TESTIMONY TO THE HOUSE HEALTH COMMITTEE ON THE WOLF ADMINISTRATION'S PLANS FOR MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS) OR THE 'COMMUNITY HEALTH CHOICES PROGRAM'

By

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NOVEMBER 23, 2015

PHCA

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Advancing quality. Improving lives.

Good morning Chairman Baker, Chairman Fabrizio, distinguished members of the Committee, and guests. I am Russ McDaid, President & Chief Operating Officer for the Pennsylvania Health Care Association or as we're better known, PHCA. I am here today on behalf of the 500 plus members of PHCA, the majority of who provide around the clock care and services for frail seniors in licensed nursing facilities, assisted living residences and personal care homes. We appreciate the opportunity to comment on the Wolf Administration's plans to serve Pennsylvania's seniors and persons living with disabilities through private managed care plans.

PHCA supports the Administration's commitment to a system of long-term services and supports that is person centered, coordinated and focused on preventative services and participant outcomes.

Our mission is a simple but important one—to ensure that those who need long-term care receive quality services in the most appropriate and cost-effective setting at each stage of their life.

The key words in that statement are 'most appropriate' and 'cost-effective'. PHCA is on record in noting that NO ONE who does not need the around the clock skilled care and services provided in a nursing home should be forced to reside in a nursing home merely because other options do not exist. However, when a consumer has multiple chronic health care needs, and the most appropriate setting to assure they get the care and services they need ***IS*** the nursing home, the system should not be stacked against the delivery of that care, whether with artificial barriers, targets of 'reduced utilization' or misplaced financial incentives to keep consumers in the community.

I would like to share our thoughts on the Administration's plans to move Pennsylvania's Medicaid funded long-term care system from one where individual providers are paid on a fee-for-service basis, to one where managed care organizations—usually a subsidiary of a larger insurance company—receive those dollars and are put 'at risk' for the delivery of care. These programs fall under the broad label of managed long-term services and supports (MLTSS).

I would like to start by thanking Secretary Ted Dallas of the Department of Human Services, Secretary Teresa Osborne of the Department of Aging and their senior leadership teams for their willingness to engage in a very open and productive dialogue on the proposed 'Community Health Choices' (CHC) managed Medicaid long-term services and supports program.

Beginning with the initial release of their 'Discussion Document' on June 1, through the 'Concept Paper' issued in mid-September and now the release of the draft request for proposals (RFP) and 'MCO Agreement' for comment one week ago, they have provided multiple opportunities for stakeholders to provide comment, and we thank them for that.

In PHCA's comments to date, we have raised consistent themes around consumer protections, continuity of care, the improvement of true 'health outcomes', provider network continuity and the adequacy of payment rates.

We have highlighted these issues as they have also been the biggest challenges faced in other states as their MLTSS programs have been implemented. In each and every case, there

have been unexpected challenges that states needed to address before the system worked for consumers, providers and in several cases, even the managed care plans themselves.

Our members view themselves in an important partnership with the consumers they serve, their families and the commonwealth. As such, they believe that there is no one size fits all approach and no single proven model that the Department can merely pull 'off the shelf' that will make this program a success.

The 'dual eligible' population—those eligible for both Medicare and Medicaid--is not homogenous. There are the over 65's, the under 65's; nursing home residents and community duals; Pennsylvanians who have been living with a chronic condition or disability for many years, and those who have experienced the acute onset of a condition requiring post-acute care in one of our member facilities or their homes, or long-term care outside their home. Pennsylvania is extremely diverse as well, with each region having its own unique geographic, cultural and health care infrastructure characteristics.

In reviewing the managed care experience nationally, we have found mixed results in the states where managed care has been implemented so far. Some have shown improved outcomes for certain populations, but have ended up costing far more than hoped. Others have shown cost savings, but consumers and providers have expressed concerns about access to care, consumer outcomes, and payments. Most importantly for the constituency that the PHCA membership serves, we have found no definitive studies that have shown improved health outcomes or cost savings under managed care for the frail elderly with chronic long-term care needs.

There are almost 400,000 Pennsylvanians aged 85+ right now, with this group making up the vast majority of the residents our members care for on a daily basis. Their care and service needs are extensive—and costly. The challenges that Pennsylvania's aging population presents are very real. We do not believe that managed care organizations will be able to 'manage away' the chronic and ongoing care needs and costs of caring for our frail elders in need of around the clock care and services.

We also have significant concerns around the issue of outcomes and quality under MLTSS. Based on the documents and presentations by the Administration to date, we fully expect one of the stated program goals to be a lower census in nursing homes. As I noted earlier, if consumers in nursing homes do not need the around the clock skilled care that they provide they should not be there. Providing additional options for those in need of around the clock care and services, such as Assisted Living Residences or Personal Care Homes under Community HealthChoices, in addition to home and community-based services, can help meet the needs of consumers who don't need skilled nursing in a lower cost, less care intensive setting.

Unfortunately, experience nationally has shown us that the reduction in use of nursing homes is often achieved by forced diversion to only home and community-based services, with the MCO's given nursing facility utilization reduction targets by states as an 'outcome measure' to achieve. A number of states even put a price tag on this measure, rewarding plans financially if they get consumers out of the facility and into the community.

I want to be very clear on this point—serving fewer people in nursing facilities isn't a measure of good quality or a positive 'outcome' in and of itself. If a managed care organization is able to successfully transition a consumer from a nursing facility to a lower cost setting in the community, and the consumer's care needs can still be met in that setting, they have done right by the consumer and have benefitted financially.

However, when fewer facility days is used as a target for managed care organizations with a price tag attached to it, it ***ISN'T*** good for consumers, serving to limit rather than broaden consumer choice. And, most importantly, it has the potential to place those consumers in risky community placements where they do not receive around the clock supervision or care—leading to a true bad outcome for the consumers, and higher costs to the LTSS system.

A 2014 story from the New York Times[1] shows the potential danger that forcing consumers from around the clock, skilled nursing settings can pose to consumers. This story chronicled the experience of one 75 year old man with debilitating arthritis, lung disease, newly blinded and with growing dementia. He was first forced from a nursing facility to inadequate services in the community, and then denied continuation of even those services. The report focuses on Tennessee, New York and Minnesota. All have been touted as states that have been successful in shifting to managed long-term care services. All have also experienced serious quality, coordination and outcome problems, as illustrated in the article.

The lesson here is that, in the aggregate numbers collected on managed care 'outcomes' in those states, this gentleman was likely shown as a program 'success' due to his placement in the community. In reality, he was failed by the very system that was designed to care for him.

We do not want this story to repeat itself here in Pennsylvania, and we know that both the Department and prospective managed care plans feel the same way. Our conversations with both have been extremely productive and indicative of their commitment to implementing the program in a manner that is responsive to the needs of consumers, and the individuals or organizations providing their care. In spite of those promising discussions, there are still many unanswered questions, and as I noted early, every state has unique challenges when implementing managed long-term care. This brings me to my closing comments.

PHCA continues to believe that the issues the Administration is attempting to fix with the implementation of managed care could be addressed under the existing fee-for-service system by leveling the playing field for HCBS consumers and providers, instituting the same rules around Medicaid financial eligibility, care plan development, service delivery and payment for HCBS as exist for nursing home care.

However, if the Administration continues to move forward with CHC, it is PHCA's strong belief that the Department's plan to procure all three planned phases of the program with a single initial RFP document issued in the next 90 days is misguided.

[1] New York Times, March 6, 2014, Bernstein, Nina. http://www.nytimes.com/2014/03/07/nyregion/pitfalls-seen-in-tennessees-turn-to-privately-run-long-term-care.html?_r=0

Just as in other states, there will be challenges during the implementation of this program. PHCA continues to believe that the commonwealth will be in the best position to make revisions to the program based on the lessons learned through the issuance of an initial RFP for 'Phase I', then subsequent RFPs for Phases II, and III.

We also believe that the Department's current roll out schedule for the program, with Phase I (Pittsburgh/surrounding counties) beginning in January 2017, Phase II (Philadelphia/surrounding counties) in January 2018, and the remainder of the state or Phase III in January 2019 is extremely aggressive, and does not allow adequate time between the implementation of each phase to make any program modifications that may be necessary and in the best interest of consumers and those providing their care and services.

I want to thank you again for the opportunity to comment. PHCA is committed to working with the Legislature, Administration, consumers, prospective Community Health Choices managed care plans, and other stakeholder groups to optimize the program for consumers and those who provide their care as the planning phase moves forward.