

Granite State
Independent Living



Home Care • Community Supports • Employment Services

Good evening Commissioner, my name is Eric Schlepffhorst. I am the Chair of Granite State Independent Living's (GSIL) Board of Directors. GSIL is a statewide nonprofit providing a variety of services and supports to persons with disabilities and the elderly. GSIL is a Choices for Independence (CFI) provider of personal care and homecare services.

First, on behalf of the board, staff and the consumers of GSIL, I want to thank you and your staff for the hard work in responding to the legislature's mandate to develop a plan with alternatives for Phase 2 of Medicaid Managed Care. I am sure it was difficult with all the other demands placed upon the Department of Health and Human Services (DHHS).

My remarks today are not a ringing endorsement of the plan. I do want to point out where the plan could be improved to assure those who depend on the services, receive them so they may live a quality life in their own homes and communities.

The plan contemplates adding additional MCO's and PACE Centers. From experience as a provider of consumer directed personal care in Phase 1 of Medicaid Managed Care, this addition will add costs to the delivery of services. Each plan will add Informational Technology costs to track authorizations, billing, denials, and rebilling. Further each MCO has its own policies and rules that require additional staff time to assure compliance.

The plan needs to recognize that these are real costs and make an investment in the provider network infrastructure to make it a success for the citizens of New Hampshire. Such an investment will enable providers to provide services, bill for them efficiently and be accountable. This investment will enhance the ability to support those at home and keep people out of nursing homes. This expenditure will assure the quality of life of those who depend on these services.

Speaking of quality, the second point is the rates paid to providers must be sufficient to not only operate the infrastructure of the program, (outlined above) but also compensate the direct care staff to earn a livable wage. In the current market providers of this difficult work are competing with other private companies for employees. Private employers who may raise prices to afford higher wages. This is not the case for Medicaid providers who rates are set by the state. Any rates which include actuarial analysis must account for the current market and employee shortage. They must recommend rates that

will attract quality workers. Such rates must be at a level so the worker themselves and their families do not live in poverty.

In closing, the Board and staff of GSIL have a long history of working with the Department of Health and Human Services to improve the lives of those we support. As we go forward GSIL will continue to work with your staff to assure the highest quality of life for those we touch.

Thank you,

Eric Schlepphorst



New Hampshire Health Care Association

March 27, 2018

MEMORANDUM

TO: Department of Health & Human Services
FROM: Brendan Williams *BW*
President/CEO
RE: Response to Senate Bill 553 Report

Almost a half-year after the last SB 553 working group meeting the Department of Health and Human Services has produced a report, "Implementation Plan for Medicaid Care Management – Nursing Facility/Choices for Independence Services," ostensibly based upon the SB 553 group process.¹

In addition to making some new assertions about the efficacy of managed long-term care services and supports (MLTSS), the report promotes a new concept, the implementation in New Hampshire of a Program for All-Inclusive Care for the Elderly (PACE). This is characterized as an alternative to managed care: "Prospective members can access clear explanations of the benefits of the PACE, allowing them to select between a local PACE center *or* one of the MCOs."²

This is a misleading implication.

We address the report in two parts. First, as it is a new concept, we will address the PACE proposal. Second, we will prove why DHHS has not met its burden of proof that managed care is viable in the long-term care space.

Part I. Program for All-Inclusive Care for the Elderly

PACE would appear to have value, as was recognized in a February 2018 report put out by the New Hampshire Association of Counties. They express interest in exploring "county-based" PACE, but acknowledge "more analysis is required in order to develop this model to fit New Hampshire's unique characteristics, both geographical and population-based."³

¹<https://www.dhhs.nh.gov/ombp/medicaid/documents/mltss-implementation-plan.pdf>

²*Id.* (Emphasis added).

³New Hampshire Association of Counties: "New Hampshire Long Term Services and Supports: An Assessment of the Current System and Implications for Reform" (February 2018) at page 2.

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Here it is important to emphasize the *scale* of PACE. As the Counties note, “The model is designed to operate around a physical site – usually an adult day care. PACE centers average 172 enrollees.”⁴

Further, as the Counties note, to begin a PACE program requires “a 65 page application accompanied by a 26-page readiness review report, and must be approved by both state Medicaid and federal Medicare directors.”⁵

The National PACE Association (NPA) has a document available online that makes clear the infrastructural challenges of properly designing a PACE center to exacting standards.⁶ Typically these are privately-financed.⁷ According to the NPA, “The total number of participants per center (and per interdisciplinary team) is usually around 120 to 150.”⁸

As the NPA notes, “The most important factors for success are the organization’s long-term commitment to PACE as a model of care for the nursing facility-eligible population, access to the capital required to start up and sustain a PACE program, and the availability of an internal champion to secure sufficient resources for the program to be successful.”⁹ This 2013 document estimates “the capital investments for PACE programs vary widely and typically range from \$1.5 million to \$5 million. Experience to date has shown that payback occurs in 48 to 72 months.”¹⁰

It would be unlikely most counties, especially rural ones, would want to take this risk on.

PACE is only available in half of the 14 counties in Massachusetts.¹¹ In three counties it is only available in a single setting. It is hard to implement in smaller states – other New England states lacking a PACE setting include Connecticut, Maine, and Vermont.¹² North Dakota and Rhode Island are the only states smaller than New Hampshire with PACE settings, and the three in Rhode Island serve large urban populations.¹³ Delaware is ostensibly developing PACE.¹⁴

⁴*Id.*

⁵*Id.*

⁶<http://pacecenterdesign.unc.edu/PDF%20Files/PACE%20Guide%204.10.07.pdf>

⁷<https://www.npaonline.org/sites/default/files/PDFs/6%20Sources%20of%20Financing%20DRAFT%201.pdf>

⁸http://www.npaonline.org/sites/default/files/uploads/2.1_guide_pace_site_selection_leftright.pdf

⁹<https://www.npaonline.org/sites/default/files/PDFs/PACE%20Critical%20Success%20Factors%20White%20Paper.pdf>

¹⁰<https://www.npaonline.org/sites/default/files/PDFs/PACE%20Critical%20Success%20Factors%20White%20Paper.pdf>. A March 20 DHHS presentation on its plan suggested no new infrastructure need be built for PACE, and even asserted existing nursing home beds could be used for it. No evidence on the NPA site supports such an assertion.

¹¹<https://www.mass.gov/service-details/massachusetts-pace-service-areas>

¹²<https://www.npaonline.org/pace-you/find-pace-program-your-neighborhood>

¹³<http://pace-ri.org/>

¹⁴http://dhss.delaware.gov/dhss/dmma/pace_home.html

Even a state like Oregon, leading the country in investing 81% of its long-term care spending in home-and-community-based services (HCBS) has only one PACE location, in urban Portland.¹⁵ The state of Washington, another strong HCBS state, also has just one location, in Seattle, under the same provider as Oregon's.¹⁶

One page 5 of the DHHS report the real truth is revealed: "All CFI and NF eligible persons will receive their acute care and medical services through the MCM programs when MCO contracts go live on July 1, 2019. *When the PACE program is available, people will be given an option to enroll in PACE.*"¹⁷ (Emphasis added).

In other words, on July 1, 2019 over 7,000 vulnerable New Hampshire residents will be placed in the hands of MCOs, with the *possibility* existing that an adult day center or two, serving an average of 120-172 enrollees apiece, will be built. And this is an "alternative"?

As DHHS notes, "PACE programs are at risk for achieving savings[.]"¹⁸ Indeed they are. They must carry a risk reserve against "potential catastrophic loss" according to their national association.¹⁹ Thus, in examining the viability of PACE, it may be instructive to look at another area of New Hampshire social services spending.

While there can be no doubt for the need for substance misuse treatment centers given New Hampshire's opioid epidemic, we have seen a churn in such facilities. This year Hope for New Hampshire was going to close four, in Franklin, Concord, Claremont, and Berlin, leaving only a Manchester facility open.²⁰ Three of those facilities were recently allocated \$600,000 from the Executive Council.²¹ Serenity Place in Manchester closed this year after 40 years, also for financial reasons and not lack of demand.²² For a time the state had to take it over, which, as New Hampshire Public Radio noted, begged a question: "why didn't the state notice one of its key providers was falling apart?"²³

Would the state's commitment to a struggling, undercapitalized PACE center, waiting as long as six years for a return-on-investment, be any greater than it has been in sustaining those facilities addressing the issue (substance misuse) most voters describe as their top concern?

¹⁵<https://oregon.providence.org/our-services/p/providence-elderplace/>

¹⁶<https://washington.providence.org/senior-care/elderplace/>

¹⁷<https://www.dhhs.nh.gov/ombp/medicaid/documents/mltss-implementation-plan.pdf>

¹⁸*id.*

¹⁹<https://www.npaonline.org/sites/default/files/PDFs/4%20PACE%20FAQs%20DRAFT%201.pdf>

²⁰<http://nhpr.org/post/hope-nh-recovery-closing-all-one-drug-treatment-centers#stream/0>

²¹<http://www.wmur.com/article/state-funds-will-allow-some-of-hope-for-nh-recovery-centers-to-stay-open/19170230>

²²<http://nhpr.org/post/serenity-place-going-out-business-after-40-years#stream/0>

²³*id.*

Financial considerations aside, the scale of PACE will never make it a viable “alternative” to managed care.

Part II. Managed Long-Term Services and Supports

As the National Association of States United for Aging and Disabilities (NASUAD) has written, “Between 2011 and 2016, the number of states operating a managed long term services and supports (MLTSS) program mushroomed from 12 to 22.”²⁴

NASUAD, although comprised of aging program directors from states that have largely not yet implemented MLTSS, has also actively advocated for managed care, even creating a “MLTSS Institute” in partnership with major insurance companies. As of March 20, 2018, the 11 advisory board members for the Institute included six insurance company executives.²⁵ Because of this fact, and the candid acknowledgment of the role NASUAD played in drafting the DHHS plan, the DHHS plan must be viewed as, at least indirectly, the product of insurance companies – including Centene, which serves on the NASUAD advisory board.

Yet, in addressing the SB 553 working group in October 2016, NASUAD was candid: “There have been *no national studies assessing the efficacy of MLTSS programs*; however, there are anecdotal indications of improvement.”²⁶ (Emphasis added).

Indeed, *just last month* the General Accounting Office found that MLTSS in the states was so opaque that even the federal regulatory agency overseeing it, the Centers for Medicare and Medicaid Services (CMS), was thwarted in a multi-state evaluation of MLTSS. The CMS task had seemed simple: “For states testing the delivery of long-term services and supports through managed care, examine the effects of these programs on spending, access, and quality of care.”²⁷ According to GAO, “Limitations in the available data, including the quality of managed care encounter data, *reduced the number of potential study states from 20 to 2—New York and Tennessee.*”²⁸ (Emphasis added). Furthermore, “Sufficient data on the costs of services and on access for New York were not available.”²⁹

Yet DHHS claims the following: “States who [sic] have implemented more comprehensive Medicaid managed long-term services and supports (MLTSS) experience better managed care

²⁴<http://www.nasuad.org/initiatives/managed-long-term-services-and-supports>

²⁵<http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/mltss-institute>

²⁶<https://www.dhhs.nh.gov/sb553/documents/mltssthenationallandscapenasuad100416.pdf>

²⁷<https://www.gao.gov/assets/690/689506.pdf> at 35.

²⁸*id.*

²⁹*id.*

for members, increased access to community-based care, improved member satisfaction and health outcomes, and improved budget predictability.”³⁰

Each factual claim, other than the empty one of “better managed care for members,” can be examined based upon the actual experience of states.

“Increased access to community-based care”

“Rebalancing” LTSS has often been cited as a motivator for managed care. The idea is to shift residents away from unnecessary nursing home utilization and into home-and-community-based services (HCBS). Such services are provided in states with 1915(c) waivers under the Social Security Act,³¹ as the only Medicaid long-term care entitlement would otherwise be a nursing home.

Certainly HCBS has been the direction public demand has gone. According to a 2018 General Accounting Office report, “Expenditures on HCBS provided under managed care have grown from about \$8 billion in fiscal year 2012 to more than \$19 billion in fiscal year 2015.”³² A 2017 report from Truven Health Analytics noted that “HCBS have accounted for all Medicaid LTSS growth in recent years while institutional service expenditures have been flat.”³³

Yet in looking at those states spending the highest proportion of their long-term care budget on HCBS there is no indication that the costly intercession of managed care companies was required. According to Truven’s 2015 data, Oregon invested more long-term care funding in HCBS, at 82% of its overall budget, than any other state, without MLTSS.³⁴ Oregon’s figure was better than that of Arizona (70%), which has only ever had MLTSS since the state, in 1982, became the last state to enter the Medicaid program.³⁵

Without MLTSS, the state of Washington in June 2017 had 1,451 fewer Medicaid clients in nursing homes than it did in July 2009 – a 13% reduction.³⁶ Over that same period, the number of HCBS clients increased by 11,414 – a 26% increase.³⁷ This suggests “rebalancing” can occur

³⁰<https://www.dhhs.nh.gov/ombp/medicaid/documents/mltss-implementation-plan.pdf>

³¹“The Secretary may by waiver provide that a State plan approved under this title may include as ‘medical assistance’ under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that *but for the provision of such services* the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.” (Emphasis added).

³²<https://www.gao.gov/assets/690/689302.pdf>

³³<https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltsexpendituresffy2015final.pdf>

³⁴<https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltsexpendituresffy2015final.pdf>

³⁵*Id.*

³⁶http://www.cfc.wa.gov/HumanServices_LTC_HCS_NH.htm

³⁷http://www.cfc.wa.gov/HumanServices_LTC_HCS_Total.htm

organically. In 2015 Washington was slightly-ahead of MLTSS state Massachusetts in HCBS investment (69% vs. 65%). Massachusetts, in turn, was tied with two states – Colorado and Wisconsin – without statewide MLTSS, and slightly behind Vermont (69%), which doesn't utilize MLTSS.³⁸

New Hampshire is among those states that have, organically, seen long-term care populations rebalance. In December 2017 it had its lowest Medicaid census in nursing homes (4,005 residents), and had achieved its highest number of Medicaid home health clients (2,920) in just the prior month.³⁹ Compared to December 2007 data, this represented an 11% drop in nursing home clients, and a 14% increase in home care clients over a decade's time.⁴⁰ These trends are notable given that the state has the nation's second-oldest population.⁴¹

Indeed, the Truven data shows some of the worst states for HCBS spending were MLTSS states – with Florida, spending just 33% of its long-term care funding on HCBSS, second-worst in the country.⁴² Tennessee, often celebrated by managed care advocates as a MLTSS pioneer, was spending just 48% of its long-term care budget on HCBS, as compared to the national average of 55 percent.⁴³ It only slightly trailed Kansas, at 49%, another MLTSS showcase.⁴⁴

How have states without MLTSS succeeded in building more robust HCBS systems? Simply by doing what policymakers in any state could do – spending more money. In Oregon, for example, the 2015-19 contract between the state and the union representing home care workers provides hourly wages of \$14.50 an hour.⁴⁵ Under the union contract in the state of Washington, each home care worker will make no less than \$15 an hour by January 1, 2019.⁴⁶

In Massachusetts, a MLTSS state, greater HCBS investment was also driven by union advocacy – not MCOs. The 2015-19 union contract for personal care attendants provides they will receive \$15 an hour effective July 1, 2018.⁴⁷

Such wages are a very significant influx of federally-matched Medicaid funding into the HCBS sector. According to a 2017 report from the Paraprofessional Health Institute, the median home care workers' wage was \$10.49 an hour nationally.⁴⁸

³⁸ *Id.*

³⁹ <https://www.dhhs.nh.gov/ocom/documents/2018-jan-30-fiscal-syf-2018.pdf>

⁴⁰ <https://www.dhhs.nh.gov/ocom/documents/2010-sep-21-fiscal-iun-2010.pdf>

⁴¹ <http://www.unionleader.com/The-changing-face-of-NH:-What-it-means-to-have-the-2nd-oldest-population-in-the-nation>

⁴² <https://www.medicaid.gov/medicaid/lts/downloads/reports-and-evaluations/ltssexpendituresff2015final.pdf>
at 11.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ http://seiu503.org/wp-content/uploads/2017/09/2015-19-HCC-CBA_FINAL.pdf

⁴⁶ http://seiu775.org/files/2017/09/Homecare17_19WebReady-signature-page-w-mou.pdf

⁴⁷ <https://www.mass.gov/files/documents/2017/08/baf/pca-fully-executed-cba-2016.pdf>

There is no evidence that one must rob Peter to pay Paul, in properly funding HCBS, as some have demagogically argued. Oregon, for example, also pays the nation's highest nursing home rate at \$301.70 per patient, per day.⁴⁹

It may be that HCBS settings, particularly in-home care, can actually be disadvantaged under MLTSS. A single home care client or worker does not have the voice that a disaffected nursing home provider would bring attention to payment delays or denials.⁵⁰

As MLTSS was rolled out in Pennsylvania in 2018, a *Pittsburgh Post-Gazette* columnist reported on "a paid caregiver in Beaver Falls since 2009 for her 28-year-old daughter, who has multiple disabilities" who saw paychecks to which she was entitled since January 1 "delayed until Feb. 16, which put her several thousand dollars behind."⁵¹ Fearing retribution, "home care agencies have been reluctant to go on the record with their complaints[.]"⁵²

In Virginia, which also rolled out statewide MLTSS in 2018, consider the example of 10-year-old Adelynn Smith, who has four heart defects and struggles to breathe.⁵³ Upon the state switching to MLTSS this year, her dad, Andrew, "developed headaches after countless hours spent making sure his daughter got the 13 prescriptions she needed."⁵⁴ A home health care nurse "spent an hour and 15 minutes talking with three different people about three drugs Adelynn has needed since birth."⁵⁵ And, then, in a typical MLTSS story:

The change affected the attendants who help take care of Adelynn. She initially had been approved for 42 hours of care, but the coverage dropped to 30 hours with CCC Plus.

⁴⁸<https://phinational.org/news/new-data-u-s-home-care-workers-earn-10-49hour-despite-surg-ing-demand/>

⁴⁹<http://www.oregon.gov/DHS/PROVIDERS-PARTNERS/LICENSING/AdminAlerts/APD%20Rate%20Schedule%20Effective%20July%201,%202017.pdf>

⁵⁰In reviewing three MLTSS states, the General Accounting Office found that "[a]dvocates in two of the three selected states with managed care HCBS programs, New York and North Carolina, expressed concerns about managed care plans' incentives to reduce their costs by reducing enrollees' HCBS service levels, leading to reduced access to needed HCBS." <https://www.gao.gov/assets/690/689053.pdf>

⁵¹<http://www.post-gazette.com/aging-edge/gary-rotstein-s-what-s-new-in-aging/2018/02/16/Community-HealthChoices-launch-Pennsylvania-Medicaid-long-term-care-success-payment-problems/stories/201802160180>

⁵²*Id.*

⁵³Cathy Dyson, *Smith family gives Adelynn dream vacation in the midst of Medicaid nightmare*, LANCE FREE-STAR (Jan. 27, 2018), http://www.fredericksburg.com/news/healthy_living/smith-family-gives-adelynn-dream-vacation-in-the-midst-of/article_a0bf08e5-f813-5b71-a867-7c91077d9c88.html

⁵⁴*Id.*

⁵⁵*Id.*

Andrew Smith called repeatedly until that problem was fixed, only to later learn that her caregivers went almost eight weeks without pay.⁵⁶

Under MLTSS, the *Des Moines Register* noted in 2016 that “Iowans who provide in-home care for disabled people have gone without pay for weeks or months, according to a state workers’ union. These are individuals who change bedpans, bathe and feed patients while earning \$9 to \$12 per hour.”⁵⁷

Matters were much the same in 2018, as the *Register* reported in a special investigation headlined “Care denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals.”⁵⁸ The paper noted that “Medicaid expenses for in-home care that had been routinely approved when the state ran the program are now being rejected by managed-care providers as unnecessary and outside the scope of what the program authorizes.”⁵⁹ Among those whose care had suffered under MLTSS was a 32-year-old whose in-home visits were reduced from twice-daily to five times a week. As the *Register* related:

AmeriHealth's Dr. Brian Morley testified that it wasn't necessary for McDonald to receive daily assistance to clean himself after bowel movements. ‘People have bowel movements every day where they don't completely clean themselves, and we don't fuss over (them) too much. ... You know, I would allow him to be a little dirty for a couple of days.’⁶⁰

The *Kansas City Star* has reported on the lack of transparency home care clients have faced under privatized Medicaid. Caregivers were routinely pressured by MCOs to sign off on care plans without seeing them, unwittingly reducing care hours and forcing legal appeals to recover them.⁶¹

In New York, another major MLTSS state, *Bloomberg* reported in 2018 that

the state Department of Health pays a flat per-patient rate to a ‘managed-care’ insurance company, which in turn contracts with home-care agencies, which in turn employ aides. The rate, once set for a particular insurer, doesn’t vary, regardless of how much

⁵⁶ *Id.*

⁵⁷ <https://www.desmoinesregister.com/story/opinion/editorials/2016/07/16/editorial-providers-medicaid-nightmare-becomes-reality/87023948/>

⁵⁸ <http://features.desmoinesregister.com/news/medicaid-denials/>

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ <http://www.kansascity.com/news/politics-government/article184167411.html>

help a patient needs, so the actuarial math for the most seriously ill—elders who are bed-bound or have advanced Alzheimer’s—is punishing.⁶²

As *Bloomberg* noted, “New York’s reimbursement scheme thus discourages managed-care companies and home-care agencies from accepting high-hours cases and masks the true level of demand.”⁶³

The *New York Times*, in 2014, found similar problems in Tennessee, noting “hidden pitfalls as the system of caring for the frail comes under the twin pressures of cost containment and profit motive. In many cases, care was denied after needs grew costlier — including care that people would have received under the old system.”⁶⁴

With the threshold raised for admission into nursing homes, Tennesseans could fall between the cracks. When a home care recipient “developed dementia and his health fell apart in the fall of 2012, the state and the insurer denied his application for nursing home placement and told him he would lose his home care, too.”⁶⁵ Then “the day after an official letter scored his need for care at zero, he fell from his short-stay convalescent bed, gashing his face and breaking his nose.”⁶⁶

One way of safeguarding against unnecessary nursing home utilization is to maintain certificate of need or bed moratorium laws. Such limitations do not apply in the HCBS sphere.

“Improved member satisfaction and health outcomes”

NASUAD has speculated that “improvement of health outcomes may be more likely when a program includes all services—physical health, behavioral health, and LTSS—under one MCO.”⁶⁷

Assuming such a motivating benevolence to be true, this is a challenging area for measurement. Against what benchmark would better quality of life be measured? Some metrics seem intuitive, such as the general consumer preference for less-restrictive settings: “In Texas, consumers receiving MLTSS services reported that having HCBS gave them a sense of

⁶²<https://www.bloomberg.com/news/features/2018-02-09/americans-will-struggle-to-grow-old-at-home>

⁶³*Id.*

⁶⁴<https://www.nytimes.com/2014/03/07/nyregion/pitfalls-seen-in-tennessees-turn-to-privately-run-long-term-care.html>

⁶⁵*Id.*

⁶⁶*Id.*

⁶⁷<http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

independence and personal space that was important for their quality of life.” However, as mentioned before, HCBS can be funded absent diverting Medicaid funds to MCOs.

One empirical quality measure we have for long-term care is the number of health deficiencies cited in nursing homes, under exacting federal standards. According to the last federal data compendium, New Hampshire had the second-fewest deficiencies per facility in 2014, without MLTSS.⁶⁸ Would MLTSS improve upon that? Neighboring Massachusetts, a MLTSS state, had over three times more deficiencies per facility.⁶⁹

Absent a control group (a similarly-situated population not in MLTSS), or a longitudinal study predating MLTSS, the quality and consumer satisfaction metric may remain nebulous. NASUAD acknowledges “states do not often collect baseline measurements across several cost and quality indicators prior to an MLTSS program launch.”⁷⁰ Further, “States have limited capacity to conduct and oversee data collection efforts across the scope of questions needed to cover all aspects of the MLTSS program.”⁷¹

As the *Kansas City Star* reported on a CMS investigation of KanCare, “The state’s failure to ensure effective oversight of the program put the lives of enrollees at risk and made it difficult for them to navigate their benefits, the investigators found. They cited concerns about the program’s transparency and effectiveness.”⁷² One 2018 Republican gubernatorial candidate “said about 90 percent of the constituent complaints he fielded while in the Kansas House from 2013 through 2016 were KanCare related.”⁷³

The opaqueness of MLTSS in the states is evident in a 2018 description by GAO of a MLTSS demonstration project in Arizona:

As part of its evaluation, the state was assessing whether the quality of and access to care, as well as quality of life, would improve during the demonstration period for long-term care beneficiaries enrolled in MLTSS. However, evaluation results submitted in October 2016—the only results submitted for the state’s most recently completed demonstration cycle—lacked data on key measures of access, such as hospital readmission

⁶⁸https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf at 61.

⁶⁹*Id.*

⁷⁰<http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

⁷¹*Id.*

⁷²<http://www.kansascity.com/news/politics-government/article127424309.html>

⁷³<http://www.kansascity.com/news/politics-government/article184167411.html>

rates, and on quality of life, such as beneficiaries' satisfaction with their health plan, provider, and case manager.⁷⁴

As noted before, GAO found that that CMS was only able to study comprehensive MLTSS data from *a single state out of 20*, Tennessee.⁷⁵

As was noted earlier, in a 2016 MLTSS presentation in New Hampshire, NASUAD admitted, "There have been no national studies assessing the efficacy of MLTSS programs; however, there are anecdotal indications of improvement."⁷⁶ One anecdotal indication was that New York MLTSS plans "increased administration of flu vaccines."⁷⁷ According to the 2015 New York State Department of Health report NASUAD cited for this claim, "Seventy-seven percent of enrollees received the recommended annual influenza vaccination. Plan results ranged from 67 to 98 percent."⁷⁸

This is a strange measure of "improvement," to say the least, and not just because there was no baseline to compare it to. According to the Centers for Disease Control, "Thirty-two states have flu vaccination provisions that expressly reference long-term care facilities or that apply to various healthcare facilities that are considered long-term care facilities."⁷⁹ In New York, for example, the law requires that *all* patients in long-term care facilities be vaccinated.

In a disappointing commentary, DHHS Commissioner Meyers wrote that, "Of the 74 private nursing homes rated by the Centers for Medicare and Medicaid Services, 22 (or 30 percent) currently are rated overall with only one or two stars out of a possible five – meaning that they are 'below average or much below average.'"⁸⁰ Of course they were. Anyone who knew federal law (let alone the law of averages) would know "CMS bases Five-Star quality ratings in the health inspection domain on the relative performance of facilities within a state" and requires *no fewer than 20%* of nursing homes in each state receive a one-star rating – and roughly 23.3% receive a two-star rating; only 10% can get the highest rating.⁸¹ **MLTSS cannot change this.** And a one-star New Hampshire nursing home could be a 5-star facility in another state.⁸²

⁷⁴<https://www.gao.gov/assets/690/689506.pdf> at 15.

⁷⁵*id.*

⁷⁶<https://www.dhhs.nh.gov/sb553/documents/mltssthenationallandscapenasuad100416.pdf>

⁷⁷<https://www.dhhs.nh.gov/sb553/documents/mltssthenationallandscapenasuad100416.pdf>

⁷⁸http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2015.pdf

⁷⁹<https://www.cdc.gov/php/docs/menu-ltcinfluenza.pdf>

⁸⁰<http://bit.ly/2pmMoCH>

⁸¹CENTERS FOR MEDICARE & MEDICAID SERVICES, *Design for Nursing Home Compare, Five-Star Quality Rating System: Technical Users' Guide* (Feb. 2018), page 5.

⁸²25 New Hampshire facilities have received recognition for being in the **top-11% nationally**.

<http://www.achca.org/2018-award-winners>. It is against *those* facilities that others are compared.

Incidentally, In Kansas, nursing home health deficiency fines have gone up 9,000% since managed care came in.⁸³

“Improved budget predictability”

At last we come to the meatiest metric for MLTSS success, and arguably the true motivation for implementing it. Can it control Medicaid costs? Even NASUAD is not entirely sanguine: “Ensuring program sustainability and cost effectiveness are important MLTSS program goals; however, inadequate data have been a barrier to states’ ability to demonstrate these outcomes.”⁸⁴ They admit states “do not often have solid cost projections for their fee-for-service programs against which they can compare their MLTSS programs. This makes it almost impossible to reliably make ‘pre—post’ comparisons.”⁸⁵

To believe MLTSS saves money requires a leap of faith. One must believe introducing an intermediary with its own profit motives between a state’s (usually-inadequate) Medicaid payments and Medicaid care providers is efficient.

And yet saving money is clearly the overriding goal. New Hampshire state law, for example, lists, as MLTSS goals, “value, quality, efficiency, innovation, and savings.”⁸⁶ Yet, even prior to the planned July 1, 2019 implementation of MLTSS, the state’s Medicaid reimbursement was among the nation’s worst, with one analysis showing the second-largest reported gap between Medicaid payments and nursing home care costs.⁸⁷ Catholic Charities New Hampshire, running eight nursing homes, has reported operating them at a loss in 2017 due to Medicaid underfunding.⁸⁸ What more “savings” could be extracted?

For purposes of this analysis, we will assume that the “delay-and-deny” claim practices that characterize many insurance companies should not cross into what the *Des Moines Register* editorially described in 2016: “Now perhaps it is becoming clear how the Medicaid belt will be tightened: *by not paying health care providers for services.*”⁸⁹ (Emphasis added).

A challenge in assessing the performance of managed care insurers is the sophistication of such companies. Many states will not possess the actuarial acumen to double-check the math of a

⁸³<http://www.kansas.com/news/politics-government/article187115848.html>

⁸⁴<http://www.nasuad.org/sites/nasuad/files/FINAL%20Demonstrating%20the%20Value%20of%20MLTSS%205-12-17.pdf>

⁸⁵*Id.*

⁸⁶RSA 204:2(II).

⁸⁷https://www.ahcancal.org/research_data/funding/Documents/2016%20Preliminary%20State%20Numbers.pdf

⁸⁸<http://www.concordmonitor.com/A-troubling-future-for-NH-elderly-15824078>

⁸⁹<https://www.desmoinesregister.com/story/opinion/editorials/2016/07/16/editorial-providers-medicaid-nightmare-becomes-reality/87023948/>

Fortune 500 company. States may feel that privatizing Medicaid is a way of reducing their own responsibilities, when, in fact, such outsourcing should require investing considerable new resources in proper oversight. That oversight will have to come not only through the state agency charged with Medicaid, but the state's insurance regulators as well.

In Illinois, according to a January 2018 report of the Office of the Auditor General, "Auditors determined that the Department of Healthcare and Family Services (HFS) did not maintain the complete and accurate information needed to adequately monitor \$7.11 billion in payments made to and by the 12 MCOs during FY16."⁹⁰ For four years the state had not even bothered to calculate the medical loss ratio for the MCOs, making overpayment a real risk.⁹¹

Monitoring the MLR, generally required to be at 85%,⁹² is going to be important in any state MCO contract. Medicaid providers are likely to be especially insistent upon it, as their own margins are so narrow. An annual report to Congress by the Medicare Payment Advisory Commission in March 2017 found nursing homes nationally were only at a 1.6% margin – or actually in the negative (-2%) if Medicare payments were excluded.⁹³ The report last week found the margin dropped to .7%, or -2.3% without Medicare payments.⁹⁴ Nationally Medicaid spending on nursing home care only went up .9% in 2015 and .9% in 2016, according to federal data.⁹⁵ As I wrote in *USA Today*, "It is impossible to understand how nursing home care, already operating at a negative margin for Medicaid, can survive a further diversion of Medicaid resources to managed care profits."⁹⁶

Not only had Illinois failed to oversee MCOs, but the MCOs were being sued in federal court for taking too long to pay nursing homes. According to a December 2017 article in *McKnight's Long-Term Care News*, "The filing says Aetna Better Health Inc., Meridian Health Plan, Humana Inc., and Molina Healthcare of Illinois Inc. violated federal law because they didn't process and pay bills in a timely manner."⁹⁷

⁹⁰http://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Performance-Audits/2018_Releases/18-Medicaid-MCOs-Perf-Full.pdf

⁹¹http://www.auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Performance-Audits/2018_Releases/18-Medicaid-MCOs-Perf-Full.pdf

⁹²See generally 42 C.F.R. 438.4 (2017).

⁹³http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0

⁹⁴http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

⁹⁵<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

⁹⁶<https://www.usatoday.com/story/opinion/2017/04/28/medicaid-cuts-real-death-panels-column/100939932/>

⁹⁷<https://www.mcknights.com/news/nursing-homes-seek-overdue-medicaid-managed-care-payments/article/720126/>

In an audit reported last year, the Office of the Inspector General for the U.S. Department of Health & Human Services reported errant practices by New York may have cost “\$1.4 billion (\$717 million Federal share) during our 1-year audit period”:

New York improperly claimed reimbursement for 36 of 100 payments made to Medicaid Managed Long-Term Care (MLTC) plans. Specifically, New York did not ensure that MLTC plans documented eligibility assessments of program applicants and reassessments of those already in the program, and conducted these assessments in a timely manner. New York also did not ensure that the plans provided services to beneficiaries according to a written care plan. Further, New York did not ensure that the plans enrolled and retained only those beneficiaries who required community-based services, and disenrolled beneficiaries who requested disenrollment in a timely manner.⁹⁸

Failed oversight is endemic to MLTSS. In Kansas, a CMS review of KanCare found in 2017 that “[t]he state’s oversight of KanCare has diminished over the four years of KanCare operation, as evidenced by its annual onsite reviews of the MCOs and subsequent reviews. The 2013 annual report was a comprehensive document The 2014 and 2015 reports were each two pages long, with little content of substance.”⁹⁹

Provider groups commissioned Leavitt Partners to conduct a November 2016 report on KanCare. According to the report, “Interviewees consistently mentioned that seeking reimbursement from Medicaid and the MCOs is extremely resource intensive. The administrative burden of managing the claims billing and adjudication process has tripled for providers.”¹⁰⁰ That burden, shifted to providers already struggling to staff, should be considered as part of MLTSS cost.¹⁰¹

In 2014, the *Kansas City Star* reported providers “have complained bitterly about having to delay paying bills and even making payroll while they’re waiting for reimbursements from the managed care companies.”¹⁰² Matters had not improved by 2018:

⁹⁸<https://oig.hhs.gov/oas/reports/region2/21501026.asp>

⁹⁹https://issuu.com/tcj5/docs/01.13.17_kansas_pre-compliance_lett

¹⁰⁰http://www.khi.org/assets/uploads/news/14677/understanding_kancare_full_final_report_nov_2016.pdf

¹⁰¹In New Hampshire, the average nursing assistant in a nursing home was making *28 cents less an hour in 2016 than in 2006* thanks to low Medicaid reimbursement. <https://phinational.org/policy-research/workforce-data-center/#states=33>. This has made recruitment and retention nearly impossible amidst low-unemployment. How many caregivers are facilities to spare for MCO paperwork?

¹⁰²<http://www.kansascity.com/opinion/editorials/article2174129.html>

Haely Ordoyne, who represents the Kansas Adult Care Executives Association, which involves approximately 300 administrators at nonprofit and for-profit nursing homes, said the KanCare clearinghouse continued to struggle with determining eligibility for consumers and with payments to providers. 'We estimate the nursing facilities led by our members are experiencing delays with as much as 90 percent of their Medicaid-dependent residents,' Ordoyne said.¹⁰³

The article notes, "The Kansas Department of Health and Environment's director of Medicaid told a legislative oversight committee that Maximus, which began contracting with the state in 2015, remained desperately far behind on handling eligibility applications and had a 40-percent accuracy rate in making financial payments."¹⁰⁴ **Amazingly, DHHS revealed on March 20 it will use Maximus!**¹⁰⁵

Iowa's 2016 Medicaid privatization scheme ended up costing more than anticipated, prompting insurers to renegotiate their rates in 2017. As the *Des Moines Register* reported, "The new rates will cost an estimated \$182.8 million more each year than the initial rates set when the program began."¹⁰⁶ In response to legislative and public concern, an unusual bill was introduced in 2018. As the Associated Press reported:

The Iowa Department of Human Services requested the filing of a bill last week in the Legislature that would reduce how often it must report performance data on the health care program for the poor and disabled. The legislation would also remove some consumer protection metrics and *eliminate a requirement that the agency report its expected savings under the privatized system.*¹⁰⁷

(Emphasis added). Why the secrecy?

In Florida nursing home providers brought suit in federal court against seven MCOs in 2017, claiming, as *McKnight's Long-Term Care News* describes the suit, that "the insurance companies

¹⁰³<http://www.hdnews.net/news/20180218/kansas-prepares-to-impose-hefty-fine-on-medicaid-contractor-for-fumbling-applications>

¹⁰⁴*Id.*

¹⁰⁵<https://www.dhhs.nh.gov/sb553/documents/mcmnfcfiimplplan032018.pdf> at 18.

¹⁰⁶<https://www.desmoinesregister.com/story/news/investigations/2018/01/16/reynolds-says-medicaid-appeals-reviewed-after-register-investigation-reveals-systemic-denial-care/1037551001/>

¹⁰⁷<https://www.usnews.com/news/best-states/iowa/articles/2018-02-11/iowa-agency-reduces-medicaid-oversight-requirements-in-bill>

fabricated reasons to reject providers' proper claims, forcing them to 'jump through unnecessary, nonsensical hoops,' and purposely delayed payments to generate larger profits."¹⁰⁸

Driving Medicaid managed care is a belief that fee-for-service is inefficient. A similar belief has driven the proliferation of the Medicare Advantage insurance option. Yet, according to the Medicare Payment Advisory Commission, average payments for Advantage plans for 2017 were 4% higher than fee-for-service, due to "quality bonuses" and sophisticated Advantage insurers coding their enrollees with risk scores 10% higher than fee-for-service patients.¹⁰⁹

The Medicare Advantage example accentuates the need for rigorous state oversight of MLTSS. As a 2016 report put out by the Center for Health Care Strategies notes:

Risk measurement may be subject to manipulation by managed care plans or assessors if they have a financial incentive to increase beneficiaries' functional status scores (e.g., record greater need for assistance with ADLs to receive a higher capitation rate). To reduce the opportunity to profit from this type of gaming, states should ensure that functional status assessments are conducted by conflict-free parties such as state-employed staff or independent contractors, or states should perform regular audits and validation of managed care plan-conducted assessments.¹¹⁰

Enormous money is at stake. Facing a revenue shortfall in Rhode Island, Governor Raimondo proposed two budget cuts for 2018 to reduce MCO margins – "a reduction of the administrative component of the MCO rates by 2.5%" (saving \$1,892,496) and "elimination of the guaranteed profit margin component of MCO rates" (saving \$6,912,796).¹¹¹ To put those proposed cuts (and MCO margins) into perspective, Gov. Raimondo's proposed 1% rate increase for nursing home care would cost only \$2,574,599.¹¹² Imagine how much more Rhode Island care funding would be available absent MCOs.

With its acquisition of rival Health Net, Missouri-based Centene became the biggest insurance company in the Medicaid managed care space. According to its 2016 annual report, it had

¹⁰⁸<https://www.mcknights.com/news/florida-snfs-suing-managed-care-groups-over-delayed-medicaid-payments/article/679798/>

¹⁰⁹http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0 at 347-48, 360.

¹¹⁰https://www.chcs.org/media/MLTSS-Rate-Setting_Final-2.pdf

¹¹¹http://www.omb.ri.gov/documents/Prior%20Year%20Budgets/Operating%20Budget%202019/ExecutiveSummary/3_Health%20and%20Human%20Services.pdf at 73.

¹¹²*Id.*

\$40.6 billion in annual revenues.¹¹³ Its CEO earned \$22 million in salary.¹¹⁴ In 2017 Centene's revenue increased to \$48.4 billion, and its 87.3% medical loss ratio allowed for enormous administrative costs and profits.¹¹⁵ Properly overseeing a behemoth like Centene is arguably a more difficult task than a state administering a Medicaid fee-for-service LTSS program itself.

The political power of the MLTSS industry is evident in this startling excerpt from a 2018 *Crain's Detroit Business* article: "In a tersely worded proposal in the 2017-2018 state budget, Section 1857 states: 'By July 1 of (2018), the department (Health and Human Services) shall explore the implementation of a managed care long-term support service.' Dom Pallone, director of the Michigan Association of Health Plans, *took credit for the language* in the current year's budget."¹¹⁶ (Emphasis added). Is this how public policy involving the most vulnerable should be made?

There is also a question of what exactly there is to pay to manage with long-term nursing home residents. Care for the rest of that resident's life will be managed by the nursing home, without the need for an MCO's cost. In 2017 a bill was introduced in the Florida Senate to take such residents, who would not be eligible for HCBS, out from under managed care. Providers maintained Senate Bill 682 would save the state \$67.8 million annually in MCO case management and administrative costs, while the MCO-friendly governor's administration asserted it would cost the state \$200 million annually in avoidable care.¹¹⁷ Of the state's calculations, Senate Appropriations Committee staff wrote, "It is believed these estimates are significantly overstated, however."¹¹⁸ Committee members apparently thought so too – voting 18-0 to pass the bill on to the Senate floor.¹¹⁹

A 2017 Florida State University study of the state's MLTSS experience in 2014-15 found significant savings had not materialized from MLTSS. "The average monthly nominal LTC program cost was estimated at \$3,517.12 versus \$3,516.23 in the Pre LTC period. This represents an increase of \$0.89. After adjusting for inflation, the average monthly LTC program

¹¹³<https://www.centene.com/content/dam/corporate/investors/pdfs/CenteneAnnualReport2016.pdf>

¹¹⁴http://www.stltoday.com/business/columns/david-nicklaus/centene-ceo-s-pay-rises-to-million/article_5e9ca872-5abc-537e-a54c-0d29f6024556.html

¹¹⁵<https://centene.gcs-web.com/news-releases/news-release-details/centene-corporation-reports-2017-results-and-increases-2018>

¹¹⁶<http://www.craigslist.com/article/20180218/news/653216/plan-would-move-medicare-long-term-care-into-managed-care>

¹¹⁷<http://www.flsenate.gov/Session/Bill/2017/682/Analyses/2017s00682.ap.PDF>

¹¹⁸<http://www.flsenate.gov/Session/Bill/2017/682/Analyses/2017s00682.ap.PDF>

¹¹⁹<http://www.flsenate.gov/Session/Bill/2017/682/?Tab=VoteHistory>. In New York, though, the Assembly is supporting Governor Cuomo's plan to disenroll Medicaid beneficiaries from a managed long-term care plan if they become permanent residents of a nursing facility, and would require only three months' nursing home residence, rather than the governor's proposed six-month timeframe.

http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A09507&term=&Summary=Y&Text=Y

cost decrease or savings comes down to \$0.03 per individual per month.”¹²⁰ Given the pending federal lawsuit against MCOs by Florida nursing home providers, it remains to be seen whether even this modest savings trend holds up.

It was reported on March 1 that Florida “Medicaid managed care plans are no longer on the chopping block. The Senate late Wednesday agreed to back off a proposal to reduce Medicaid HMO payment rates by as much as \$230 million in state and federal funds as lawmakers craft a budget for the fiscal year starting July 1.”¹²¹

Another confounding factor on cost is the so-called “woodwork effect” as HCBS services become available to those who would not normally have gone into a nursing home. The evidence on cost savings from HCBS is inconclusive, according to a literature review summarized in a 2017 Kaiser Family Foundation issue brief.¹²²

That brief also notes that a cross-state evaluation of the federal Money Follows the Person Rebalancing Demonstration Grant found that “[d]espite large investments in resources over several years, however, relatively few people have been transitioned to the community; from January 2008 to December 2015, approximately 63,000 Medicaid beneficiaries in institutions had been transitioned to the community.”¹²³ They compare that 63,000 over seven years to the “about 1,000,000 Medicaid beneficiaries each year in nursing homes.”¹²⁴ This evidence suggests peril in overselling savings from MLTSS with the expectation of significant cost savings from shifting Medicaid beneficiaries toward HCBS. **Settings such as in-home care and assisted living facilities deserve to be promoted on their own considerable merits, not through false apples to oranges cost comparisons.**

In the DHHS report, there is the suggestion of a huge cut in provider rates on page 11: “For the first year of the program, MCOs will be required to use rates established by the State. Such rates will be no less than the rates paid to providers in SFY 2018.”¹²⁵ As nursing homes fought to get additional resources for SFY 2019, which begins July 1, 2018, it would be quixotic if rates beginning July 1, 2019 were lower. At its March 20 presentation, DHHS was confronted with the incongruity of SFY 2018 rates being paid in SFY 2020. It stated such rates were a “floor,” and could be set higher by the actuary. When the actuary’s admission that it would use the

¹²⁰ https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/contracts/mcd186/MED186_Final_Interim_Report.pdf at 5.

¹²¹ <https://newsserviceflorida.com/app/post.cfm?postID=28292>. It appears impossible to ever scale back Medicaid managed care once it’s implemented.

¹²² <http://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review>

¹²³ *Id.*

¹²⁴ *Id.* Further, a 2017 report to Congress shows that only “about” 71% of those transitioning were in nursing homes. See <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf> at 4.

¹²⁵ <https://www.dhhs.nh.gov/ombp/medicaid/documents/mltss-implementation-plan.pdf>

existing rate structure (“baked-in” as a participant put it) before the SB 553 working group was brought up, DHHS disputed the admission. When it was noted that the admission was *recorded*, DHHS stated “recordings are recordings.”

The Department admits on page 23 of its report that under MLTSS “New Hampshire may not make MQIP and ProShare payments directly to NFs once NF services are included in the MCO contract.”¹²⁶ It then suggests ways around this unlikely to pass muster with CMS. President Trump’s proposed budget prioritizes “reducing State gimmicks, such as provider taxes, that raise Federal costs” – and yet the Department appears to propose *new gimmicks* that would not withstand serious federal scrutiny.¹²⁷ We would not be so sanguine about the catastrophic, facility-closing loss of tens of millions of dollars in federal funding. Our own legal counsel, from the leading national long-term care law firm, is that DHHS is unlikely to prevail in its approach.

It’s perhaps worth noting that, according to the Winter 2018 Granite State Poll, New Hampshire voters *overwhelmingly* oppose this change (see Appendix A).

We do appreciate the work of DHHS on this effort. We understand that it is following a legislative directive, and one that would have been better-defined in states with more legislative staff infrastructure. Many people labored hard, and in good faith, during the SB 553 process – both in working group meetings and, especially, in subgroup meetings.

A defense offered by DHHS to years of unanswered questions posed to it regarding MLTSS has been that those questions might be more properly directed to legislators, and that might be fair – we certainly understand the frustration evinced in that response. Our position on this issue is not so much a rebuke of the Department as it is an *expression of faith in the Department* to continue work that would otherwise be outsourced to insurance companies.

Yet, in conclusion, we feel much more work is needed to measure the performance of MLTSS. No conclusive evidence exists that it has achieved its aims. As the Kaiser Family Foundation cautions, “despite the popularity of these initiatives, there is a marked paucity of evaluations of their effectiveness in lowering unnecessary utilization and expenditures and improving quality of care.” Kaiser warns that “managed care always carries risks because of the financial incentives to provide less care and to contract only with only low-cost providers.”¹²⁸

To quote a March 25 *Concord Monitor* editorial, “We suggest that lawmakers hold off and enact House Bill 1816, which would prevent the privatization of Medicaid services for the elderly and disabled.”¹²⁹ While MLTSS *success* has not been clearly established, its *failure*, given the

¹²⁶<https://www.dhhs.nh.gov/ombp/medicaid/documents/mltss-implementation-plan.pdf>

¹²⁷<https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf>

¹²⁸[http://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-](http://files.kff.org/attachment/Issue-Brief-Strategies-to-Reduce-Medicaid-Spending-Findings-from-a-Literature-Review)

[Review](#)

¹²⁹<http://www.concordmonitor.com/Longterm-care-in-NH-16398113>

vulnerability of those receiving services, can be measured in human lives. The state of New Hampshire should not take this leap of faith.

Appendix A – Granite State Poll Results (2/10-21, 2018)

Figure 1a: The Medicaid Program that pays for long-term care, including 64% of nursing home patients, is currently administrated by the New Hampshire Department of Health & Human Services. It has been proposed that administration of this program be moved to Managed Care Organizations, which are private insurance companies that make determinations on eligibility and reimbursement. Which statement comes closest to your opinion?

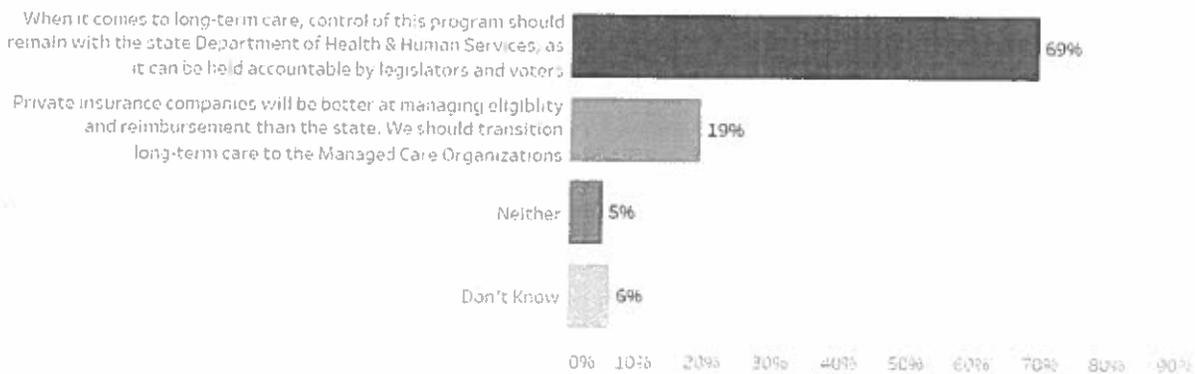
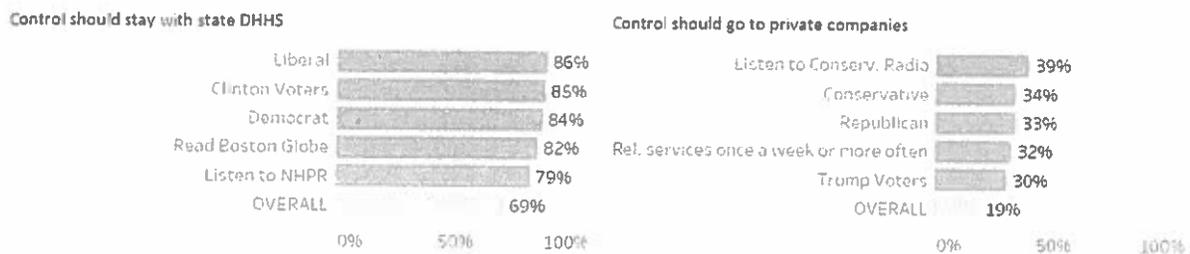


Figure 1b: Who Should Administer Medicaid in New Hampshire? - By Selected Demographics



Good evening. My name is Tom Argue and I am the Administrator of Webster at Rye nursing home and assisted living community located in Rye NH.

Webster at Rye has a cash flow loss of over \$400,000 per year that is directly associated with the Medicaid budget neutrality payment formula. That formula reduces our Medicaid reimbursement by almost 30% to help balance the state's budget. Our average net return on overall operations over the past six years has been a loss of \$20,000 per year. Based on the 15% administration and profit margin built in to the payments to Medicaid Managed Care organizations, I expect to loss an additional \$215,000 per year. How are we possibly expected to absorb that type of reduction in an already grossly underfunded Medicaid reimbursement system when we can barely keep our head above water now? Reports that old reimbursement rates will be used to calculate rates under Medicaid Managed Care, and that pro-share and MQIP payments are at risk, add to the concerns that we will be at a much greater financial risk than we can possibly withstand.

Widely reported stories of inaccuracies and delays in payments, and nursing homes suffering serious financial harm, even going out of business, in virtually every state where Medicaid Managed Care has been implemented can only make one wonder why anyone would support implementation of such a program here in New Hampshire where we have consistently over the years been recognized for providing the highest quality long-term care, at the lowest reimbursement rate.

On behalf of Webster at Rye and the frail and vulnerable senior citizens of New Hampshire that we serve, I would ask that the efforts to further privatize Medicaid services be discontinued.

Thank you, I appreciate the opportunity to speak with you this evening.

Date: March 26, 2018

Comments/questions regarding: Implementation Plan for Medicaid Care Management – Nursing Facility/choices for Independence.

Feedback from SB 553 Group member Chuck Crush Parent Alternate Amy Girouard parent

Please find the following questions regarding the Implementation plan for NF/CFI.

We ask these questions as points of clarification from the department regarding the plan. We feel the department has had a very serious and cumbersome task to develop this plan as legislatively mandated. While we are seeking clarification we feel the plan is thoughtful and inclusive. We hope that dialogue continues in a productive fashion enhancing quality cost effective healthcare in New Hampshire.

1. How will per member/per month or capitated rate be determined?
2. What are the qualifications for case management?
3. What are the TCM's roles once the MCO's are implemented and operational?
4. How do you develop risk adjusted rates? Is it diagnosis specific or is it based upon the individual and their diagnosis plus other social determinants or is it categorical based upon another reason?
5. Under the PACE program since it is Medicaid and Medicare reimbursement, how is the reimbursement structured? (Do the dollars flow through the state or do they go directly to PACE centers?)
6. Under the MCO plan, if a resident required an acute hospitalization stay (Medical or Geri psych) how would a readmission to the skilled nursing facility be handled with a combination of services to include Medicare and Medicaid? (Medicaid is often a co-payer in these situations) Would the skilled stay be co-managed by the MCO? Would the MCO ensure that appropriate medical and behavioral supports are in place for the facility to ensure a smooth transition to the nursing facility and/or community?
7. Under participant directed services, how are the "soft services" of quality of life going to be addressed? For example, if there is someone living in the community who requires transportation to meet friends for breakfast and/or other recreational activities that are important to their quality of life will want to continue to keep their routine even if they are not able to drive. If they do not have the supports required to drive, will the MCO be able to support them living in the community and provide transportation? The same goes for someone who requires transportation to a place of employment.
8. Free counseling to people who need to make a choice of a MCO or PACE Center: The idea for free counseling is a wonderful idea. That counseling also needs to have a simple and culturally appropriate explanation of the choices along with expectations of the MCO and of the consumer.
9. Would individual providers such as physicians as well as behavioral health be required to be credentialed and contracted with the MCO and the nursing facility, just the MCO or both?

10. Would the MCO and/or PACE in their case management service manage who is seen by behavioral health? Would the MCO provide supports for the nursing facility that requires additional education and support to take care of the resident back at the nursing facility vs staying in an acute care setting?
11. Quality Measures: Will there be a mechanism in place to track and trend quality measures such as but not limited to: ER admissions avoidable admissions/length of stay in nursing facilities, falls at home, and antipsychotic medication use both in the NF and in the community?
12. Lastly, could you provide more clarification regarding PACE centers and their relationships within the nursing home?

Respectfully submitted,



Chuck Crush, CDAL, Member SB 553 and parent



Amy S. Girouard, MSW, LICSW alternate member and parent



Residential & Rehabilitative Health Care For All Ages

March 27, 2018

Members of the Committee,

My name is Patricia Ramsey and I am the owner of the Edgewood Centre Skilled Nursing and Long Term Care Facility located in Portsmouth. Our Residents appreciate who we are as an organization and the level of quality care we provide. I am proud to be a small business, not part of a corporate chain. I am here today to support the elimination of Medicaid Managed Care for Nursing Homes. I will be direct and brief.

First, we cannot afford another layer of bureaucracy that will redirect dollars from patient care and away from a woefully under funded system, the Nation's third worst.

Second, , given the staffing crisis that is impacting the entire health care system, redirecting our already stretched staff from direct care roles to deal with more administrative paperwork to interface with the MCO model is wasteful and a huge disservice to our residents. We are already plagued with increasing regulation and burdensome paperwork requirements. For example, we already spend countless hours with Medicare Managed care Plans and Medicare and Medicaid Drug plans attempting to obtain prior authorizations that rarely lead to denials.

Third, we are already managing the care of our residents. Per requirements set forth by CMS, we are obligated to coordinate

care for our residents in the following areas: Primary Care, Specialty Services, Dental, Optometry, Podiatry, Rehabilitation Services and Mental Health Services to name few. We execute a well coordinated managed care system within our facilities meeting the needs of those we serve.

Finally, the only way to save money is to keep people out of facilities. I welcome anyone to come to my Nursing Home or any in the State and tell me which Residents in our care could be better cared for elsewhere. Nursing homes provide 24 hour nursing care, medical management, medication management, social services, activities, food and nutrition services to maintain Residents at their highest level of function. What we provide is not just quality health care but a quality of life for those nearing end of life. In the last 10 years, the Medicaid population in my facility has dropped by 35%. Given the challenges we face with lack of funding and the lack of Staff, can we instead focus our energy and limited resources on solving these REAL ISSUES. It will not matter where our elders are cared for in the future if we do not have the human resources to meet their needs.

Thank you for your time.

*Patricia M. Ramsey, NHA
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