Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of

2013-2014 Executive Budget Proposal
Mental Health Spending

February 27, 2013

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 22 health plans that provide comprehensive health care services to nearly seven million New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals. Our member health plans have long partnered with the state in achieving its health care goals, including improved access to quality care in its government programs as well as providing access to care that exceeds national quality benchmarks for commercial enrollees. Our plans include those that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health state plans (PHSPs) and managed long term care plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus, Family Health Plus and Healthy New York. Starting next year, hundreds of thousands of additional New Yorkers will be receiving coverage from HPA members as New York implements the Affordable Care Act (ACA). Accordingly, we appreciate the opportunity to offer our view on the proposed 2013-2014 Executive Budget in relation to its application for spending in the area of mental health care in New York.

MEETING EXPECTATIONS AND CHALLENGES

New York's health plans see many opportunities in the year head to be a partner with New York to expand access to affordable care to New Yorkers who are currently uninsured or underinsured. However, plans face numerous challenges this year as well. We ask you to be mindful of these as you deliberate a final spending plan.

Health plans are working in partnership with the New York Health Insurance Exchange to prepare for and implement the ACA. This is an unprecedented expansion

of health insurance requiring the expenditure of millions of dollars in investment and many thousands of hours of staff time to prepare for a smooth transition.

HPA's membership includes 15 health plans that participate in government sponsored programs, providing comprehensive health care services to nearly four million New Yorkers who are enrolled in Medicaid Managed Care, Child Health Plus, Family Health Plus and Managed Long Term Care. Plans have been a strong partner with the state in the Medicaid Managed Care program for close to 20 years, have been staunch supporters of New York's efforts to implement and expand the Managed Long Term Care (MLTC) program and, over the past two years, have worked diligently to successfully enact the multiple reforms of the Medicaid Redesign Team (MRT). Together, these joint efforts have resulted in expanded access to care for many New Yorkers and improved quality of care.

In adopting the MRT plan, the Governor and the Legislature embraced managed care as a model capable of delivering quality, accountability and cost savings. The historical data of the state's Medicaid managed care program and the recent MRT reform experience underscore the ability of plans to provide needed services and manage patient care that results in improved quality outcomes with the added advantage of delivering cost savings to the state and its taxpayers. Examples of this include:

- Improved access to important primary and preventive health services as well as management of chronic conditions as measured and reported annually by the Department of Health's Quality Assurance Reporting Requirements;
- The transition of numerous previously excluded populations into managed care plans (e.g., the homeless, personal care and consumer directed personal care, restricted recipients and low birth weight newborns);

- The implementation of mandatory MLTC enrollment and preparation for the Fully Integrated Duals Advantage (FIDA) initiative; and
- The successful integration of the Medicaid pharmacy benefit into the Medicaid managed care package, which has saved New York more than $100 million.

Recognizing these accomplishments, the Governor's 2013-2014 budget plan includes MRT proposals to remove any barriers to enrolling remaining populations into Medicaid managed care, and HPA supports these proposals. This includes certain "special needs" populations who have significant behavioral health requirements. Higher need populations to be incorporated into Medicaid managed care include:

- Individuals requiring rehabilitation and recovery services who will receive behavioral health benefits through Health and Recovery Plans (HARP) that will be integrated into mainstream Medicaid managed care plans; and
- Individuals with developmental disabilities will similarly have their care needs better coordinated through new Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs).

The HARP and DISCO proposals in this year's budget plan, following two years of efforts to implement provider-based Behavioral Health Organizations, seek to further capitalize on the capabilities of the managed care model. We support the integration of physical and behavioral health, and the coordination of care achieved through management of a single entity. Additionally, since many Medicaid recipients are already enrolled in Medicaid managed care, changing enrollment to a special needs plan is needlessly disruptive, potentially confusing and possibly stigmatizing.

The governor's 2013-2014 budget also acknowledges the success of the Medicaid pharmacy "carve-in" through a proposal to repeal not only the "prescriber prevails" authority for atypical antipsychotics in Medicaid managed care, which HPA supports,

but also in the fee-for-service Medicaid system. Data collected on prescription drug claims have shown Medicaid patients are neither "being forced" off effective medications nor are health plans "playing doctor." The data show less than 1% of prescription require "prior authorization" — meaning more than 99% are filled according to the doctor's order. Of that 1% seeking prior authorization, more than three-quarters (77%) get approved on review. The total number of claims denied is 0.3% of all claims — a very small amount that is largely capturing potential abuse and misuse, addressing lack of evidence or documentation of medical necessity, and excessive utilization or unsafe off label usage.

Moreover, during the time frame of these claims — between October 1, 2011 and December 31, 2012 — there was no evidence of turmoil in the Medicaid managed care pharmacy program. People didn't die; patients got the medications they needed; and the state and its taxpayers realized savings.

In short, the current prescriber prevails program is ill advised. Furthermore, eliminating prescriber prevails in the Medicaid pharmacy program is projected to save the state $12.5 million — money the legislature would have to find elsewhere to "buy back" a bad policy.

Looking at further challenges, Governor Cuomo's 30-day Amendments released last week included a number of proposed changes to his pending 2013-2014 budget that aim to address a $1.1 billion reduction in federal funds for the Developmentally Disabled program. Seeking to manage this significant revenue loss, the state is pursuing enhanced federal revenue for resubmitted emergency medical claims and federal funding for developmental disability system reform.

In addition, the Governor's original budget plan estimated the ACA would generate $82 million in Medicaid savings this fiscal year. That figure has now been increased by more than $100 million for a total ACA savings of approximately $200 million. However, both the original budget plan and the amended one calls for moving all but $40 million of these funds outside of the Medicaid global cap to fund other public health programs. These savings — along with any future ACA related savings — should stay within the Medicaid system and be applied to the global cap.

CONCLUSION

For more than 20 years — through both the Medicaid managed care program and in the commercial health insurance world — managed care has proven to be part of the solution to providing quality, affordable health care. It has the statutory and regulatory framework — i.e., requirements for contracting, credentialing, reserves — and oversight. Managed care has resources and access to capital, the infrastructure and expertise or ability to acquire expertise. Managed care has a proven track record with members, providers and New York State. Managed care has been a partner with New York as it continues improving access to affordable health coverage and quality of care for its residents. HPA and its member plans remain committed to working with you and your colleagues on initiatives that keep New York moving forward on this course. We thank you for the opportunity to share our views today.