their members need it.

Finally, in crafting the definition of care management, it must be appreciated that people with disabilities' needs extend beyond the medical and include transportation, housing, and social services. A comprehensive care coordination team must be familiar with all services necessary to independent living, including peer supports, which are a critical element of a successful team approach for people with disabilities.

Ensure access to medically necessary care, including durable medical equipment and assistive technology

Any model for managing the care of Medicaid beneficiaries must utilize the standard for medically necessary care that is embodied in state law. Unfortunately, not all managed care plans understand that the practices and standards from commercial contracts cannot be the framework for interacting with Medicaid patients. Fair hearings are not an efficient means of addressing inappropriate plan policies and practices. Medicaid enrollees should be allowed to enforce the provisions of the Medicaid program as embodied in the contract between the plans and the state.

Durable medical equipment in particular has been a problem in Medicaid managed care. Consumer advocates report misuse of prior approval requirements and confusion over the appropriate standard for medical necessity. Durable medical equipment and assistive technologies are not only necessary for independent living but also reduce reliance on other costly Medicaid services. In order to ensure access to these critical services under managed care, Medicaid enrollees should be allowed to enforce the provisions of their plan's contract.

Ensure compliance with EPSDT (C/THP)

Children receiving Medicaid services are among the poorest, most vulnerable residents of our state. The state must therefore ensure compliance by health plans with the Early Periodic Screening, Diagnostic, and Treatment program (EPSDT; referred to as the Child/Teen Health Plan in New York). Continually and proactively screening, diagnosing and treating their physical, mental and emotional health issues will have a significant positive impact on cost containment, whether it is the provision of assistive technology, behavioral health management, chronic care, or anything else they need to provide for their health and well-being.

Employ innovative service design to meet the needs of people with chronic medical conditions

The Patient-Centered Medical Home Incentive program and the Health Homes for Medicaid Enrollees with Chronic Conditions initiative offer promise for those with chronic medical conditions. High-cost Medicaid enrollees should be referred to the community-based providers that meet the standards for these programs. Specialty behavioral health homes are encouraged under the ACA and should be developed to ensure that consumers with mental health, substance use and medical conditions get the most personalized and relevant care possible. Such homes embed or offer strong linkages to appropriate health care for consumers with primary behavioral health conditions.

Require meaningful behavioral health care coordination

Individuals with complex mental health, substance abuse and co-morbid medical conditions require specialized methods of outreach, engagement, and recovery and crisis support. Current care models fail to sufficiently engage and provide effective, well coordinated care to this group of "high needs; high cost; at risk" individuals, costing the state millions of dollars in avoidable inpatient care and emergency room visits.

The best way to administer care to this population is to employ a model that includes the elements of coordination and integration mentioned above, appropriate outreach and engagement, care teams that include peer specialists, transition planning and tracking, accessibility, and particular attention to housing and social service needs. One such model that has proven to work well in New York which could be examined is the Special Needs Plans (SNPs) for people living with HIV.

People with more advanced disability-level mental health and substance use conditions require particularly active outreach, engagement and follow up support, along with access to a range of specialized recovery support services. The state must be careful to adopt successful evidence-based models of managed behavioral and health care that can demonstrate improved care engagement and outcomes for these groups. Examples include Pennsylvania's Behavioral Health Choices and the New York Care Coordination programs. These approaches take advantage of innovative new tools such as person centered care, peer support, wellness recovery action plans and other approaches that encourage healthy behaviors.

Further, collaboration with housing agencies to develop permanent integrated housing for unstably housed or homeless people with co-morbid conditions must be part of any effort to reduce Medicaid costs for the homeless population. A good start could be made by establishing a state rental assistance program or a Mitchell-Lama set-aside for homeless people with disabilities.

Managing long term care needs

New York's long term care services are highly fragmented and confusing for consumers. We recognize the need for thoughtful reform to simplify the system and capitalize on opportunities for enhanced federal funding. We offer the following recommendations for reform in long term care.

- **Promote the most-integrated setting for people with disabilities of all ages.** The U.S. Supreme Court in *Olmstead v LC* requires that services be provided to people with disabilities in the most integrated setting—at home and in the community rather than in institutions. This decision has been backed with federal funding for waiver programs and rebalancing dollars. Costly overreliance on institutional care is particularly acute in upstate communities. One in three dollars spent on long-term care is spent on nursing homes outside of New York City, whereas one in four dollars are spent on nursing homes in New York City.

- **Preserve self-management whenever possible**. Many long-term care consumers are capable of managing their own health care decisions. Reliance on an aide for bathing, toileting,

shopping, cleaning and eating does not mean that one is unable to make appropriate self-care choices. Participants should have the option of developing, negotiating, and implementing plans to accept risk for and take control of their activities of daily living, instrumental activities of daily living, and health maintenance activities, such as medicine administration and catheterization.

- **Expand consumer-directed personal care options.** Consumer directed services are cost-effective and should be offered as a first delivery option for all covered individuals. Implement the Community First Choice Option (Pub. L. 111-148 §2401) to provide consumer directed budgeting as a distinct service. Exclude for-profit organizations from providing this function and require regional consumer-controlled non-profit organizations to provide consumer directed services (beyond budgeting).

- **Continue current waiver programs for people with disabilities.** Current waiver programs should be continued while the state considers new delivery systems. It is especially important to maintain programs that foster service coordination by integrating care and services between physical, mental and emotional needs; promote caregiver support and respite; emphasize community integration through the provision of assistive technology, consumer directed services, and transitional care services; and provide these services with a transparency that will allow further recipient input for the management of these services.

Consumer Protections

If the state goes forward with broad expansions of Medicaid managed care, it must include the following contractual obligations for potential vendors:

- User-friendly plan marketing and enrollment brokers
- Consumer and provider education and training to minimize auto-assignment and disruptions in care
- Full, clear disclosure of plan policies and options
- Consumer-friendly comparison of plan-participating provider networks
- Accessible plain language consumer notices
- Provision of language assistance services, including translation of important documents
- Consumer choice and rights protections
- Person-centered planning
- Fiscal incentives for provision of innovative recovery, independent living centered service models
- Extensive use of peer staff and supports
- Responsiveness and sensitivity to special needs and diversity
- Clear and responsive grievance and appeals processes
- Appropriate staffing levels at the Department of Health to monitor quality and compliance
- Consumer rights to enforce health plan contractual obligations