NYLAG
New York Legal Assistance Group

MEMORANDUM IN SUPPORT

MLTC DATA TRANSPARENCY ACT - S 9266 (May) / A 10176 (Gonzalez-Rojas)

Co-Sponsors: Senate -- Cleare, Krueger, Skoufis
Assembly – Paulin, Dinowitz, Weprin, Simon

A bill to amend the public health law, in relation to data reporting required on the administration of managed long term care plans

The New York Legal Assistance Group (NYLAG) supports this legislation.

NYLAG uses the power of the law to help New Yorkers in need combat economic, racial, and social injustice. We address emerging and urgent legal needs with comprehensive, free civil legal services, impact litigation, policy advocacy, and community education. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality. Among the array of free legal services we provide is representation of older persons and people with serious illness or disabilities in retaining Medicaid eligibility and accessing Medicaid home care services in order to live safely in their homes and avoid institutionalization.

Introduction – MLTC Data is Needed for Transparency and Oversight

This bill is urgently needed to increase accountability for how Medicaid Managed Long Term Care (MLTC) plans spend over $22 billion in public funds they receive as monthly premiums for nearly 300,000 New Yorkers each year. Numerous government and watchdog reports have found State oversight of MLTC plans to be deficient. An October 2023 report commissioned by the NYS legislature in 2022 states in part, "There is significant room for improvement in … improving [MLTC] plan quality (especially Upstate); enhancing measurement of access and quality data…."[1] In 2022, the NYS Comptroller found that NYS paid $2.8 billion in premiums to MLTC plans that provided little or no services.[2] The Comptroller found the "…Department does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period." Id.

Federal agencies have also criticized the lack of adequate oversight of MLTC plans in NYS, including:

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[1] The legislature commissioned the report in 2022 to evaluate managed care procurement options. Part P, Ch. 57 L. 2022. The Boston Consulting Group issued the report in Oct. 2023, which the NYS DOH provided to the legislature by letter to Assembly Speaker Heastie dated January 22, 2024. Boston Consulting Group, *Final Report on Managed Care Organization Services, p. 47* (available https://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf.

[2] New York State Comptroller, "Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility," Aug. 5, 2022, available at https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf.

- U.S. Office of Inspector General, *New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests* (2023), available at https://oig.hhs.gov/oas/reports/region2/22101016.asp (focusing on Centers Plan for Healthy Living, which is the second largest MLTC plan with nearly 20% of all enrollees as of April 2023).

- U.S. Government Accountability Office (GAO), *MEDICAID LONG-TERM SERVICES AND SUPPORTS: Access and Quality Problems in Managed Care Demand Improved Oversight*, GAO 21-49 (Oct. 2022), available at https://www.gao.gov/assets/gao-21-49.pdf.

At the same time, NYS has failed to adopt recommendations by the federal Medicaid agency, CMS, that States adopt numerous quality and outcome measures to better track access to home and community-based services, and to further the national goal of "rebalancing" long term care from institutional care to community-care. This bill requires NYS to use some of these key measures.

Description of Bill

The bill adds six new types of data, numbered in subparagraphs (A) – (F), for DOH to include in its regular reports to the legislature about MLTC.[3] Most of this data, described below, is already reported to DOH by plans, so would not be burdensome. Other data has long been recommended by CMS and is long overdue. The regular DOH reports would now be annual, instead of biannual. The bill also requires DOH to make the data available in interactive format online, for which technology is readily available and is already used by DOH in its Open Health Data website at https://health.data.ny.gov/.

The six new data points required by the bill are discussed below.

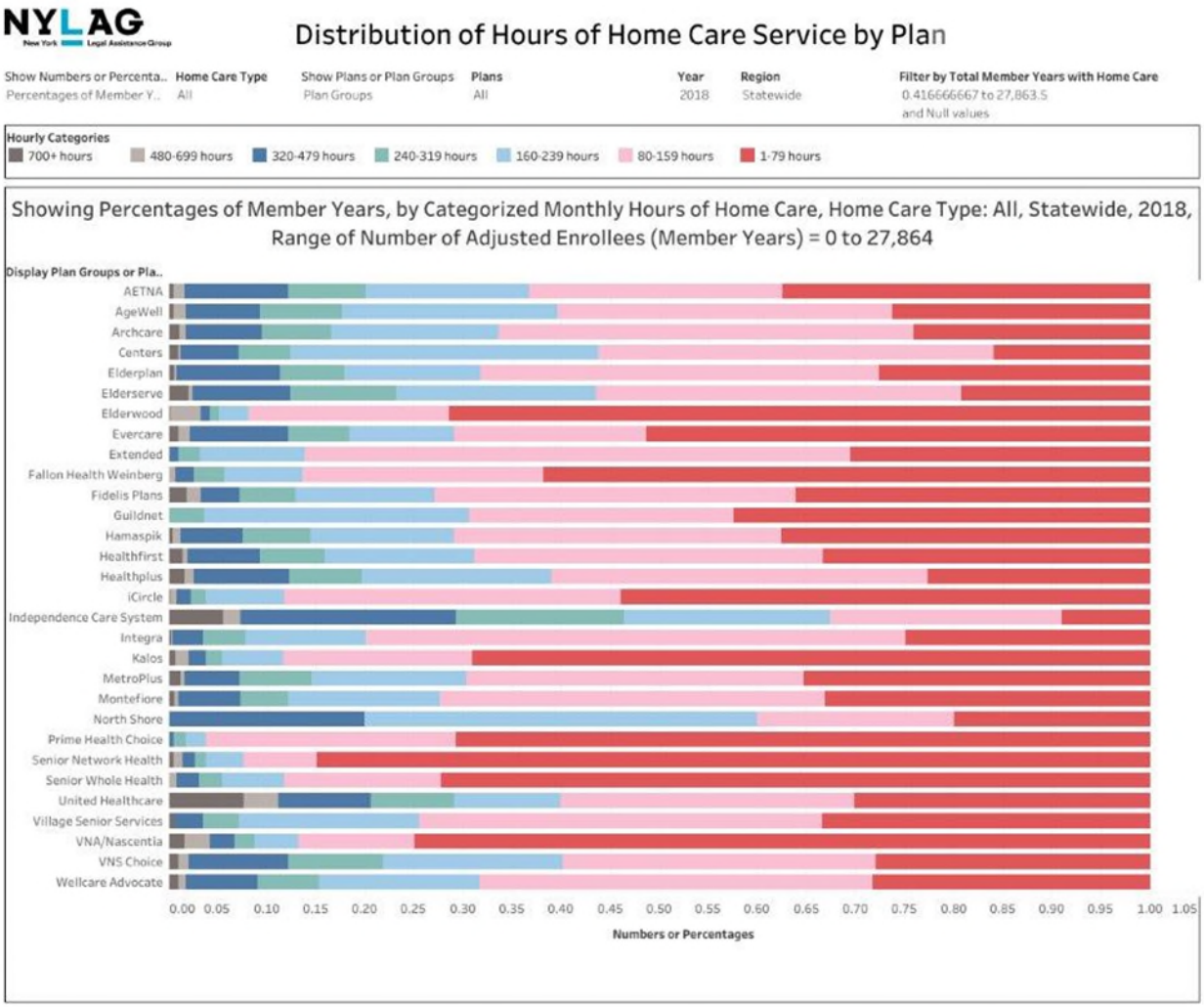
A. Subparagraph (A) -- Service Utilization Data for each type of home care service authorized by MLTC plans, with breakdown by geographic region

For each different home care service (personal care, CDPAP, and home health care), plans now report the number of members receiving the most hours per month (700+), the least hours per month (< 80), and five ranges of hours/month in between. The bill requires that DOH make this data public in an interactive format that enables a consumer, legislator or others to compare plans. These reports are now only released with a Freedom of Information request, in a format that only a data expert can understand. NYLAG obtained these reports for 2017-2018 and posted interactive visualizations of this data in its MLTC Data Transparency Project

[3] The bill adds proposed new subparagraph (2) to Public Health Law 4403-f, subd. 7(b)(ix). That subparagraph (2) lists the six new data elements A – F.

(https://nylag.org/MLTCdatatransparency/). The chart below shows the percentage of members of each plan, on a statewide basis, who received personal care in the seven different hourly ranges reported by the plans. As is evident, the vast majority of members received under 160 hours/month (pink and red bars), with many of those receiving under 80 hours/month (red bar). Only a small percentage received 24/7 care, represented by the black and gray bars on the left, indicating more than 480 hours/month, of which only a few received 700+ hours. This bill would make that data publicly available, to improve accountability and consumer choice. If a plan provides less 24/hour care than other plans, but places more members in nursing homes (see below), this raises a red flag to consumers and should trigger DOH audits.

Exhibit 1 – MLTC Cost Reports Statewide for 2018 – interactive version available at https://nylag.org/home-care-member-years-by-hourly-category/



- **Explanation of some Technical Terms in subpar. (A) and (B) of the Bill:**

a. Why report data by "Member Month" Rather than by Member?" The bill requires DOH to report the data the same way that plans report it in their cost reports -- by "member month." Exhibit 2 below is an actual Exh. A-5 of the statewide Cost Report filed by Centers Plan MLTC for 2018, showing the number of "member months" in which the plan provided personal care services in each of seven different groupings of hours/month. This is the source of the data in Exhibit 1 above. Similar exhibits in the cost reports have the same type of data for CDPAP and Home Health services.

Exhibit 2 – CPHL Statewide Cost Report 2018 – Exhibit A-5 – Personal Care hours

Centers Plan for Healthy Living MLTC (03506989)
Period Ending : 12/31/2018

DCN : 08152019174647
Created : Thursday, August 15, 2019

Exhibit A5 - Personal Care Hours Year-to-Date		Member Months	Total Number of Hours
00471	47148	03501	03502
MEMBER BREAKDOWN BY USE			
Category Based on Hours per Month			
700+ hours per month	0001	2,824	2,076,178
480-699 hours per month	0002	689	416,533
320-479 hours per month	0003	16,260	5,928,941
240-319 hours per month	0004	11,005	3,051,500
160-239 hours per month	0005	53,682	10,478,149
80-159 hours per month	0006	71,647	8,669,216
1-79 hours per month	0007	36,124	1,855,048
TOTALS	0010	192,231	32,475,565

A "Member Month" is equivalent to one person for whom the plan has received a monthly capitation premium for one month. The "member month" adjusts for turnover so that plans whose enrollees receive the services for shorter periods, or who are enrolled only for a short time, can be compared. For example, if the plan gave 700+ hours/mo. of personal care to 100 members for 2 months in the year, it would be misleading to say that 100 members received 700+ hours of personal care. Instead, the plan would report it provided 700+ hours for 200 member months. Dividing that figure of 200 by 12 approximates the number of members (16.7) receiving the specified service, allowing comparison between plans.

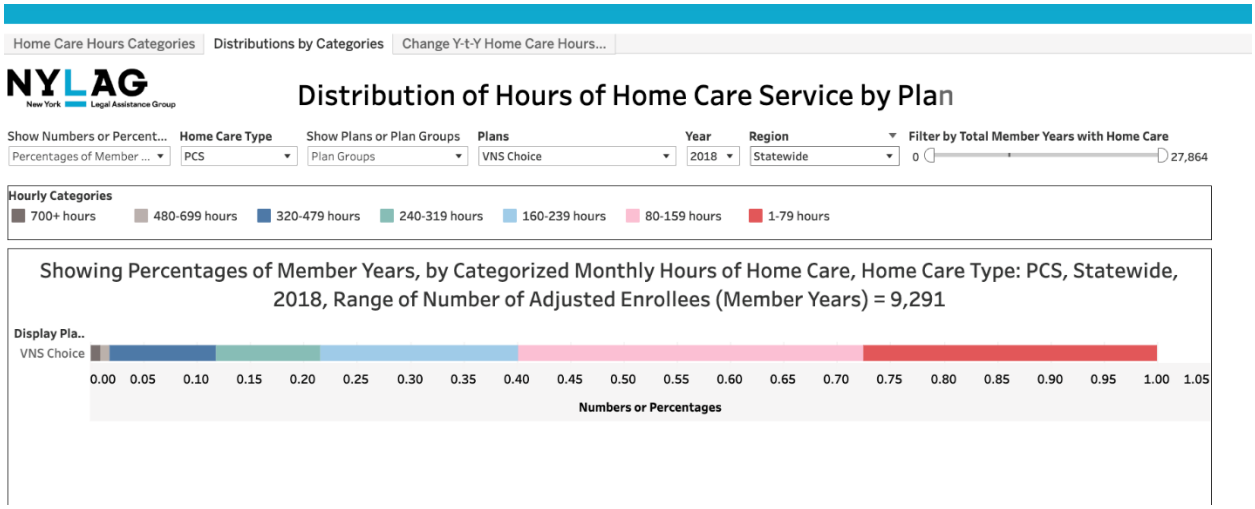
b. Why Require Regional data in addition to Statewide data? – The bill requires DOH to provide data for each plan on a statewide basis and for each of four geographic regions in the State in which the plan operates.[4] Plans already report data by region as well as statewide. There are stark differences in utilization of MLTC services in different regions. In its recommendations adopted by CMS to improve quality measures for long term services and supports, the policy institute Mathematica warned, "Aggregate state-level rebalancing measures mask

[4] List of counties in each region at https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf

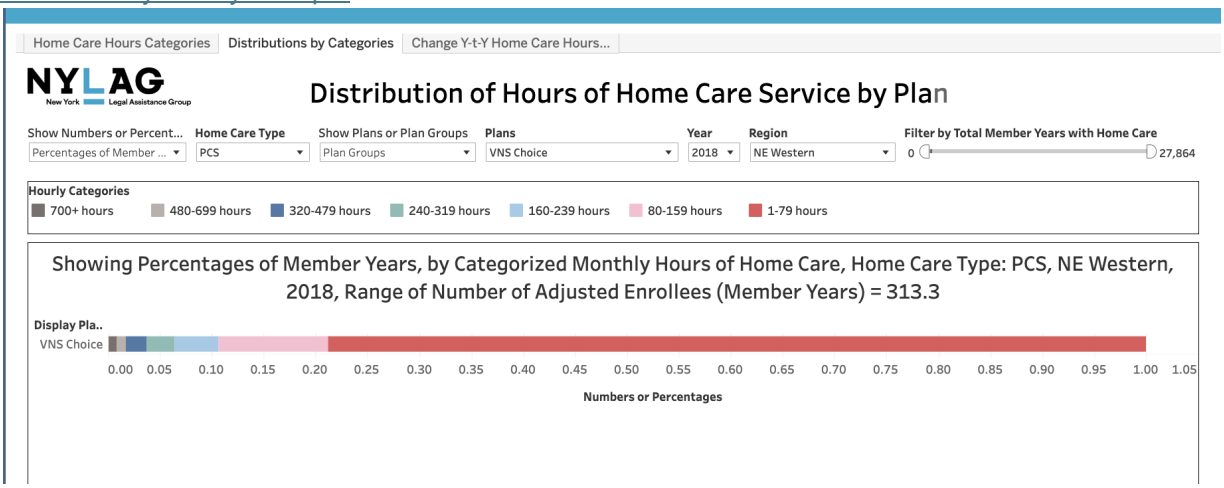
differences across populations and regions within states."[5] The following Exhibit 3 shows an example of one MLTC plan, VNS Choice, which provided hours in very different amounts in the 16-county NE Western Region compared to its statewide hours, which reflect higher NYC hours. It is critical that each plan's data be provided by region, and not aggregated statewide, to improve plan accountability.

Exhibit 3 Regional Differences in Hours Example – VNS Choice 2018

1. **STATEWIDE**



2. NE Western (16-county region) List at https://nylag.org/wp-content/uploads/2022/09/Upload-B-REGIONS-by-county-PDF.pdf



[5] Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures issue Brief,* Mathematica, Nov. 2019, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf, p. 6, ["Mathematica HCBS Quality Measures"].

c. Why Report Date by *Percentage* – such as Percentage Receiving Different Amounts of Services – Rather than the number of Members?

Exhibits 1 and 3 above each show the percentage of members of each plan receiving personal care in each grouping of number of hours, from highest to lowest, based on the number of member months. This enables a comparison between plans which would not be possible if instead DOH reported the actual number of members of each plan receiving services in the various amounts. Exhibit 2 shows how the straight numbers are reported, which are meaningless without the context showing the percentage of members each number represents. Plan size varies greatly, so percentages enable an apples-to-apples comparison.

B. Subparagraph (B) – Expenditures for each service and administrative expense provided by MLTC plans, broken down by region

The bill requires the State to make public the costs reported by plans itemizing the amount spent on each covered service and the number of "member months" in which each service was provided – for personal care, CDPAP, dental care, adult day care, short-term nursing home care, and all other services. From this data, the bill also instructs DOH to calculate the percentage of expenditures for community-based services versus the percentage for institutional services. This ratio of community versus institutional costs is the key indicator of success in the national goal of "rebalancing" long term care from institutional to community-based care.[6]

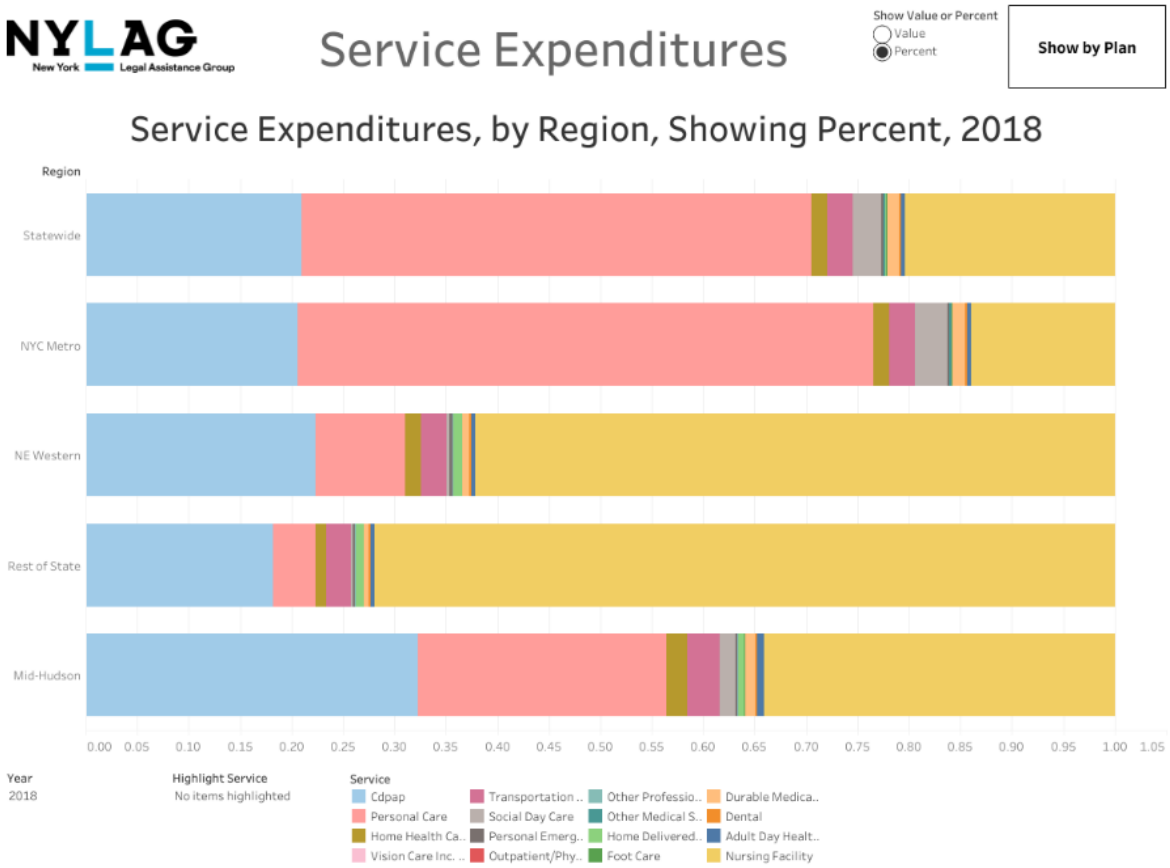
When long-term nursing home care was "carved out" of the MLTC benefit package in 2020, MLTC plans were no longer responsible for the cost of nursing home care for residents, but still provide short-term nursing home care. This change defeats the goal of rebalancing, behooving the State to closely monitor its impact. Before, plans were on the hook for all nursing home costs for their members. Since those costs are usually more than the cost of home care, that incentivized plans to help members return home. However, a small number of members need high hours that may cost more than nursing home care. These are represented by the miniscule gray and black color blocks on the far left of the graphic in Exhibit A. Plans are incentivized to disenroll members who need high hours of home care in order to be discharged home from a short-term rehab stay. New York has failed to monitor plan behavior since this 2020 change. Just as the

[6] CMS, Medicaid Long Term Services and Supports (LTSS) Annual Expenditures Report for FFY 2020, June 9, 2023, pp. 24 et seq., available at https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2020.pdf, posted with attachments at https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations/index.html. NYS ranked 10th in percentage of LTSS expenditures spent on for HCBS in 2020. Id. P. 93.

federal government tracks each state's progress in rebalancing, see n. 6, each plan must be held accountable for its own track record on rebalancing. This bill would track the percentage of plan expenditures on community-based compared to institutional services, taking an important step on this goal. See more rebalancing measures in Subparagraph F below.

For the same reason discussed above in (A), this data should be reported for each region in which each plan operates as well as statewide, and by *percentage* of all of a plan's expenditures spent on each service. Exhibit 4 below shows the huge differences in expenditures for nursing home care (gold blocks) compared to personal care and CDPAP (blue and pink areas) between regions in NYS. Again, plans report the data by *member month*, which can be used to approximate the number of members.

Exhibit 4: Regional Differences in Percentage of Service Expenditures on Nursing Facility Services - 2018. *SOURCE: Cost Report Data 2018 - https://nylag.org/mmcor-service-expenditures/*



GOLD is Nursing Facility care, blue is CDPAP and pink is personal care.

C. Data on personal care and CDPAP contracting with hours of care provided and expenses allocated by contracted entity.

There is no transparency concerning the personal care and CDPAP agencies that each plan contracts with, with the number of hours of care provided by each agency, and the cost of services under these contracts with. Transparency concerning expenses allocated for each contracted home care agency is important for accountability for paying home care workers the wages and benefits to which they are entitled. While the creation of a single statewide CDPAP Fiscal Intermediary required by the SFY 2024-25 Budget may eventually simplify this requirement for CDPAP, it is still important for licensed home care services agencies that provide personal care services.

D. Number and type of complaints, appeals and fair hearings with their outcomes

Transparency about member complaints, appeals and fair hearings and their outcomes is essential for plan accountability. If an MLTC plan routinely is reversed in appeals or hearings that find the plan did not assess the member's needs properly and failed to approve enough hours of care, this reflects on quality, and should trigger an audit and sanctions by the state. DOH's current annual MLTC quality reports make no mention of how many appeals, complaints or hearings members filed and won.[7]

DOH provides some aggregated data on complaints and appeals in its annual reports to CMS as required in the 1115 waiver, but no plan-specific data as needed to promote accountability.[8] Moreover, these 1115 reports include only the number of the first level internal "plan appeals," for which DOH's 1115 Report indicates that 85 are decided unfavorably to the member. However, there is no disclosure of how many of those adverse decisions are appealed to a Fair Hearing or to an "External Appeal," both run

[7] The most recent DOH MLTC Report is for 2022, pp. 26-29, posted at https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2022.pdf, with other NYS reports posted at https://www.health.ny.gov/health_care/managed_care/mltc/reports.htm.

[8] The Special Terms & Conditions ("STC") of the 1115 waiver that authorizes NYS to operate managed care and MLTC programs requires DOH to report, "The total number of complaints, grievances and appeals by type of issue with a listing of the top 5 reasons for the event." STC posted on https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm at the dropdown for *MRT Plan Current STC*'s. The most recent STC dated Jan. 9, 2024, is at https://www.health.ny.gov/health_care/managed_care/appextension/docs/2024-01-09_ny_stc.pdf. NYS DOH's 1115 Demonstration Annual Reports ["1115 Report"] are also posted at https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm, with the most recent report for 2022 available at https://www.health.ny.gov/health_care/medicaid/redesign/reports/docs/2022_pp_annual_rpt.pdf

by state agencies, and the outcomes of those higher level appeals. Notably, the 1115 Reports include *no data* on MLTC Fair Hearings requested at all, only data for mainstream plans. 1115 Report p. 60. Fair hearing results can illuminate patterns of wrongful denials by plans, as shown by a 2016 study of fair hearing decisions challenging plans' reductions of hours of home care.[9]

The bill requires that data on appeals and complaints be dis-aggregated by plan, and be broken down by the type of service at issue in the appeal, and the nature of the disputed action, such as denial of a new service, denial of an increase in a service, reduction of a service, termination of a service, lateness, lack of staffing, or other issue.

E. Metrics to Track Staffing Capacity & Timely Access to Authorized Services

With the severe shortage of home care workers, MLTC plans often delay providing home care services they have authorized. Despite the recommendation by the federal Medicaid agency CMS,[10] and despite the NYS Comptroller's report that thousands of MLTC enrollees went without services for lengthy periods, New York has never instituted measures to track timely access to services.

This bill would adopt evidence-based measures to track staffing capacity recommended by CMS and to make this data public. See n. 10. CMS recommends "Service fulfillment standards" for which plans report metrics to track timely access to authorized services. Other states have adopted CMS recommendations to set a maximum wait time for home care services to be initiated after authorization (Texas requires a plan to initiate services within 7 days for 90% of members authorized for PCS). Id n. 10. CMS also recommends states to require plans to submit a Monthly Unstaffed Case Report or a

[9] In 2016, the Medicaid Matters NY coalition issued a report on a study of fair hearing decisions finding a pattern of illegal reductions of hours of personal care and CDPAP services by MLTC plans. See *Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans, June-December 2015*, available at https://medicaidmattersny.org/mltc-report/. The report identified striking differences between plans in terms of the number of fair hearings and their outcomes, and makes specific policy recommendations for better oversight and monitoring of plan activities. See Nina Bernstein, *Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients,* New York Times, July 20, 2016, available at https://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html?_r=0.

[10] CMS, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long Term Services and Supports Access Monitoring Toolkit*, June 2022 ['CMS LTSS Toolkit"] available at https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf; see also http://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-monitoring-and-oversight-initiative/index.html.

Late & Missed Visit report. CMS LTSS Toolkit at p. 36. Electronic Visit Verification can also be used to track timely delivery of services, which the plan would aggregate by region and report to DOH. Id. Some states require a Utilization Report to track members who have been without LTSS for various specified periods of time, with an explanation of why the services were not provided and when they are expected to begin (see CMS Toolkit pp. 35). Armed with this data, the State as well as the public can hold plans accountable for failing to provide timely access.

F. Improve Metrics to Track Rebalancing LTSS from Institutionalized to Community-Based Care

New York lags behind other states in tracking how plans are performing in "rebalancing" long term care, meaning how good a job the state is doing in shifting long-term care expenditures from nursing homes to community-based services. The bill improves these metrics and would make them public by plan and by region.

It is not uncommon for chronically ill and disabled MLTC members to require a hospitalization or stay in rehabilitation facility. These incidents too often cascade into a permanent nursing home placement because the MLTC plan refuses to reinstate or increase services as needed when these enrollees are ready for discharge home. This problem increased since 2020, when long-term nursing home care was "carved out" of the MLTC benefit, leading an MLTC member to be disenrolled from the plan after 120 days in a rehab facility. Once disenrolled from the MLTC plan, it becomes much more difficult to return home, since enrolling in an MLTC plan is mandatory for any dual eligible adult (has both Medicare and Medicaid) needing home care.

While a member should not be disenrolled from the plan after 120 days in a rehab facility if they have an active discharge plan to return home, DOH relies on the plans to indicate which members have an active discharge plan. NYLAG has represented numerous MLTC members who were disenrolled from the plans because the plans failed to identify them as expecting to return home – especially those who have filed an appeal against the plan when it refused to reinstate or increases services needed to return home. This is not surprising as plans have an incentive to disenroll members who require more costly home care. These disenrollments that result in permanent nursing home placement defeat goals of rebalancing and should be tracked and reported publicly.

Now, DOH includes some minimal so-called "rebalancing data" in its annual 1115 Reports to CMS. The following Exhibit 5 is from the most recent 1115 Report.. See n. 8, pp. 29-30 of Report. This data is inadequate for reasons described below.

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Exhibit 5 - Rebalancing Efforts – excerpt from DOH 1115 Report to CMS for 2022

Rebalancing Efforts	7/2022-9/2022
1. Enrollees who joined the plan as part of their community discharge plan and returned to the community this quarter	129
2. Plan Enrollees admitted to a nursing home (for any length of stay) and return to the community	1,611
3. Number of current plan enrollees who were in nursing homes as permanent placements at the end of the quarter	2,940

SOURCE: NYS DOH 1115 Report for 2022, pp. 29-30 available at https://www.health.ny.gov/health_care/medicaid/redesign/reports/docs/2022_pp_annual_rpt.pdf

The data in Exhibit 5 above is lacking for several reasons. First, Line 2 states the number of enrollees who were admitted to a nursing home and return to the community, but not the number who did not return to the community. Without that context, the numbers are meaningless. Moreover, the data is not broken down by plan or region, but aggregated statewide. As stated above and illustrated by Exhibit 4, aggregated statewide data masks regional variations, particularly given the higher reliance on nursing homes outside of NYC. Additionally, the data is provided only for one quarter and not a full year.

The bill adopts evidence-based recommendations made by CMS that better track rebalancing, based on research by Mathematica.[11] Line 2 in the table above would, under the bill, measure the *rate* of each plan's nursing home admissions, with the percentage successfully discharged back to the community with MLTC services compared to the percentage who remained permanently in the nursing home. A "successful" discharge back to the community is defined in the CMS quality measures as one lasting sixty days or more, excluding discharges where the member was quickly readmitted to the hospital or rehab facility. Id. n. 11 at p. 7. The bill adapts the CMS/Mathematica recommendation to NYS by adding the percentage of members who had been admitted to a nursing home who were then disenrolled from the plan based on having a long-term nursing home stay of 120 days or more. Of those who were disenrolled on this basis, the bill also tracks the percentage who re-enrolled in the plan within the next six months, as a member is entitled to do under the CMS waiver

[11] Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures issue Brief*, Mathematica, Nov. 2019, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf.

approval.[12] Measuring the "rate" of admission, discharge, and disenrollment rather than the *number* of admissions or discharges allows comparison between plans of different sizes, just as using percentages instead of numbers do in sections (A) and (B) above.

Line 1 of Exh. 5 above from the 1115 Report commendably indicates the number of new enrollees to an MLTC plan who joined the plan after having been in a nursing home. This is a worthy measure of rebalancing, but the bill would require it to be broken down by plan for each region in which they operate. Also, the DOH report counts all new enrollments from a nursing home regardless of the length of the nursing home stay. The bill adopts the evidence-based measures recommended by CMS (n. 11), which break down the rate of enrollments of new members who had been in nursing homes by the length of stay in the nursing home. (n. 11 p. 8). Enrolling a consumer who had been in a nursing home for a 3-week rehab stay is a weaker indicator of rebalancing success than enrolling a consumer who had been in a nursing home for a year. Tracking this data could become the basis for new quality measures to reward plans for rebalancing success.

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The bill would add vital data to existing reports by the Department of Health needed to improve transparency for this $22 billion dollar program and hold plans accountable for goals of rebalancing long term care away from nursing homes and to improve staffing capacity. The reports, which would be annual instead of bi-annual, would be available in an interactive format online to enable comparisons between plans. This would not be burdensome as the Department already makes much data available online in interactive format at https://health.data.ny.gov/, and since plans already report this data, both on a statewide basis and separately for each geographic region in which the plan operates.

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[12] CMS Letter to DOH Donna Frescatore, Dec. 19, 2019, available at https://www.health.ny.gov/health_care/managed_care/appextension/2019-12-19_cms_stc.htm.