



**TESTIMONY TO THE DEPARTMENT OF HUMAN SERVICES ON
THE WOLF ADMINISTRATION'S PLANS FOR MANAGED LONG-
TERM SERVICES AND SUPPORTS (MLTSS)**

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PRESIDENT & COO**

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Good morning Secretary Dallas, Deputy Secretary Burnett, and distinguished 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 450 plus members of PHCA, the majority of who provide round 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. Our mission is a simple 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 round the clock skilled care and services provided in a nursing home should be there. 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 with artificial barriers or financial incentives to keep consumers in the community.

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. However, we have serious concerns regarding the timing and approach outlined in the Discussion Document.

In short, **the Administration's plan is too broad, the timeframe is too aggressive, and the desired outcomes are too uncertain.**

Plan is Too Broad

The Administration has referenced the recommendations of the Governor's 'Long-Term Care Commission', noting that the MLTSS plan in front of us for comment is consistent with those recommendations. As one of the 'Advisors' to the previous Governor's Commission that developed the MLTSS recommendation, I think it is important to note that while the Commission recommended that the Administration explore MLTSS, it did so by specifically suggesting that several different models be tested and proven effective before the decision is made to expand the program statewide.

This recommendation was intentional, and was made to ensure that we have Pennsylvania specific data to evaluate which model is most effective in ensuring the best outcomes for consumers and optimal cost effectiveness for the Commonwealth. It would also allow the Administration to assess whether any segments of Pennsylvania's population would be better served in an alternative model, or even held out of MLTSS altogether if the evaluation didn't show enough benefit.

PHCA recommends that the Administration focus their efforts on the Duals population, as the vast majority of the savings which can be achieved while caring for frail elders with chronic need for long-term services and supports are on the Medicare side of the ledger. There is little

data to support cost savings related to stand alone Medicaid LTSS programs, with Indiana serving as one example which I have included for your review.

Indiana's ABD Taskforce report to the General Assembly in 2013 determined that MLTSS would actually have a negative impact on cost, due at least in part to increased state administrative costs associated with implementation of MLTSS. While many states are moving their LTSS populations into a managed care arrangement, most are doing so under a Duals financial alignment project with CMS which allows the shared savings to occur, primarily through reduced hospital costs on the Medicare side.

Timeframe is too Aggressive

If the Commonwealth is going to consider entering the MLTSS arena beyond the limited experience and population we have covered to date, we must learn from the mistakes made in other states and take a more incremental approach.

The initial comment period of roughly 45 days is insufficient to allow for adequate input from consumers, providers, the prospective managed care plans, and other key stakeholders in the process. We believe that the stated goal of issuing an RFP for all three (3) proposed implementation phases of the program is also too aggressive. PHCA recommends that the Administration extend both the comment period and the timeframe for issuance of the RFP to allow the necessary time for discussion and stakeholder input.

This will provide the state with sufficient time to thoroughly review the current national landscape, and closely examine the challenges, barriers and lessons learned in other states which **chose** to move to managed long-term services and supports. This will also afford the state the opportunity to assess the fiscal and logistical realities that has many states continuing to serve the Duals population in a fee for service environment.

The Duals and the nursing facility clinical eligible populations are both fragile and vulnerable. States that have moved precipitously to cloak these folks in managed care have experienced problems in each of the areas the state has listed for comment: Program Design, Planning Phases, Implementation, Oversight and Quality. Our members view themselves in an important partnership with the consumers they serve, their families, and the Commonwealth. I believe that is true for all of the provider groups you will hear from during this process, making it essential that their comment be sought on the discussion document and the more detailed RFP or procurement document.

We feel very strongly that the Department's plans to procure all three planned phases of the program with an initial RFP document are misguided, and we urge you to reconsider that decision as well. I noted that the Long-Term Care Commission under the prior Administration recommended demonstrations or pilots which develop Pennsylvania specific data.

No matter the label, it is critically important to build in time to evaluate the program and make necessary changes based on the experience of consumers and providers already in the program. The plan in the discussion document, which proposes an RFP issued this October for all three proposed phases of implementation and a stacked phase in each year for three (3)

consecutive years will not allow sufficient time for program study and design modifications which are in the best interest of consumers and those providing their care and services.

Outcomes Too Uncertain

While we believe that a Duals program is the only viable choice for Pennsylvania, there is no one size fits all approach and no single proven model that the Department can merely pull 'off the shelf' for implementation. The duals population is not homogenous: there are the over 65's, the under 65's, nursing home residents and community duals. Pennsylvania is extremely diverse as well, with each regional having its own unique geographic, cultural, and infrastructure characteristics. In short, we do not believe that a 'one size fits all' approach will work in Pennsylvania.

Some states have backed out of the duals demonstration because they couldn't find enough MCOs to participate. The reality of the true costs and complexity of the population became clear to the plans only after capitation rates were reviewed. I have included some examples from Minnesota, Tennessee, Massachusetts, and Kansas for your review in my testimony today.

- *Minnesota and Tennessee said part of their reasons for withdrawing was that the plans would receive lower rates than they get under the current Medicare Advantage Dual Eligible Special Needs Plan program, known as D-SNPs.*
- *In Massachusetts, three of the original six managed-care plans that intended to offer plans, including Blue Cross and Blue Shield of Massachusetts, dropped out over payment issues a few months before enrollment began Oct. 1. As a result, the One Care program pared back its goal to serving about 90,000 duals.*
- *A spokesperson for one of the Massachusetts plans said they dropped out because they "would not have been able to adequately support the complex health needs of the dual-eligible population under the proposed rates."*
- *In January 2013, Kansas began phasing out the traditional fee-for-service model and enrolling low-income, disabled and frail elderly patients in a managed care program called KanCare. The administration contracted with three for-profit health insurers to coordinate care for a patient population that currently numbers about 400,000. KanCare was launched with promises, some of them written into the contracts with Amerigroup Kansas Inc., United Healthcare Community Plan and Sunflower Health Plan, a subsidiary of Centene. Medicaid eligibility would not be reduced. More than a year and a half in, KanCare's record is spotty at best. All three of the managed care companies lost money in 2013, and the shortfalls accelerated in the first half of this year, amounting to \$182.6 million total.*
- *The other big problem with KanCare has been late payments of claims submitted by hospitals, nursing homes, doctors, pharmacists and other health care providers. Some have complained bitterly about having to delay paying bills and even making payroll while they're waiting for reimbursements from the managed care companies.*

Further, there are no definitive studies that have shown improved health outcomes or cost savings on the frail elderly who are most likely to need the round the clock care that our members provide. Pennsylvania is solidly 4th in the 'Residents age 65 and Older' category, both in the percentage of our population and the overall number of residents that age. Among the 'oldest old'—those age 85 plus—Pennsylvania is even higher, numbering almost 400,000 as we provide this testimony. The 'oldest old' make 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—and the Administration

should not assume that MLTSS can somehow ‘manage away’ the chronic and ongoing care needs and costs of caring for our frail elders in need of round the clock care and services.

Finally, I would like to address the issue of outcomes and quality under MLTSS. Based on the Administration’s discussion document and experience in other states, we can expect one of the program goals to be a lower census in nursing homes due to forced diversion to home and community-based services. The reduction of nursing facility days is treated as an ‘outcome measure’ in many states where MLTSS is already in place, with plans given NF and HCBS utilization targets. 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’—it is a process measure.

Other levels of care licensed to care for consumers with round the clock care and service needs like Assisted Living Residences or Personal Care Homes should be considered as alternatives for consumers under MLTSS if appropriate.

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 consumers in risky community placements where they do not receive round the clock supervision or care—leading to a true bad outcome for the consumers, and higher costs to the LTSS system.

In closing, I would like to share a 2014 story from the New York Times¹. This story chronicled the experience of one 75 year old man with debilitating arthritis, lung disease, newly blinded and with growing dementia who was first forced from a nursing facility to inadequate services in the community, and then denied continuation of even those paltry 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. In the aggregate numbers collected on process measures, this gentleman was likely shown as a ‘successful’ community placement. In reality, it was a failure.

We should not allow this story to repeat itself here in Pennsylvania.

PHCA is committed to working with the Administration, consumers, and other stakeholder groups to that end in the weeks and months ahead.

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