

NEW YORK STATE MANAGED LONG-TERM CARE

INTERIM REPORT

Report to the Governor and Legislature



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Attachment: Listing of Managed Long-term Care Plans in New York State

EXECUTIVE SUMMARY

The report has been prepared in fulfillment of the statutory requirement under the Managed Long-term Care Integration and Financing Act (Chapter 659 of the Laws of 1997) to provide an interim report to the Governor, Temporary President of the Senate and the Speaker of the Assembly on the status of the managed long-term care plans established under Chapter 659.

Managed Long-term Care Plans in New York State

In 1997, the Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997) was enacted, consolidating under one legislative authority all managed long-term care demonstrations and plans. The legislation was intended to create the necessary building blocks for integration of long-term care and other health care services for aged and disabled populations.

There are two (2) basic models of managed long-term care in New York State; Programs of All-Inclusive Care for the Elderly (PACE) and partially-capitated managed long-term care plans.

Each PACE is approved by the U.S. Centers for Medicare and Medicaid Services (CMS). A PACE organization provides a comprehensive system of primary, acute and long-term care services to enrollees age 55 and over who are otherwise eligible for nursing home admission. Both Medicare and Medicaid reimburse PACE services on a capitated basis. Enrollees are required to use PACE staff physicians and an interdisciplinary team develops care plans. The PACE is responsible for directly providing or arranging all primary, acute and long-term care services required by an enrollee.

The prepaid partially-capitated managed long-term care model is unique to New York State. Plans provide long-term care services, and ancillary and ambulatory services, and receive Medicaid capitation for these services. Enrollees access services from their primary care physicians and obtain inpatient hospital services on a fee-for-service basis. Enrollees must be age 21 and over and be eligible for nursing home admission.

As of May 1, 2003, there were 9,078 enrollees in fifteen (15) MLTCP plans in the State. Eleven (11) plans are partially-capitated managed long-term care services; four (4) plans are PACE sites.

For calendar year 2002, \$340 million in Medicaid capitated payments were made to MLTC plans. For calendar year 2003, Medicaid capitation payments are expected to increase 30% over 2002, based on plan projected enrollment of 10,500 by December 2003.

Findings

Managed Long-term Care Plans (MLTCPs) have evolved slowly, but steadily in New York. Department of Health monitoring indicates that the plans currently operating are providing high quality services in a culturally sensitive manner to a population with significant needs. As care models, preliminary indications are that the MLTCPs have been successful and client satisfaction appears to be high.

As insurance models, the effectiveness of MLTCPs is less clear. The relatively small enrollment of most plans has presented major challenges in terms of being able to project risk, achieve administrative efficiencies and establish appropriate pricing. These issues have been exacerbated by difficulties experienced by a number of plans in producing accurate and timely cost and utilization data. The ability to demonstrate cost-effectiveness, as required by statute, is a concern. Resolution of these issues will be important factors in considering the future of the managed long-term care program.

1. INTRODUCTION

The New York State Department of Health respectfully submits this interim report to the Governor of the State of New York and to the Honorable members of the New York State Legislature, in compliance with the provisions of The Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997), regarding the development and operation of managed long-term plans in New York State.

Chapter 659 established a framework under Article 44 of the Public Health Law (Section 4403-f) for the integration of long-term care service delivery and an alternative financing model through the development of managed long-term care plans (MLTCPs). The statute consolidated under one legislative authority all operational managed long-term care plans at the time of the enactment of the legislation, and authorized the development of additional plans. The objectives of the MLTCPs are to test a prepaid capitation finance model for a variety of service delivery, networks, target populations and organizational structures.

Paragraph 9 of Section 4403-f of the Public Health Law requires the New York State Department of Health to provide an interim report to the Governor and the Legislature on or before April 1, 2003, and a final report on or before April 1, 2006, on the results of implementing the managed long-term care plans authorized under The Long-term Care Integration and Finance Act of 1997. The present interim report is being submitted in accordance with this provision, and addresses the following issues consistent with the framework provided in the legislation:

- Quality, accessibility and appropriateness of services.
- Level of consumer satisfaction.
- Distribution of impairment levels of enrollees.
- Rate-setting methodology.
- Enrollment levels and enrollee characteristics.
- Levels of disenrollments.
- Utilization of services.
- Report prepared by the Superintendent of Insurance as to the results of the plans.
- Feasibility of increasing the number of plans that may be approved.

This interim report also identifies a number of factors that may influence the success of the managed long-term care model, based on the Department's experience with the current managed long-term care plans. Finally, recommendations regarding next steps for the managed long-term care model are included.

2. DEVELOPMENT OF MANAGED LONG-TERM CARE IN NEW YORK

Long-term Care in New York

Long-term care¹ services represent a substantial share of total health care spending in the United States. Medicaid is the single largest purchaser of these services in the country (almost 15% of overall health spending)². In Federal Fiscal Year (FFY) 2001, national Medicaid expenditures for institutional and non-institutional long-term care were \$64.9 billion, almost one-third (30%) of total Medicaid program costs.³

Caring for an increasingly elderly population is an issue nationwide. The challenge is particularly acute in New York State which has more elderly Medicaid recipients than any other state; almost 10% percent (452,651) of all elderly Medicaid beneficiaries in the country live in New York State. The increasing cost of caring for this population has created budgetary burdens in every state. Additionally, long-term care costs for the younger disabled populations are increasing. In New York, long-term care costs represent the single largest component (36% in FFY 2001) of total State Medicaid expenditures.⁴ In addition to cost pressures, there has been steady demand for programs to enable the elderly to safely remain living in the community for as long as possible. The convergence of these factors has resulted in a search for cost-effective alternatives to institutional-based long-term care for the elderly; New York State has been a leader in this regard. The managed long-term care (MLTC) program is one model, which has emerged out of these efforts.

The managed long-term care model provides a wide array of services and is designed to reduce the costs of long-term care by making clinical and non-medical services available to frail elderly and disabled populations in a home or community setting rather than in an institution. The availability of a range of services minimizes the use of high-cost institutional resources and makes services available in settings more satisfactory for consumers and their families. MLTC differs from other models of non-institutional long-term service delivery insofar as it places a greater emphasis on care coordination, as well as reimbursement methods designed to contain cost growth.

MLTC provides a coherent system of long-term care services, care coordination and social supports. The managed long-term care plan (MLTCP) services and operations are developed around patient requirements and preferences. Plans arrange for a wide range of clinical services, backed by support services (e.g., transportation, personal care and care management). All services required by

¹ Long-term care services are defined as nursing home, personal care, home health and other community-based long-term care services in this report.

² Levit, K., et al. "Health Spending in 1998: Signals of Change," Health Affairs, January/February 2000: Vol. 19, No. 1, 124-132.

³ Brian Burwell, The MEDSTAT Group, Cambridge, MA. Data from the HCFA-64 and the CMS Office of State Agency Financial Management.

⁴ Burwell.

enrollees are coordinated through the plans' care managers who serve as a central point of contact for all providers.

MLTC is intended to:

- provide a better coordinated system that allocates resources effectively and efficiently by providing the right service to the right consumer at the right cost;
- encompass a flexible system that decreases reliance on institutional care and makes long-term care more responsive to individual needs and preferences;
- allow for better coordination between Medicaid and Medicare;
- permit plans to place a greater focus on prevention;
- offer consumers another long-term care choice; and
- provide consumers opportunity for increased participation in their care delivery and management.

Evolution of Managed Long-term Care in New York

During the early 1990's several managed long-term care plans (Programs of All-Inclusive Care for the Elderly) were established in New York State on a demonstration basis. Subsequently, in 1994, the Department received a planning grant from The Commonwealth Fund to implement a demonstration project of capitated managed care programs for persons eligible for both Medicare and Medicaid who were eligible for nursing home placement. The goals of the project were to provide greater service flexibility, increase client satisfaction, improve health status, and test the effectiveness of capitation as a way to limit cost growth. Participating organizations were recruited in 1996.

In 1997, The Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997) was enacted, consolidating under one legislative authority all managed long-term care demonstrations and plans. This statute established a regulatory framework under Article 44 of New York Public Health Law (Section 4403-f) for the integration of long-term care service delivery and financing through managed long-term care plans. The objectives of the legislation are to create the necessary building blocks for enhanced coordination of long-term care and other health care delivery and financing, and to test a variety of service delivery, target population and financing models. Additionally, Chapter 659 permits plans to attempt more effective alignment of Medicare and Medicaid reimbursement within managed long-term care, and provides a framework for the full integration of financing and service delivery for beneficiaries who are dually-eligible for Medicare and Medicaid.

Other states (e.g., Minnesota, Arizona) have developed a single model for managed long-term care health care delivery and financing. However, New York State's legislation enables the development of a variety of service delivery and financing models. This flexibility permits the establishment of MLTCPs that meet the varied needs of the State's culturally and geographically diverse elderly and disabled populations.

3. MANAGED LONG-TERM CARE PLAN OVERVIEW

There are two (2) basic models of managed long-term care in New York State; Programs of All-Inclusive Care for the Elderly (PACE) and partially-capitated long-term care plans.

PACE Organizations

PACE organizations serve older adults who are medically eligible for nursing home care. The PACE sites are authorized by the federal Balanced Budget Act (BBA) of 1997. The BBA establishes the PACE model as a permanent health care provider type within the Medicare program, and enables states to provide PACE services to Medicaid beneficiaries as a state option, subject to approval by the Centers for Medicare and Medicaid Services (CMS). PACE is modeled on a comprehensive system of primary, acute and long-term care services tested nationwide through a number of demonstrations sponsored by CMS (then the Health Care Financing Administration) over several decades.

The PACE model was developed to address the multiple and sometimes competing needs of long-term care consumers, providers, and payers. It is a fully integrated health care delivery system. Enrollment is voluntary. For most participants, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized.

PACE participants must be at least 55 years old, live in the PACE service area, be certified as eligible for nursing home care, be in need of the long-term care services for 120 days and be able to safely live in the community at the time of enrollment. Most PACE enrollees are dually eligible for Medicare and Medicaid, although a small percentage of enrollees are Medicare and private pay or Medicaid-only.

A PACE organization receives monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing apply. The PACE assumes full financial risk for participants' care, without limits on amount, duration or scope of medically-necessary services. The PACE becomes the sole source of care and services for its enrollees.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing home services). The ability to completely integrate services ensures seamless provision of all necessary care. PACE organizations provide social and medical services, primarily in an adult day center, supplemented by in-home and referral services in accordance with the participant's needs. In most instances, enrollees are required to use PACE staff physicians as their primary care physicians.

The PACE is responsible for directly providing or arranging for all primary, acute and long-term care services required by an enrollee. PACE services include those traditionally covered by Medicare and Medicaid, as well as social and environmental supports. Services covered under Medicare and Medicaid capitation payments include: care management and coordination; inpatient and outpatient hospital services; primary and preventive care; adult day care (medical and social); meals; nutrition services; ambulance and non-emergency transportation; audiology; dentistry; home health and personal care; radiology/laboratory; prescription/non-prescription drugs; occupational, podiatry; physical, speech and occupational therapies; respiratory therapy; medical equipment and supplies; orthotics/prosthetics; personal emergency response systems (PERS); nursing home services (some Medicaid eligibility restrictions apply), and other social and environmental supports.

Partially-Capitated Managed Long-term Care Plans

The prepaid partially-capitated managed long-term care model is unique to New York State. These plans provide long-term care services, and ancillary and ambulatory services under capitated Medicaid funding. Enrollees access services from their primary care physicians and obtain inpatient hospital services on a fee-for-service basis.

Most enrollees are dually-eligible for Medicaid and Medicare, although a small number of people who are eligible for only Medicaid are enrolled. Enrollment is voluntary. Although not all Medicaid reimbursed services are covered under the capitation rate, the MLTCPs are responsible for coordinating all services, whether they are covered by the plan or available to enrollees on a fee-for-service basis through Medicaid and/or Medicare.

Enrollees must be age 21 and over, although target population ages vary; some plans have opted to enroll only those individuals age 65 and over. Enrollees also must be nursing home certifiable, be able to live safely in the community at the time of enrollment and in need of the long-term care services covered by the benefit package for at least 120 days.

Covered services include: care management and coordination; home health and personal care; nursing home care (Medicaid eligibility restrictions apply); physical, speech and occupational therapies; respiratory therapy; medical and social day care; meals; nutrition services; prescription/non-prescription drugs; podiatry; dentistry; optometry; audiology; non-emergency transportation; medical equipment and supplies; orthotics/prosthetics; PERS, and other social and environmental supports.

Acute and primary care services are reimbursed on a fee-for-service basis by Medicare and/or Medicaid. These services include: physician services; inpatient and outpatient hospital services; radiology/laboratory; mental health and substance abuse services; and emergency transportation. Since physician services are reimbursed on a fee-for-service basis, enrollees of partially-

capitated MLTCPs do not need to change their existing primary care providers when they join a plan, although the physicians must agree to collaborate and coordinate services with the MLTCP. In addition, care managers are responsible for arranging and/or coordinating non-covered services with the services covered by the plan.

How Do Managed Long-term Care Plans Provide Services?

To provide a better understanding of how the MLTCPs actually arrange, deliver and coordinate services; two enrollee case studies are included. The first study provides an overview of an enrollee of a PACE; the second describes an enrollee in a partially-capitated MLTCP. Both case studies demonstrate how the MLTCPs not only improve enrollees' health, but also contribute quite positively to their quality of life.

PACE Enrollee Case Study

Mrs. C. is an eighty-three year old widow, with a medical history of vascular disease, hypertension and double cataracts. She speaks little English; Cantonese is her primary language.

Mrs. C. enrolled in the PACE in February 1998. Since then her health has improved with regular monitoring by her interdisciplinary health care team. She has biweekly appointments with her nurse and monthly doctor visits at the PACE medical office. Both her nurse and physician are Asian and speak Cantonese.

Mrs. C. receives a broad spectrum of health services. While enrolled in the PACE, Mrs. C. has undergone cataract and gallbladder surgery. Her PACE health care team guided her through the treatment and surgery for both procedures, facilitated her return home and made arrangements for post-operative appointments with medical specialists. Throughout the process, a PACE staff member was available to translate and explain to her what was happening.

Mrs. C.'s home health aide, who was selected in part because she speaks Cantonese, keeps the apartment clean, buys food and prepares meals. She also attends to Mrs. C.'s personal hygiene needs and ensures that Mrs. C. takes her medications appropriately, as part of her PACE care plan.

Mrs. C. spends four days, each week at the PACE day center, which is near her apartment. In addition to appointments with medical staff or a social worker, she participates in the sewing club, regular Tai Chi classes and socializes with her Asian friends.

Five years after enrolling in the PACE, Mrs. C.'s chronic condition has stabilized and her overall health has improved. Thanks to daily care from a home health aide and regular PACE visits, she has been able to avoid institutionalization in a skilled nursing facility.

Partially-Capitated MLTCP Enrollee Case Study

Mrs. B. is an 83-year-old woman with Type I diabetes and hypertension, who also is legally blind. Her husband is elderly and debilitated. Their family support is limited; she has a mentally disabled granddaughter living in a group home and a 30-year-old grandson with a wife and 3 preschool children. The grandson works two jobs and is available for drop-in visits or emergencies only.

Upon enrollment into the MLTCP, Mrs. B. and her husband were living in a first floor flat in a high crime area. The house was in poor repair resulting in high heating bills. Because of the location it was difficult for Mrs. B to obtain home care in the evening hours.

Several months after enrollment in the plan, Mrs. B. fell and fractured her hip. Following hospitalization, she spent two months in rehab in a nursing home in the plan's network. At the time her husband did not need home care, and neighbors assisted him with errands and meals. The plan's care management team worked closely with nursing home discharge planners to facilitate a safe and workable discharge plan. Mrs. B. returned to her apartment, but an application was made to a nearby senior-housing complex that is handicapped accessible; Mrs. B and her husband were relocated to that complex several months later. Two years later Mrs. B. again fell and fractured her ankle and knee. She was readmitted to the same nursing home for rehab and returned home again. She has remained wheelchair bound. Several months ago her husband was hospitalized. He is immobile and confused, and has been admitted to a nursing home permanently. Mrs. B. wants to remain in her apartment alone. A certified home health agency provides a nurse once a week to set up Mrs. B.'s medications, which she is able to self-administer. She has a personal care aide 8 hours a week. A housekeeper is in the home once a week to do laundry, grocery shopping and errands. She wears a personal emergency response system (PERS) alarm at all times. Two meals are home-delivered daily. Due to declining vision Mrs. B. is no longer able to write out checks to pay bills; a volunteer from the local senior services visits her monthly to assist her in paying bills and writing checks.

Mrs. B. attends an adult day health care program three times a week. She also is receiving physical therapy at day program to improve her transfer techniques to reduce the likelihood of any future falls.

Managed Long-term Care Plans in New York

There are currently fifteen (15) plans operating across the State; eleven (11) are partially-capitated managed long-term care plans; four (4) plans are PACE sites. (New York has more PACE sites than any other state, with the exception of California and Massachusetts.)

- The first managed long-term care plans in New York State, Comprehensive Care Management Corporation (CCM) and Independent Living for Seniors (ILS), were established in 1992. CCM serves some areas of New York City and Westchester County; ILS serves Monroe County. They are both PACE demonstrations seeking to become approved PACE providers later this year.
- In 1996 Eddy Senior Care (Schenectady County) was established, and became a PACE provider approved by CMS in November 2002.
- In 1997 Independent Living Services (Onondaga County) became operational; it is currently a PACE provider approved by CMS (November 2002).
- In 1998 and 1999 five (5) MLTCPs were established with financial support from the Commonwealth Fund:
 - VNS CHOICE (New York City –1998);
 - CO-OP Care Plan (New York City – 1998);
 - Senior Network Health (Oneida County –1998);
 - Broadlawn Health Partners (now Health Partners NY) (Nassau County –1998), and
 - Partners in Community Care (Orange and Rockland Counties – 1999).
- Four (4) MLTCPs became operational in 2000:
 - Independence Care System (New York City);
 - HomeFirst (New York City);
 - GuildNet (New York City), and
 - Elant Choice (Orange County).
- In 2001, Senior Health Partners (New York City) was established.
- Total Aging in Place (Erie County) became operational in April 2003.

(See the Attachment to this report for a listing of the MLTCPs in New York State.)

As of May 1, 2003, there were 9,078 managed long-term care enrollees. While this is not a large percentage of the total New York State Medicaid population in managed care nor of total New York State Medicaid nursing home eligibles, it represents the nation's largest number of community residing Medicaid eligibles served by capitated long-term care plans.

The vast majority (82%) of enrollees are members of the seven (7) plans with sites in New York City. Enrollment growth in managed long-term care continues at a steady pace; in 2000, enrollment grew by 44%; the rate of enrollment growth in 2001 was 24%, and in 2002 enrollment grew by 41%. However, only a few plans drive the overall enrollment growth; many plans have remained at relatively constant enrollment levels.

For calendar year 2001, Medicaid expenditures (gross) for MLTCPs were approximately \$250 million. For calendar year 2002, the gross expenditures increased to \$340 million. For calendar year 2003, Medicaid gross expenditures are expected to increase by approximately 30% compared to 2002.

4. ENROLLEE CHARACTERISTICS

Over one-third (35%) of the enrolled population in MLTCPs is White (not of Hispanic origin); somewhat less than one-third (29%) is White (of Hispanic origin), and 25% of the enrollment is Black. The relatively large number of Black enrollees poses an interesting contrast to the population of New York State Long-term Home Health Care Programs, licensed home care services and certified home health agencies – of which 7% is Black.⁵ Another 9% of enrollees are Asian American. The remaining MLTCP enrollees (2%) identify themselves as Native Americans/Alaskan Natives and Hawaiian/Pacific Islanders.

By way of comparison, the age 65 and over population in New York State is 82% White (not of Hispanic origin); 6% is White (of Hispanic origin), 10% is Black; 2% is Asian-American and less than 1% are identified as Hawaiian/Pacific Islanders or Native Americans/Alaskan Natives (based on the 2000 U.S. Census).

Table 1 provides a breakdown of the MLTCP enrolled population as of January 1, 2003 by gender and age group.

Table 1
MLTCP Enrollee Population by Gender and Age

	NYC		Rest of State		Total	
	Number	%	Number	%	Number	%
All Enrollees	7,092	83	1,419	17	8,511	100
Gender:						
Male	1,808	25	264	19	2,072	24
Female	5,284	75	1,155	81	6,439	76
Age Groups						
21 – 54	510	7	45	3	555	7
55 – 64	424	6	84	6	508	6
65 – 74	1,744	25	260	18	2,004	24
75 – 84	2,666	38	525	37	3,191	37
85+	1,748	25	505	36	2,253	26

⁵ Data on primarily Medicare patients from the “New York State Quality Improvement Demonstration”, Center for Health Services and Policy Research, Denver, Colorado, 1998.

The majority (75%) of enrollees are female, which is to be expected in an elderly population, given the relative longevity of the female population. Independence Care System, which serves a primarily younger disabled population, has a relatively higher level of male enrollment (41%).

The predominate primary language of the MLTCP enrollees is English (57%). However, there is a certain degree of diversity in the other languages spoken by enrollees. In only one plan do enrollees speak English exclusively. Spanish is the primary language of 25% of enrollees. Chinese (primarily Mandarin and Cantonese) is the primary language of almost 6% of the enrollment, while Russian is the primary language of 5% of enrollees. The remaining 1% of enrollees account for at least 16 other languages, including Yiddish, Hebrew, Greek, Italian, German, Korean, Ukrainian, Bengali, Pakistani, French, Polish, Arabic, Serbian, Haitian-Creole, American Sign language and Romanian.

Chapter 5, “Culturally Competent Services”, describes how the plans have adapted and integrated various initiatives to increase cultural competence of staff and ensure services are delivered in the most appropriate manner for individual enrollees.

5. CULTURALLY COMPETENT SERVICES

The MLTCPs are required to establish policies, procedures and materials that address the service needs of the culturally and ethnically diverse populations they serve. Plans are expected to meet the “National Standards for Culturally and Linguistically Appropriate Services in Health Care” (CLAS), issued by the U. S. Department of Health and Human Services, Office of Minority Health (2001). The standards were developed to make services more responsive to the individual needs of all patients and consumers.

All MLTCPs assess the demographic and cultural needs of the populations in their service areas prior to beginning plan operations. Plans must have the capability of oral translation services for all languages they expect to encounter in the target population. Written promotional, marketing and enrollment materials are translated into the prevalent languages among the target population. All pre-enrollment screening includes questions about language, religious affiliation, and dietary needs; demographic information is included in each care management chart.

Most plans employ at least several bi-lingual staff members; in larger plans at least 50% of staff may be bi-lingual. In New York City, plan staff are available to translate as many as nine (9) languages. Plans also use the services of community-based civic organizations, and local colleges and universities for translation services. Subcontractors often are selected based on their ability to provide bi-lingual services. Most network provider listings include languages spoken.

All plans have the ability to access a telephonic translation service (e.g., AT&T Language Line) that provides simultaneous translation and interpretation over the telephone for those circumstances in which a bi-lingual staff person is not available. Several plans use portable electronic/telephonic language translation devices for use in a home-based setting. Both options permit the translation of almost 150 languages via translators.

Across the State, but especially in the Metropolitan area, addressing cultural issues and the health care needs of members are intertwined. While there is a certain commonality in the ways in which the plans address issues of cultural competency, there also is some variation, generally driven by the needs of a specific plan’s enrollee population.

Plans ensure that meals provided to enrollees meet their cultural and ethnic needs; the most prevalent examples are Chinese, vegetarian, vegan, halal (Muslim) and kosher diets. Whenever possible, staff from similar cultural backgrounds are assigned to care for enrollees, especially home health aide staff. Plans with day centers (generally the PACE sites) offer a number of types of religious services. The day centers celebrate national and religious holidays. Music and dance programs are drawn from a variety of cultures. All

plans have close affiliations with religious organizations and the houses of worship in their service areas. In addition, a wide array of civic and community organizations, ranging from the Hispanic Brotherhood to the Survivors of the Holocaust, provide services to the plans and their enrollees.

Most MLTCPs provide cultural sensitivity training for employees and contractor staff. Each plan includes general non-discrimination statements in staff recruitment and training materials, in member and provider communications, and in the core operational policies that guide the plan. Training programs focus on the value of promoting tolerance and understanding across all cultures. Many plans have made efforts to integrate sensitivity to cultural belief systems into health assessment activities. For example, staff is trained to understand different belief systems about death and dying, and to respect individual beliefs.

6. ENROLLEE IMPAIRMENT LEVELS

Medical Diagnoses/Conditions

The majority of managed long-term care plan enrollees have multiple chronic medical conditions. The most prevalent diagnosis (60%) among MLTCP enrollees is hypertension. Osteoarthritis is the second most frequent diagnosis (30% of enrollees). Over one-quarter (26%) of enrollees have diabetes; 25% have been diagnosed with some form of heart disease. Visual impairments (cataracts, glaucoma, blindness, other visual impairment, etc.) affect 17% of enrollees. Nine percent (9%) of enrollees have suffered a stroke or other cerebrovascular accident (CVA). Other less frequent diagnoses include endocrine and lipid/metabolic diseases (e.g., hypothyroidism); joint and cartilage diseases (e.g., osteoporosis, fractures); and asthma and gastrointestinal disorders. (Note: Diagnostic information is based upon the *International Classification of Diseases, Ninth Revision, Clinical Modifications*, the ICD–9CM.)

Functional Status

The MLTCPs collect information on enrollee behaviors and levels of chronic functional impairment, in addition to clinical diagnostic data. One of the tools used by the plans to collect this information is the federal (Medicare) Outcome and Assessment Information Set (OASIS). The OASIS data set includes a collection of core items for comprehensive assessment of an adult home care patient. It is designed to assist health providers in care planning and outcome monitoring, as well as clinical assessment. A key component of the OASIS is functional status data. These data are an integral element of the MLTCP's care planning process since they facilitate the plan's identification of areas where patient status differs from optimal health or functional status. The OASIS includes several key functional assessment sections, a behavioral assessment and an assessment of impairment related to activities of daily living.

Behavioral Assessment Results

Based on the MLCTPs' OASIS assessment of their enrollees:

- 49% display some level of confusion;
- 47% display some impairment of cognitive functioning (e.g., level of alertness, orientation, comprehension, concentration);
- 45% demonstrate some level of anxiety;
- 24% exhibit depressive feelings (e.g., feeling sad, tearful, sense of failure, hopelessness, thoughts of death);
- 18% exhibit memory deficits to the extent that some level of supervision is required (e.g., failure to recognize familiar persons/places, inability to immediate events), and
- 16% demonstrate impaired decision-making abilities (e.g., failure to perform usual activities, jeopardizing safety of enrollee and/or others).

Other less frequent behaviors include verbal aggression/disruption; physical aggression; other disruptive or inappropriate behavior, and delusional or paranoid behavior.

Activities of Daily Living (ADL) Assessment Results

The OASIS data set also captures information about activities of daily living (known as ADLs). "Activities of daily living" is a term commonly used to describe a person's ability to care for him or herself. ADLs are everyday activities such as eating, dressing, bathing, moving from a bed to a chair (also called transferring), toileting and walking. When people are unable to perform these activities, they need help, either from other human beings and/or mechanical devices.

Most enrollees of managed long-term plans experience multiple ADL impairments. The following section describes the level of ADL impairment among MLTCP enrollees.

Grooming

- 69% of MLTCP enrollees require assistance with grooming.
- Thirty percent (30%) of enrollees must have grooming utensils placed within reach, 28% require the assistance of another person and 11% depend entirely on someone else for grooming.

Dressing

- 81% of MLTCP enrollees require assistance with dressing.
- 24% require that clothing be laid out or handed to them to enable them to dress. 41% require assistance of another person to dress and 16% depend entirely upon another person to dress.

Bathing

- 82% of MLTCP enrollees require assistance of another person or use of an adaptive device in bathing in the shower or tub.
- Eighteen percent (18%) of enrollees are able to bathe themselves *without* the assistance of an adaptive device or assistance of another person; however, 66% are able to bathe themselves with the aid of devices or assistance of another person. Sixteen percent (16%) of enrollees are bathed in a bed or bedside chair by another person.

Toileting

- 43% of MLTCP enrollees require assistance with toileting.
- The majority (57%) of enrollees are able to get to and from the toilet independently; 27% are able to get to and from the toilet with assistance or supervision of another person, but 16% must use a bedside commode, etc. or are totally dependent on assistance in toileting.

Transferring

- 67% of MLTCP enrollees require assistance with transferring.
- One-third (33%) of enrollees are able to transfer independently. The majority of enrollees (52%) can transfer with limited human assistance or an assistive device. However, 15% of enrollees are unable to transfer without assistance or are completely bedfast.

Walking

- 92% of MLTCP enrollees require assistance walking.
- Only 8% of enrollees are able to walk independently. The vast majority of enrollees (80%) require use of a device (e.g., cane or walker) or some assistance. Another 5% are able to wheel themselves independently; 5% are wheelchair bound and require assistance. Only 2% of enrollees are bedfast.

Eating/Feeding

- 68% of MLTCP enroll require assistance with feeding or eating.
- Almost one-third (32%) of enrollees are able to independently feed themselves. The majority of enrollees (66%) require assistance. (e.g., meal set-up). Two percent (2%) of enrollees are so disabled that they require use of a nasogastric or gastromic tube.

A comparison (Table 4) of the functional status of MLTCP enrollees with recipients of services of New York State home health care agencies indicates that MLTCP enrollees demonstrate comparable or greater levels of functional impairment than those populations based on the OASIS assessments.⁶ A final comparison (Table 5) demonstrates MLTCP enrollee levels of impairment vs. PACE participants across the country.

⁶ Based on OASIS assessments of primarily Medicare patients in certified home health agencies, the long-term home health care program and licensed home care services agencies from “the New York State Quality Improvement Demonstration”, Center for Health Services and Policy Research, Denver, Colorado, 1998.

Table 4

Mean ADLs of MLTCP Enrollees vs. Home Health Patients

ADL	ADL Range*	MLTCP Enrollee Mean ADL	NYS Home Health Patient Mean ADL
Grooming	0-3	1.22	0.91
Dressing	0-3	1.60	1.30
Bathing	0-5	2.53	2.60
Toileting	0-4	0.82	0.70
Eating	0-5	0.84	0.30
Transferring	0-5	0.94	0.06
Walking	0-5	1.32	1.00

*Note: the higher the mean ADL, the greater the level of impairment

Table 5

**Prevalence of ADL Dependency
MLTCP Enrollees and PACE Participants Nationwide**

ADL	MLTCP Enrollees	PACE Participants⁷
Bathing	82%	81%
Dressing	81%	69%
Toileting	43%	52%
Transferring	67%	47%
Eating	68%	37%

⁷ National PACE Association, 2001.

7. ROLE OF THE LOCAL DEPARTMENTS OF SOCIAL SERVICES

Medicaid contracts for managed long-term care are executed between the plan and the New York State Department of Health. However, as with New York 's general Medicaid managed care program, the local departments of social services (LDSS) retain certain responsibilities, primarily in the areas of Medicaid eligibility determination, enrollment and disenrollment.

Medicaid Eligibility Determination

The LDSS makes the final determination about an individual's Medicaid eligibility for managed long-term care enrollment. In addition to determining financial eligibility, the LDSS also verifies that the applicant meets clinical eligibility criteria and that the enrollment is voluntary. Verification of clinical eligibility for enrollment is extremely labor intensive for the districts, and requires a significant commitment of resources to ensure appropriateness and timeliness of enrollment. At times, MLTC plans have expressed concerns about delays in the enrollment process.

Denial of Enrollment

If the plan proposes to deny enrollment, the applicant is afforded the protection of a local district review of the plan's decision. If the district agrees with the plan's determination that the applicant be denied enrollment, the district notifies the plan of its agreement. The LDSS also sends a notice to the Medicaid recipient indicating the enrollment has been denied, the reason for the denial and information about applicable fair hearing rights.

Should the district *disagree* with the plan's determination that the applicant be denied enrollment, a dispute resolution process must be used to decide if the applicant should be enrolled or denied enrollment.

Disenrollment

When a Medicaid recipient voluntarily disenrolls from a MLTCP, the plan notifies the local district of the disenrollment so that the district can process it as quickly as possible. The plan is required to document that the member wishes to disenroll. However, before the disenrollment can take place, the local district must also ensure that arrangements for Medicaid fee-for-service home care or other services are in place in order to protect the health and safety of the recipient. At times, plans have expressed concern about the length of time that it takes to ensure that home services are in place and the difficulty they encounter in continuing to serve a member who wishes to be disenrolled from the plan.

If a plan proposes to involuntarily disenroll a Medicaid recipient, the LDSS must agree with the plan's decision. The LDSS also may initiate disenrollment under certain circumstances. If the district agrees with the plan's decision about the

proposed disenrollment, it will send a notice to the Medicaid enrollee regarding disenrollment. If the district disagrees with the plans proposed involuntary disenrollment, the district and the plan must use the dispute resolution process to determine if the member should be disenrolled.

Fair Hearings

Medicaid fair hearing rights are preserved under managed long-term care. All notices normally issued during the Medicaid eligibility process continue. Additional notices are required when there is a denial of an enrollment by the LDSS and when an involuntary disenrollment from the plan is approved by the LDSS.

A denial of enrollment requires the LDSS to provide adequate notice to the applicant about the reason for the denial and the applicant's rights to a fair hearing. In the case of an involuntary disenrollment, the enrollee receives a notice about the reason for the proposed disenrollment, its effective date and the enrollee's right to a fair hearing. Districts must allow at least 10 days between the date of the notice and the date of the disenrollment action.

The enrollee has 60 days from the receipt of the notice to request a fair hearing. If the enrollee requests a fair hearing before the effective date of the disenrollment, the member remains enrolled in the MLTCP until the fair hearing decision is issued. When an individual is to be involuntarily disenrolled because of loss of MA eligibility, the LDSS sends the enrollee fair hearing notices regarding the eligibility loss as well as the proposed disenrollment.

If the fair hearing is decided in favor of the enrollee, the enrollee will remain enrolled in the plan. If a fair hearing is not requested or the fair hearing upholds the decision to disenroll the member, the disenrollment is processed by the LDSS, and the LDSS notifies the plan and the enrollee of the effective date of disenrollment.

The local district is expected to attend any fair hearings (and the plan may be requested to attend by the LDSS) to present the reasons for the denial of enrollment or for the involuntary disenrollment. The likely remedy would be for the Medicaid recipient to be enrolled or remain enrolled in the MLTCP if the fair hearing officer rules in favor of the Medicaid recipient.

Complaints

While the Department is responsible for investigating complaints regarding MLTCPs, issues may arise that are best addressed by the LDSS. These include technical problems with the Medicaid cards or systems delays in processing an enrollment or disenrollment.

8. RATE SETTING METHODOLOGY AND FINANCIAL STATUS OF PLANS

Capitation Risk Model

One of the innovative aspects of the managed long-term care demonstrations is the use of an insurance or “risk” model where plans are paid a predetermined amount per member per month (PMPM), and in return must manage and pay for all services included in the benefit package. This PMPM amount is referred to as the monthly capitation rate. Different capitation rates are paid for an enrollee depending on age category (generally 21-64 and 65+ for the partial capitation plans and 55+ for PACE), Medicare eligibility status (i.e., whether an enrollee is dually eligible for Medicare and Medicaid or is eligible only for Medicaid), and acuity level (high or low). Acuity level is determined using the enrollee’s score on the DMS-1, the assessment tool used by the plans and local social services district to determine eligibility for enrolling in managed long-term care plans. The monthly capitation rate is intended to cover the costs of all medical services in the benefit package, as well as the care management and administrative costs of the plan. Capitation rates are set on a calendar year basis.

Federal and State Requirements

Capitation rates for managed long-term care plans are currently subject to federal regulations which require that the plan not be reimbursed more than it would have cost the State to provide State plan-approved services to an equivalent non-enrolled population group. This is referred to as the Upper Payment Limit (UPL). In addition to Federal requirements, Section 4403-f of the Public Health Law requires that Medicaid capitation rates reflect savings when compared to the cost of providing comparable services on a fee-for-service basis to an actuarially equivalent non-enrolled population. These requirements are intended to ensure that the MLTC program is cost-effective for the state and federal governments.

To meet these requirements, the Department each year must calculate a UPL for each premium group. The UPL is to be based on historical Medicaid fee-for-service costs of an actuarially equivalent non-enrolled population group, which would be all Medicaid long-term care recipients who are nursing home certifiable.

For actual enrollment into an MLTC plan, a person is determined as nursing home certifiable if he or she has a score of 60 or more on the DMS-1 assessment form completed for the individual as part of the enrollment application process. Since the DMS-1 is not used in many long-term care fee-for-service programs, a proxy for determining a recipient’s nursing home certifiability is needed to identify the fee-for-service population for the purposes of calculating the UPL. This proxy was defined as any Medicaid recipient who incurred a minimum amount of long-term care expenditures for at least four continuous months. The proxy nursing home certifiable population used to calculate the UPL would thus include all residents in nursing homes, or

individuals receiving long-term care services in the community for four or more consecutive months. The result of using this proxy is that almost half of the individuals identified as nursing home certifiable are nursing home residents and half are community-based long-term care recipients.

Effective August 2003, the federal regulations issued by the Centers for Medicare and Medicaid require that states use a prescribed method and process to determine the actuarial soundness of MLTC plan Medicaid reimbursement rates. The new regulations require that for any capitation payments under risk contracts, the state must obtain an independent actuarial certification of the plans' capitation rates in lieu of an Upper Payment Limit test. The Department is working with an actuarial firm, Mercer Human Resource Consulting, Inc., to meet the requirements of these new regulations. The actuarial certification is based upon analysis of actual Medicaid fee-for-service data for an equivalent non-enrolled Medicaid population, which is very similar to the process used to develop an Upper Payment Limit in the past, and continues to use the proxy nursing home certifiable population. PACE organizations are not subject to the new federal regulations, and must continue to meet the Upper Payment Limit test.

Plan-Specific Premium Development

While all plans' capitation rates are subject to the federal and state requirements as described above, rates are determined separately for each plan. Each plan submits an annual premium rate proposal and operational budget to the State, based on its specific network of providers, target population, and benefits covered. The plan must project enrollment levels, and identify the type and amount of services that will be provided to its enrollees in the upcoming rate period. This plan specific budget reflects each plan's approach for managing care and providing services, and provides benchmarks for evaluating actual plan performance.

The Department reviews each plan's proposal, and negotiates with the plan to arrive at acceptable capitation rates, subject to the Upper Payment Limit and new BBA requirements described earlier. All capitation rates are subject to approval of the State Division of the Budget.

Financial Performance of Plans

Consistent with an "insurance" or "risk" model, plans must be able to pay for case management, administration and all needed medical services within premiums paid in order to be financially viable. The basic assumption is that the savings that will be derived from the delivery of medical services in managed care as compared to fee-for-service will be sufficient to cover the cost of care management and administrative expenses incurred by the plan. In general, medical savings are generated when a plan is successful in avoiding nursing home placements and maintaining people in the community at a lower cost than would have occurred in fee-for-service. In addition, plans must control

administrative and care management costs incurred under this model so that medical savings can cover these. (Several factors affect the ability of plans to operate in a cost-effective manner and maintain financial viability; these are discussed in Chapter 9.)

Overall, the managed long-term care industry has operated profitably, although individual plan performance has varied. In 2000, of the twelve plans operating, nine (9) reported an operating surplus. Two of the three plans reporting a loss for the year opened in 2000 and were in their start-up phase. In 2001, nine (9) of fourteen (14) operating plans reported a surplus for operations, and five (5) plans reported losses. Of the five (5) plans reporting losses, two (2) were in their first year of operation with very few enrollees. One (1) other plan had been open less than two years and incurred significantly higher costs than any other plan, including very high administrative and care management costs. This particular plan, serving a younger and more disabled population, merits further analysis to determine whether this targeted group is appropriate for an insurance risk model, or whether another type of care management structure would be a more appropriate vehicle to serve this group.

In 2002, while overall the managed long-term care industry continued to operate profitably, only six plans (6) reported an operating surplus, while eight (8) reported an operating loss. Four (4) plans that reported a surplus for 2001 incurred losses for 2002, and one plan with a loss in 2001 operated profitably in 2002. The four (4) plans with a 2001 surplus and 2002 loss all incurred significant increases in medical costs. Two (2) plans who began operation in 2001 with losses improved their financial performance for 2002 as enrollment increased, although they were still in a loss position.

9. FACTORS AFFECTING COST-EFFECTIVENESS OF THE MANAGED LONG-TERM CARE PROGRAM AND PLAN VIABILITY

From a regulatory perspective, the cost-effectiveness of the managed long-term care program can be evaluated through comparison of the MLTC plan capitation rates to the Upper Payment Limit to determine if the State is achieving cost savings. Based upon the calculated Upper Payment Limit (UPL) (see Chapter 8), the State has demonstrated cost-effectiveness of the managed long-term care program, and has determined that it is not paying more than it would have paid in fee-for-service for enrollees in the MLTC plans. However, the comparability of the proxy nursing home certifiability criteria used to determine the UPL to the population actually enrolled in the MLTC plans is vital to ensure that the cost-effectiveness test is appropriate. To the extent that the proxy population is not reflective of the population actually enrolled in MLTC plans, the cost-effectiveness test could be misleading. Another factor impacting this comparability question is the accuracy of the DMS-1 assessment tool in identifying nursing home certifiable eligibles, in ensuring that the UPL accurately reflects the same population that is enrolling in MLTC plans, and that “high” and “low” capitation premiums are paid appropriately. Additional analysis is required and consideration should be given to refining the current way that nursing home certifiability is determined.

From a programmatic perspective, cost-effectiveness is a function of how effectively the model operates. This includes how well MLTCPs manage their medical, care management, and administrative costs, and also whether they achieve enrollment levels sufficient to maximize efficiencies. The role and involvement of the local social services districts also affects the cost-effectiveness of a plan, in that it affects the plans ability to achieve enrollment growth and to ensure that enrollees meet clinical eligibility. There are also key differences between the two main types of MLTC plans; fully-capitated plans and partially-capitated plans that may affect plan efficiency and cost-effectiveness. These factors are discussed below.

- **Management of Expenditures by MLTC Plans**

The expenditures incurred by managed long-term care plans may be broadly classified into three categories: (i) Medical services, which are the expenditures for all medical and social services provided to enrollees, including home health or personal aide care, prescription drugs, transportation, nursing, therapies, and nursing home care; (ii) Care management, which are the costs of the plan in coordinating and planning the delivery of medical services, including the costs of nurse care managers, social workers, care management supervisors, and other professional staff employed by the plan; and (iii) Administration, which includes salaries of executive management, professional, marketing, and enrollment, finance, management information systems (MIS) , claim processing, and other

functions. Plans must properly budget and manage each category of services in order to assure cost-effectiveness and plan viability.

- **Medical Services and Utilization**

A key assumption in the MLTC model is that by supplying care management services, the plan can avoid or delay placement of many enrollees into nursing homes by substituting other community based long-term care services, such as personal care, home care, or day services. In fact, plans reported as of June 2002 that, on average, only 6% of enrollees were in nursing homes, although there is significant variation by plan (individual plans report between 1.6% and 21% of enrollees in nursing homes). As a comparison, the proxy nursing home certifiable population in fee-for-service has 50% in nursing homes. This suggests the plans have been successful at allowing enrollees to remain in the community.

However, plans have reported a growing trend in the number of enrollees receiving a significant number of hours per day of in-home care, including 24-hours per day of in-home aide care, which can be more expensive than nursing home placement. When this occurs the savings that were anticipated from avoiding or delaying nursing home admission are not realized and it becomes increasingly difficult to demonstrate that the plan is cost-effective compared to fee-for-service.

Many partially capitated plans theorize that their intensive care management services result in avoidance of hospital admissions for which the savings accrue to the Medicare and Medicaid programs. This theory is as yet unproven but warrants further evaluation.

Plan management of the type and amount of care provided and its particular network can greatly impact on its overall medical cost per member per month (PMPM) amount. Of the services provided by partially-capitated plans, the majority are non-institutional long-term care services, including personal care aides, home health aides, nursing, social day care, therapy, medical social services, and meals. The next largest medical cost category is care management, followed by pharmacy.

Tables 6 and 7 identify the major medical service categories for partially-capitated plans and PACE organizations, respectively.

Table 6
Non-PACE Plan Medical Cost Data Per Member Per Month
as Reported on the 2001 Annual Cost Report
by Collapsed Medical Expense Category

Total Cost Section – 2001 Costs	Weighted Average	Weighted Medical Expense Category as Percent of Total Medical
Total Member Months	48,405	
Skilled Nursing Facility	\$146.28	4.54%
Non-Institutional Care	\$2,102.30	65.31%
Pharmacy	\$289.19	8.98%
Transportation	\$101.17	3.14%
DME/Hearing	\$68.74	2.14%
Care Management	\$476.26	14.80%
Other	\$34.95	1.09%
Total Medical Expenses	\$3,218.89	100.00%

Table 7
PACE Medical Cost Data Per Member Per Month
as Reported on the 2001 Annual Cost Report
by Collapsed Medical Expense Category

Total Cost Section – 2001 Costs	Weighted Average	Weighted Medical Expense Category as Percent of Total Medical
Total Member Months	17,663	
Physician Primary & Specialty Care	\$375.34	7.89%
Inpatient Hospital – General	\$357.35	7.51%
Skilled Nursing Facility	\$360.29	7.57%
Non-Institutional Care	\$2,017.56	42.38%
PACE Center	\$824.80	17.33%
Pharmacy	\$284.80	5.98%
Emergency Room	\$13.01	0.27%
Transportation	\$223.56	4.70%
DME/Hearing	\$97.47	2.05%
Care Management	\$62.57	1.31%
Other	\$141.72	2.98%
Total Medical Expenses	\$4,760.09	100.00%

- **Administration and Care Management**

A factor that plays a critical role in the cost-effectiveness of the managed long-term care program and plan viability is administrative and care management expenditure levels. Together they constitute a substantial portion of the plan's total costs, and they can vary depending on the plan's enrollment level and the care management model employed by the plan. In 2002, the weighted average Medicaid capitation rate was \$3,750 per member per month. Of this amount, administrative and care management components together averaged \$750 per member per month, or about 20 percent of the capitation. Also important to note is the tremendous variation in these costs on a per member per month basis across plans. The range of these expenditures as a percentage of the overall capitation rate varied in 2002 from 17 percent to as high as about 50 percent of the total premium. Two key factors affect MLTC administrative costs; the financial arrangements agreed to regarding the purchasing of administrative services, and enrollment levels.

Many plans purchase a portion or all of their administrative services from other entities, primarily "related party" providers that operate other types of programs such as nursing homes, home health agencies, and housing. The financial terms of these contracts strongly influence the level of a plan's administrative costs. The method used by the related party to allocate the value of certain shared services from the parent organization to the plan may vary greatly from plan to plan, and, in some cases, may not be related to services actually used by the plan. In some instances, the amount of costs allocated to the plan are not determined until after year-end, which does not provide the plan with the opportunity to appropriately manage its costs. The Department has begun to work with plans to assess whether current contracts are reasonable and represent what a prudent purchaser would incur for such services.

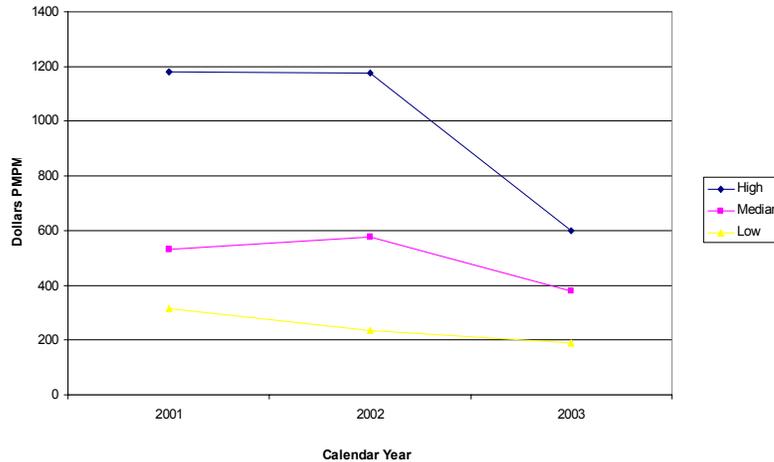
- **Enrollment Levels**

The second key factor in achieving administrative efficiency is the plan's enrollment level. In order for any prepaid capitation insurance model to be financially viable, there is a minimum enrollment level the plan must obtain, in as short a time as possible. For traditional HMO models, the "break even" point is generally expected to require at least 5,000 enrollees, so that administrative staff and "fixed" costs such as claims processing systems, rent for its administrative offices, and other expenses, are reasonable on a PMPM basis. Plans with low enrollments face a tremendous challenge in achieving such efficiencies.

A summary of plan administrative costs PMPM for 2001 and 2002, and 2003 projected costs included in plan premiums, is shown in Table 8. The

median, as well as the highest and the lowest plan administrative cost per member per month is shown for each year.

Table 8
New York State Managed Long Term Care Program
Administrative Costs, 2001 - 2003
High, Median, and Low Values



In 2001, the median administrative cost per member per month was \$530, with the highest plan having a cost of \$1,199 and the lowest having a cost of \$315. In 2002, the median cost level was at \$575, but there was more variation among plans, with the highest plans at \$1,175, and the lowest plan at \$236. In each of these years, generally the plans with high administrative costs on a PMPM basis had relatively small enrollments, and plans with lower administrative costs had large enrollments. The projected administrative cost component of the 2003 capitation rates contemplates PMPM reductions (median cost of \$380. PMPM). The expected range of PMPM cost is also narrowed from a low of \$190 to \$600. Early indications are that a number of plans are experiencing difficulty operating within these levels.

On average, the 2003 rates for plans having fewer than 250 enrollees included administrative expenditures of about \$600 per member per month. The rates for plans having enrollment greater than 250 but less than 1,200 members included administrative costs of about \$400 PMPM, and the rates for plans with enrollment over 1200, included administrative costs at \$300 or lower.

In addition to its importance in assuring administrative economies, enrollment levels can also impact a plan's ability to project utilization and absorb risk. Small plans experience significant variability in enrollee utilization – the variation between MLTCPs in nursing home admissions is a good example. The ability to accurately project costs is critical to any insurance model, both in terms of effectively operating the plan and appropriately pricing the product.

For MLTCPs to be successful as insurers, they must be able to manage their operations within the premiums established. Increasing enrollment levels is essential to achieving administrative efficiency and increasing the predictability of plan utilization and cost. The sooner a critical enrollment mass is reached, the more likely it is that a plan can be financially secure. The likelihood of a plan achieving such a critical mass is an important consideration in any future approval process for new plans.

- **Impact of DMS-1 Assessment Tool on Eligibility and Reimbursement Levels**

The DMS-1 currently affects the reimbursement amounts paid to the plans as separate Medicaid capitation premiums are paid for enrollees based on DMS score. The “high” premium group is for enrollees whose DMS-1 score is 180 or above, and the “low” group is for enrollees who score between 60 and 180. The “high” monthly rate for a given plan can be as much as \$1,000 higher than for the “low” group.

Therefore, the reliability of the DMS-1 is an extremely important factor related to the cost-effectiveness of the managed long-term care program, both for the plans and for the State.

There are some indications that the DMS-1 assessment tool, and its scoring, may not be sufficiently reliable for the managed long-term care program. The DMS-1 assessment tool had been originally designed by the Department in the 1970’s to assess the level of nursing home care for individuals residing in a nursing home. The assessment form collects information on Activities of Daily Living (ADL) needs, nursing and therapy needs, medical diagnoses, and functional impairments. A scoring method was developed by the Department that assigns points to various levels of need or impairments to represent intensity of service needs. That scoring process results in an overall score that can range from zero to a score that exceeds 700.

However, there may be differences in scoring that are subjective and open to clinical interpretation. In one instance, for almost 75% of a sample from a plan’s enrollees, the local district’s classification was different from the plan’s classification. In this case, the local district classified enrollees as “low” where the plan had classified them as “high”. The Department has had to issue updated instructions and clarifications for the completion of the DMS-1. For some plans, this has impacted revenues by a reclassification of enrollees from the “high” payment group to the “low” payment group.

Furthermore, a number of medical conditions and diagnoses may not be captured or scored properly by the DMS-1. Many MLTC plans have pointed out that the DMS-1 does not include an adequate assessment of

cognitive impairments, including dementia, which can significantly impact the cost of care for that enrollee.

For 2003, the Department has moved away from the “high” and “low” rate categories and is reimbursing plans one average rate. Over the coming months, the Department intends also to review options for a better assessment process and tool, including the feasibility of refining the DMS-1, assessing federal clinical assessment and outcome instruments that may be applicable as alternatives to the DMS-1, or incorporating sections of existing alternative instruments with the DMS-1.

- **Local Social Service District Involvement**

Local social services districts (LDSS) determine whether a Medicaid eligible applicant of a MLTC plan is clinically eligible to enroll in the plan. This requires a clinical assessment of every applicant to determine whether he/she is nursing home certifiable. The districts also must be involved when an applicant is denied enrollment by a plan, or when a Medicaid recipient chooses to voluntarily disenroll from a plan.

There is significant variation in the level of district support for the MLTC plan and its enrollment activities. For example, districts may verify the clinical eligibility of a potential MLTC applicant in one of several ways, depending upon their staff resources or other factors. A district may conduct an independent assessment of the applicant, including the completion of the DMS-1, to verify a minimum score of sixty; or do so jointly with the plan; or not assess the applicant directly but simply review plan documentation. These variations in local district involvement, as well as the timeframes to complete eligibility and enrollment activities, can directly affect plan enrollment levels. In addition, some districts may have available alternative long-term care programs that they determine to be more appropriate than the managed long-term care program for one or more applicants.

Thus, local district involvement affects plan enrollment levels, level of depth of DMS-1 assessment reviews, and the correctness of rate cell placement. The Department has developed, and disseminated to the districts, a manual that summarizes the responsibilities and review procedures that the districts need to address. The Department will continue to work with the districts in providing support for the MLTC plans and enrollment process. In general, the local social services districts have been very supportive to the MLTC program, especially in light of budgetary limitations. However, the variations in degrees of district involvement remain an important factor in assessing the success and effectiveness of the managed long-term care program.

- **Plan Data Reporting Capability**

The ability of a plan to produce cost and utilization data in an accurate and timely manner, by premium group and by service, is a critical factor in the plan's ability to manage its own operations. It is also critical for the State to receive accurate and timely information, which is used to establish sound capitation rates; monitor the financial viability of the plans, and assess the quality of services being provided to plan enrollees.

Each plan is required to submit an annual certified cost report of the plan's medical costs broken down by specific medical service and premium group, actual utilization and price for services provided and detailed administrative and care management expenditures incurred by the plan. Balance sheets, revenue and expense statements and related financial information are also required on an annual basis as part of this report. In addition, plans submit modified quarterly cost reports, with less detail, which are not required to be certified. Each plan submits a premium proposal for each rate year, based on its historical cost and utilization experience and its budgeted projections for the upcoming rate year.

A number of plans have had significant difficulties in meeting these reporting requirements. Some plans, for example, still do not have the ability to track and report expenditures of their enrollees separately for the "high" and "low" premium groups. Other plans have indicated only limited ability to track what services have been authorized, and one plan has stated it will not know what its actual costs are until at least six months after the year ends. A number of plans are in the process of converting to more sophisticated MIS/reports systems that will mitigate these problems in the future. Similar problems exist with reported utilization data, which can vary from the information on the cost reports, primarily because the plans' internal reporting systems are not integrated. In 2002, the Department contracted with The Island Peer Review Organization (IPRO) to analyze the data collection and reporting systems of the MLTCPs. This study found that most of the plans do not have adequate processes in place for collecting and reporting utilization data.

Many plan reports are not filed in a timely manner. None of the fifteen (15) operational plans, for example, submitted a complete and timely annual cost report for calendar year 2001; all but three plans were more than two months late, and four of the plans were more than three months late. Only two of the 15 plans submitted complete and timely rate proposals for 2003 rates; six were less than one month late, while four plans were two or more months late in submitting their rate proposals.

Currently, plans are not required to submit encounter data. Instead, plans submit summary utilization data on a quarterly basis of each enrollee's services. A number of plans compile this information manually and significant discrepancies exist between such reports and other submitted

data. The Department believes that, consistent with other managed care plans, the MLTC plans should be required to submit encounter data. This will greatly enhance the ability of the Department to evaluate the amount and quality of care rendered, relieve plans of the requirement to submit compiled summaries, and serve as an added source for information used to establish premium rates. The Department has initiated discussions with the plans regarding submission of encounter data.

- **Varying Models of Care**

As described earlier in the report, there are two basic models of managed long-term care in New York State: Programs of all-inclusive Care for the Elderly (PACE) and the partially-capitated long-term care plans. Of the fifteen (15) plans currently operating, four (4) are PACE organizations and eleven (11) are partially-capitated plans.

An important difference between the two models is that PACE receives a Medicare capitation payment, which permits the plan to accumulate savings from substituting Medicaid covered services for Medicare covered services. In fee-for-service, Medicare generally pays for acute care services, such as physician and inpatient, but only limited long-term care services (i.e., up to 100 days of nursing home); Medicaid pays for most of the long-term care services.

When a PACE organization is successful at reducing acute care costs because of enhanced care management and use of chronic support services such as personal care, it reaps the benefit of the “saved” acute care dollars because Medicare pays the plan a capitation premium.

However, in a partially-capitated plan, the Medicare covered acute care services not used result in direct savings to the Medicare program, rather than to the plan. In fact, a partially-capitated plan may spend more than Medicaid would have paid in fee-for-service, by substituting long-term (Medicaid funded) services for acute care (Medicare funded) services. There is evidence that suggests that the plans that began as partially-capitated or pre-PACE models did not become financially viable until they became PACE organizations, which allowed them to retain the portion of the Medicare capitation not used to pay for acute services, and until they achieved sufficient enrollment levels.

However, even under the PACE model, there is some national evidence that the Medicare capitation levels have not been fully covering the Medicare share of the costs of these services. Thus, the Medicaid program may be helping cover some of the costs resulting from this substitution of services. A national study sponsored by the federal Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services) and conducted by Abt Associates, Inc. found that there was a significant difference in the PACE program’s impact on Medicare

vs. Medicaid costs. The study, released in 2000, was entitled “Evaluation of the Program of all-inclusive Care for the Elderly Demonstration: A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment.”

According to the study, the combined Medicaid and Medicare costs under the PACE organizations nationally were very slightly higher than the combined Medicare and Medicaid costs for a comparable population in fee-for-service. However, the study pointed out a dramatic shift in costs from Medicare to Medicaid under the PACE model. While the program was much less expensive for Medicare (which paid only \$1,037 PMPM in capitation to the PACE organizations, vs. \$1,921 PMPM in fee-for-service) it was much more expensive for Medicaid, which paid an average of \$2,176 PMPM in capitation to PACE organizations vs. \$1,193 in fee-for-service.

Thus, while it is conceptually a “better” and more integrated model to have both Medicare and Medicaid participating in a capitation model, so that the plans can reap the benefit of any overall savings from fee-for-service even with a shift in care from Medicare to Medicaid covered services, unless the Medicare capitation is adequate, the State could end up paying more than its “share” of plan costs. Further, it is not clear that, even on an overall basis, PACE programs have demonstrated cost-effectiveness. The federal government cited the study’s limitations and the need for further evaluation before drawing any conclusions regarding the PACE model.

There are other differences between the PACE and partial capitation models that may affect cost-effectiveness. The PACE model utilizes an inter-disciplinary team of professionals to assess and plan the care needs of the PACE enrollees. Although it may cost more to have enhanced intensive care management, there may be cost benefits accruing from this interactive team approach. While the joint Medicare and Medicaid funding stream and the team approach to care planning may be considered positive features of the PACE model, there are some PACE features that may be less cost-effective. The PACE model relies on a day care model, where enrollees come one or more times a week to socialize and receive some services. This feature means that PACE organizations must deal with physical plant restrictions and hence may have enrollment capacity limitations. This could in turn impact their cost-efficiency, since the plan’s fixed costs can only be spread over a smaller enrollment base.

The PACE organizations must also face greater up-front capital investment than the partial capitation plans for building the day center. Finally, since PACE enrollees must use the plan’s staff physicians, there has been some reluctance on the part of potential applicants to forgo their freedom of choice of physicians and join a PACE program, again impacting enrollment.

The partial capitation plans generally have greater flexibility in their operational requirements. With the absence of a day center, partial capitation plans are able to increase their enrollment base without significant capacity considerations. This helps reduce administrative and overhead expenditures on a per member per month basis. Given the freedom of choice of physicians, the non-PACE models are also more able to attract applicants who may be reluctant to forgo this independence and consider a PACE organization. Partial capitation plans also generally need less capital investment at start-up. In the area of care management, these plans also have greater flexibility in formulating models of coordinating and planning the care of services to their enrollees vs. the inter-disciplinary team model of PACE. Finally, partial capitation plans do not assume the full risk for the care of their enrollees, and thus, avoid financial exposure due to a catastrophic hospitalization.

There are, however, some limitations. Since these plans do not assume the risk for primary care and hospitalizations, plans may be less aggressive in developing care plan strategies that are aimed at avoiding hospitalizations. Moreover, since the enrollees are free to come and go to their own physicians in addition to receiving services and care management through the MLTC, coordination of care and meeting the medical needs of these individuals may not be as cost effective as if the MLTC had full responsibility.

While the PACE and partial capitation models of managed long-term care each have their unique characteristics and factors that influence their success and effectiveness, both models are heavily impacted by the presence of sponsorship by a parent organization. This factor must be taken into account in assessing the feasibility of expansion of the managed long-term care program. The absence of sponsorship could mean more difficulty in raising adequate start-up capitalization, which is critical to support the financial viability of the plan in its initial, low-enrollment, period of operation and be a safety net in the event of operating losses.

10. QUALITY, ACCESSIBILITY AND AVAILABILITY

New York State's assessment of quality, accessibility and availability in managed long-term care plans is based on several types of monitoring. The first level consists of the plans' own internal quality management systems. These quality systems are approved by the Department and subject to on-going periodic review. In addition, the Department conducts other external monitoring through readiness, operational and targeted reviews, and monitoring and analysis of information/data submitted by the plan.

This quality assurance approach is intended to: 1) ensure the quality, accessibility and availability of care and services; 2) support the plan's internal quality assurance and improvement activities, and 3) identify issues requiring State intervention.

MLTCP Internal Quality Management

Each MLTCP's internal quality assessment and performance improvement (QAPI) system is designed to promote healthy outcomes, identify and correct problems, and ensure care is consistent with generally accepted medical standards and clinical guidelines. The Department approves the plan's proposed QAPI system before the MLTCP begins operations. After program implementation subsequent periodic on-site reviews ensure the QAPI is functioning appropriately. The MLTCPs' quality management program includes standards and processes for monitoring accessibility, availability, continuity, and quality of clinical care and non-clinical services. These standards should be linked to enrollee health outcomes, functional status and satisfaction. Quality programs also include performance improvement projects intended to realize significant improvements in both clinical care and non-clinical services.

State Monitoring of MLTCPs

The Department has established standards and processes for monitoring the MLTCP during all phases of operation. Readiness reviews assess a plan's pre-operational capacity to deliver quality care and services. When the MLTCP is operational periodic on-site reviews of plan administration, service delivery and quality management systems are conducted. The Department also analyzes plan data submissions (e.g., utilization, complaints and grievances, enrollments/disenrollments, and enrollee satisfaction data) on an on-going basis.

MLTCP Readiness Reviews

Certain aspects of a plan's ability and readiness to provide necessary care and services can be evaluated based upon review of plan materials, policies and procedures. For example, all marketing materials are reviewed to ensure that they communicate all necessary information in plain language. Additionally, an on-site readiness review is performed prior to the start of enrollment to

determine if the plan has appropriately implemented necessary operational components. The plan's infrastructure is examined, including adequacy of quality and information systems; staffing patterns; qualifications and training; and the roles of the Board of Directors and the Medical Director. The review also covers an assessment of plan policies and procedures, including: provider recruitment and credentialing; adequacy of the provider network; practice guidelines; care management processes; marketing plan and materials; enrollment/disenrollment materials and processes, and member services. Approval of marketing and enrollment materials is especially important, insofar as they must ensure that the voluntary nature of the program is effectively communicated to applicants and enrollees. (The Department collaborates with the State Insurance Department and the State Office for Aging in review of marketing and member materials.) During the readiness review, the MLTCP must demonstrate that it is prepared to operate according to Departmental standards before the plan is authorized to begin marketing.

Ongoing MLTCP Monitoring/Technical Assistance

The Department monitors information submitted by the MLTCPs and provides technical assistance to plans on a regular basis. Data reported by the plans include enrollment and disenrollment data and provider network information. Data are reviewed for trends or patterns that may warrant further examination of such issues as marketing practices, satisfaction with services, capacity to deliver covered services and appropriateness of providers within the network.

MLTCP Performance Reviews

Performance reviews are intended to assess whether plans are in compliance with applicable laws, regulations and guidelines. They also enable the Department to identify areas in which plans can make improvements.

These reviews are conducted annually; they focus on aspects of plan performance that cannot be readily monitored from the data submitted by the plans. The reviews provide an opportunity to evaluate marketing, enrollment and disenrollment practices, complaint and grievance information/processes and the plans' QA programs. The performance review also provides an opportunity to scrutinize any potential problem areas. Provider records are examined to ensure the plan has properly instituted its credentialing process. Additionally, a random sample of care management records is reviewed for completeness, timeliness of service delivery, consistency with the plan's practice guidelines, verification that the enrollee's plan of care is current and appropriately implemented, and accuracy of functional assessments.

Annual Performance Review Findings

During the most recent series of annual reviews, the Department found that the plans were performing satisfactorily for the most part. The commitment of the MLTCP staff across the State is impressive. For example, during the World Trade Center tragedy, plans located in Manhattan continued to maintain services with little interruption. The staff located at one plan's Adult Day Center near the Trade Center site has been commended by the Department for the remarkable manner in which they quickly reacted and adequately provided for the ongoing care and safety of enrollees. The plan's ability to creatively organize resources and maintain professionalism was exemplary.

- **Administration and Governance**

Several plans are still resolving issues about their governance structures and the role of their governing body in plan operations and quality oversight. Some plans have been required to institute more formal mechanisms to assure consumer participation and input into plan operations

- **Marketing, Consumer Information and Cultural Diversity**

While the performance reviews have not identified any major problems related to marketing or other consumer information activities, at least half of the plans have been required to make technical and/or editorial changes to their member handbooks. Many of the same plans (and others) also have enhanced their marketing plans and have improved their ability to reach out to non-English speaking communities. They also have increased the number of languages in which plan materials (e.g., member handbooks, enrollment/disenrollment and medical release forms) are written, and expanded their ability to address the needs of culturally diverse populations.

- **Care Management**

Care management activities are at the very heart of managed long-term care and, as a result, they are closely scrutinized during performance reviews. The plans' abilities to fully integrate and actualize a continuum of comprehensive care activities into overall program operations (as well as tailoring care management and coordination to individual enrollees) is somewhat challenging for some of the newer plans. Consequently, some plans have been directed to improve methods of client assessment, ensure up-to-date and comprehensive care plans, and/or enhance communication among staff and providers. Several plans also have been required to improve their care management tracking systems and to establish processes for auditing and monitoring care management activities. The role of care management in improving clinical and functional status rather than simply arranging services also has been stressed.

However, physician services are not covered in the benefit package of the partially-capitated plans. This exclusion results in a critical need for close coordination between the MLTCP and the enrollee's primary physician, which does not always occur. The result has sometimes been the inability of the plans to have an optimal impact on service delivery and clinical outcomes.

- **Provider Network**

A number of plans have been required to make changes to their provider manuals, develop additional manuals to encompass all provider types and/or expand provider training.

Adequate personal care services and selection of nursing homes have been issues in two plans. Availability of adequate home care services is a critical aspect of managed long-term care. Consequently, the Department required the plan with home care issues to correct the problem within 30 days or face suspension of all new enrollments. The MLTCP corrected the problem, and the Department has been monitoring its activities on an on-going basis to assure continued availability of all necessary services. Expansion of another plan's nursing home network was recommended, as a limited network is an important issue for consumer satisfaction, and lack of choice appears to have contributed to some disenrollments.

- **Intake/Enrollment and Disenrollment**

Issues needing remediation have included interpretation and application of functional assessment and eligibility criteria, and use of intake and enrollment materials. A number of plans were advised to pursue greater coordination of enrollment and disenrollment activities with the LDSS. The enrollment and disenrollment processes are extremely time consuming and labor intensive; plans must work closely with the LDSS to prevent delays and problems. (The districts also must have the ability to ensure timeliness of both enrollments and disenrollments, especially disenrollments, to ensure prompt return of the enrollee to fee-for service Medicaid.) Some plan policies for applicant withdrawal, determination of ineligibility (including applicant acknowledgement) and member disenrollment required changes. In certain instances, plans were instructed to revise their policies, including clarification of voluntary vs. involuntary disenrollment. Several MLTCPs also were required to revise and coordinate their policies about application of the Medicaid spenddown criteria with the LDSS.

Quality Assurance Programs

Most MLTCPs have made satisfactory progress towards implementing their quality assurance and improvement programs. For example, one plan has established a process of “customer service home visits” to monitor the care and services delivered. Other plans have developed creative approaches to focus the topics of their quality of care studies. Still, some plans need to enhance their review of clinical concerns, while others need to expand quality monitoring beyond clinical issues to other plan operations (e.g., care management, client intake). The ability to collect and analyze appropriate data to support quality related activities is one area where a number of plans continue to exhibit some difficulties, and absence of these data has created a negative impact on utilization review and management efforts.

State Complaint Investigation Process

Although the Department encourages plans and members to resolve complaints and grievances at the plan level, members are advised (in the member handbook) they have a right to complain to the Department of Health at any time. (The Department’s hotline telephone number is published in the member handbook.) Complaints can be received by the Department at either the central or regional office level.

Depending on the severity of the complaint issue, it will be investigated by the Department or forwarded to the MLTCP for self-investigation (with follow-up by the Department). If the complaint is substantiated, corrective action is required and implementation monitored by the Department.

The Department has received a small number of MLTCP complaints. Since 1998, there have been approximately 50 complaints regarding eight (8) of the MLTCPs; about one third (1/3) have been unsubstantiated. Complaint issues have included: allegations of inappropriate marketing practices and disenrollments; quality of care concerns; enrollment misunderstandings; allegations of contracted staff misconduct; denial of service issues and assertions of failure to provide services.

In 2001, in the most significant circumstance to date, the Department received multiple complaints about a plan in Upstate and its related home care agency, which resulted in decertification of the home care provider. In this instance, the plan worked extensively with the Department and the CMS to improve its operations.

(See Chapter 10 for a more detailed discussion of complaints in managed long-term care.)

Other State Monitoring

- **Focused Quality Studies**

The Department is requiring the plans to conduct at least one major quality improvement study that reflects enrollee needs, care and services during 2003. The Island Peer Review Organization (IPRO) has assisted in the review and selection of the plans' study topics and will be providing technical assistance to the plans throughout the study period. The MLTCPs will report their study findings to the Department by January 2004. At that time, the Department will distribute information about the various study methodologies and results among all the MLTCPs. Additionally, in 2003, IPRO will be conducting a survey/audit of each plan's fall prevention activities, and will provide recommendations to the Department and the plans.

- **Diabetes Survey**

In 2002, the Department contracted with IPRO to conduct a survey among all MLTCP enrollees to obtain their perspective on the diabetes care they receive from their plan. Treatment of diabetes is a major concern for the MLTCPs and their enrollees because over one-quarter (1/4) of all MLTCP enrollees have diabetes. Diabetes is one of the major causes of mortality and morbidity (e.g., reduced mobility and functional disability, increased infection risk, eye disease, increased incidence of amputation). However, most diabetic complications are preventable if the disease is controlled properly.

The survey data were analyzed to measure the extent to which the MLTCPs and their provider networks met American Diabetes Association (ADA) guidelines for diabetes management and to evaluate patients' access to and satisfaction with their diabetes care. Findings were shared with the plans to allow them to improve their overall quality of diabetes care.

The results of the survey were quite positive; 96% of MLTCP enrollees queried indicated they were satisfied with the information they receive about diabetes care. Almost all (98%) enrollees surveyed rate the diabetes care they receive from their MLTCP positively .

- **Data Audit**

In 2002, the Department also utilized IPRO to analyze the data collection and reporting systems of the MLTCPs. With the growth of managed long-term care comes a greater need for regulatory oversight, including monitoring service utilization reported by plans. Consequently, the study's objectives were to validate the completeness and accuracy of data reported by the plans to the Department and to analyze the plans' data

collection and reporting systems. IPRO found that all plans audited have adequate systems for processing enrollments and membership data; service authorizations; claims processing; data protection, and patient confidentiality. Most plans have satisfactory systems for subcontractor oversight, and adequate systems to ensure accuracy and completeness of data reported to the Department. Data reporting is the one area where most of the plans were found to be deficient. IPRO reported that most plans do not have adequate processes in place for collecting and reporting utilization data. This shortcoming is also discussed in Chapter 9. (This finding by IPRO corroborated similar findings by Department staff during plan performance reviews.)

IPRO recommended that the MLTCPs implement systems capabilities compatible with the Department's reporting requirements; develop integrated systems for verifying that all authorized services are provided; and work cooperatively with the Department to develop a forum to address issues regarding utilization data reporting. IPRO also recommended that the Department provide explicit documentation (including detailed definitions) of the data elements for all service categories for which utilization data are to be reported, and continue to monitor the accuracy of the data reported by the plans and systems for data collection and reporting.

However, in the near future the Department expects to modify its systems to accommodate the submission of individual client-specific encounter data from managed long-term care plans, which will provide a more efficient way for plans to submit data on service utilization to the Department.

- **Quality Training for MLTCPs**

In June 2002, IPRO conducted a training seminar for MLTCP staff on quality improvement (QI) processes in managed long-term care. The seminar was designed to help plans identify areas to target for QI, develop QI indicators, and develop, implement and evaluate QI strategies and focused studies. The training addressed topic selection, sampling methodologies, action plans and use of available data sets for quality improvement, as well as successful approaches for quality improvement.

The IPRO seminar was one of a series of meetings initiated by the Department in September 2001 to foster increased collaboration with the plans, and to help improve their ability to provide quality, cost-effective care and services. The meetings provide a forum for plan representatives to discuss issues, share best practices, identify challenges, and develop strategies for enhanced care management and delivery of quality services.

Other meeting topics have included:

- eligibility and payment issues;
- clarifications on use of the DMS-1;
- application of health and safety criteria to determine if an individual can appropriately received home-based services (Note: a separate workgroup including local district staff also was convened to discuss this issue);
- care management guidelines;
- creating a stable workforce;
- subcontract monitoring, and
- transportation issues.

11. CONSUMER SATISFACTION

Consumer satisfaction is one indicator of the quality of care provided by the managed long-term care plans. There are several different ways to assess this aspect of quality. Plan-administered consumer surveys measure outcomes at a group level and are designed to identify aspects of plan operations that enrollees find satisfactory, as well as those with which enrollees find fault (and therefore represent opportunities for improvement). At the individual enrollee level, an additional indicator of enrollee satisfaction is the extent to which enrollees file complaints and/or grievances with their plan. The volume of and reasons for enrollee disenrollments from their MLTCP are another potential measure of enrollee satisfaction and plan performance. The MLTCPs (and the Department) are able to use this information to identify and prioritize aspects of plan operations that need improvement and make appropriate changes.

Consumer Satisfaction Surveys

Every MLTCP in New York State conducts at least one consumer satisfaction survey of its enrollees annually. Many plans perform an annual survey of all enrollees, while others conduct surveys more frequently (semi-annually and/or quarterly) on a sample of enrollees. Some plans conduct an initial survey of new enrollees, followed by an annual survey. Most of the consumer satisfaction surveys are conducted by mail. However, two (2) MLTCPs with the largest enrollments conduct telephone surveys.

Enrollee response rates to the mail surveys vary significantly. The highest rate of consumer response is 61%, while the lowest is 21%. For the majority of plans, the response rate to their consumer satisfaction surveys is about 40%, the norm for mail surveys of a primarily elderly, infirm population. The two plans that conduct telephone surveys have much higher response rates (almost 100% and 75% respectively), as would be expected. Telephone surveys are, however, costly, but as enrollment levels increase in the MLTCPs the Department anticipates that other MLTCPs may switch to telephone surveys to increase their response rates. In the interim, the MLTCPs with lower rates of response are developing innovative approaches to obtain adequate and appropriate enrollee satisfaction information. For example, in the plan with the lowest rate of survey response program managers select approximately 40-enrollees/month and conduct in-home consumer satisfaction visits. During the visits, staff follow-up on issues identified as areas potentially needing improvement in survey responses, through complaints, member services, etc.

While survey questions asked by each MLTCP vary, there is a core set of questions common to every plan's survey. That is, although the specific wording of the question may differ, each plan queries its members about the following.

- Enrollees' overall satisfaction with their MLTCP experience.
- Enrollee rating of the care they receive.
- Do enrollees feel they are treated with dignity, respect and courtesy?

- Do enrollees feel they are sufficiently involved in decisions about their care?
- Are enrollees satisfied with the various service components of their plan (e.g., home aides, transportation, care management, nursing care, etc.)?

Other questions attempt to identify how enrollees feel about certain aspects of their services, and include questions about enrollees’:

- ease in accessing and obtaining services;
- satisfaction with member services staff;
- satisfaction with waiting time for appointments;
- understanding about how the MLTCP works (including complaint and grievance processes) and how it can help the enrollee, and
- perception of responsiveness of the MLTCP in addressing enrollee concerns.

Each MLTCP survey includes questions that are of specific concern to that plan. For example, if a new transportation system has been implemented, the survey may focus on transportation issues. If the previous survey identified problems (e.g., food service, scheduling of aides, etc.), the next survey will attempt to determine the extent to which there has been a change in enrollee satisfaction.

Consumer Survey Satisfaction Levels

Based on the most recent surveys, enrollee satisfaction in the MLTCPs is high. The majority (90%) of enrollees rate their plans from good to excellent. Overall consumer satisfaction levels with services, as measured by the surveys, are good to excellent. Enrollees universally indicate high levels of satisfaction with their medical and nursing care. High levels of satisfaction also correlate with care management and staff responsiveness, and the manner in which enrollees feel they are treated by MLTCP staff.

But the surveys also identify a few services which enrollees find problematic. Although levels of dissatisfaction in these areas are fairly low and limited to only a few plans, they are worth noting. The most common problem relates to home health aides (e.g., timeliness of aides, personality issues). Additionally, enrollees of several plans are somewhat dissatisfied with their congregate and/or home-delivered meals (e.g., taste, temperature). Transportation also surfaced as an issue (e.g., promptness, behavior of drivers, etc.). Enrollees in several other plans indicate that they do not have an opportunity for sufficient input in the development of their care plans or into the overall operation of their MLTCP. Finally, enrollees in two MLTCPs indicated that they did not have sufficient knowledge of their plans’ complaint and grievance procedures.

The actions taken by the MLTCPs to address areas of concern reflected in the survey responses are generally similar to those that the MLTCPs develop in response to consumer complaints and grievances. A description of the ways in which the MLTCPs modify their operations to resolve various problems is

discussed in “Complaints and Grievances”, below. However, it is interesting to note the impact of the consumer survey on one plan’s operations. As a result of a telephone survey, it became apparent to the MLTCP that far too many enrollees were expressing concern about their ability to understand their rights and the complaint and grievance processes. Consequently, the MLTCP developed and distributed informational material to all enrollees about these issues even before the survey was completed, to ensure enrollees had necessary information.

Complaints and Grievances

Complaints and grievances also are indicators of enrollee satisfaction. These expressions of dissatisfaction provide 'real time' information and allow the MLTCP to stay in close touch with quality issues as they occur. Complaints and grievances may be submitted orally and in writing by either the enrollee or any other person who wishes to make a complaint on the enrollee’s behalf.

Despite on-going dialogue between the Department and the MLTCPs, each MLTCP tends to define and differentiate complaints and grievances in its own way. This issue may make plan comparisons difficult and is an area for future emphasis by the Department. The Department is working with plans to establish more uniformity in the categorization of complaints and grievances. However, all MLTCPs are required to document all expressions of enrollee dissatisfaction, whether the plan considers the expression of dissatisfaction to be a complaint or a grievance, and are required, to address the enrollee’s concern in an appropriate and timely fashion. The Department’s annual performance reviews indicate general compliance with these requirements, including timeframes for grievances and complaint resolution. Several plans have implemented excellent compliance and grievance monitoring systems. However, some of the less established plans have been directed to improve their record keeping with respect to complaints, i.e., logging and tracking processes, as well as complaint acknowledgement and other enrollee notifications.

- **Grievances**

Five (5) of the fourteen (14) operational MLTCPs received a total of 46 grievances in CY 2001 from enrollees and/or their family members (*all* MLTCPs reported they had received complaints in that year as well). Home health aide behaviors and/or activities were the basis for the majority of grievances. Pharmacy concerns (delivery problems, several medication errors) also resulted in grievances, and there were several grievances relating to injuries and denial of service. All injuries were treated as critical incidents, and the Department monitored the implementation of necessary corrective actions by the plan. Individual grievances about care management, medical record confidentiality, and staff actions were filed as well.

Based upon assessment of plan records and information provided to the Department by the plans, all but a handful of grievances were resolved to the satisfaction of enrollees and/or their family members. In many instances, the grievances resulted in the MLTCP adopting new policies or changing contractors when it found the grievances reflected systemic problems. When the grievance was related to a particular concern about provider performance, the MLTCP generally assigned new staff to serve the enrollee, reevaluated the enrollee's service needs, or provided additional guidance/training to the provider.

- **Complaints**

Enrollee complaints for CY 2001 encompassed the same issues as grievances. The most common reason for complaints across all MLTCPs was home health aide staffing. Transportation and pharmacy issues also generated a number of complaints. Other less frequent reasons for complaints included service availability, quality of care, type and quality of food provided by the MLTCPs, interpersonal issues between enrollees and staff, and availability of staff with specific language capabilities to meet enrollee needs. More so than individual grievances, complaints appear to reflect systemic issues for the MLTCPs. Consequently, the plan's response to complaints frequently results in changes to the its core operations.

Complaints about pharmacy issues have resulted in plans switching pharmacy benefit management contractors, as well as changes in policies and procedures. MLTCPs that experienced complaints about service availability have expanded their service delivery networks to include additional providers.

Complaints about home health aides range from issues of staff shortages, to aid performance, lateness or failure to arrive at the enrollee's home. The plan's have dealt with these issues in a number of ways, including closer collaboration with the home care agency on case staffing and scheduling, changes in scheduling procedures, requiring contractors to meet plans of correction, enhanced training for aides, changing home aide contractors with unsatisfactory performance, and expansion of the number of home health aide contractors. One plan decided that it would directly employ home health aides, rather than depend on contractors.

In order to resolve transportation issues identified through complaints, the MLTCPs expanded their transportation networks; required transportation contractors to provide improved training and supervision of their staff; made changes to both plan and contractor scheduling procedures; hired plan staff dedicated to coordination and supervision of transportation services. In one case, a plan purchased its own vehicles and established in-house transportation services.

Less frequent complaints also resulted in changes to MLTCP operations. One plan experienced a few complaints about the quality of care of its nursing home services. While no confirmed quality deficiencies were found, the plan established mechanisms to work more collaboratively with nursing home staff, enrollees and their families on care management issues. One plan has resolved concerns about food (e.g., quality, temperature) by establishing food preparation capabilities in-house. Enrollee/staff interpersonal issues which are individual-specific are addressed through staff training and counseling, re-assignment and, when necessary, disciplinary action.

Disenrollments

Enrollment in managed long-term care is voluntary. Consequently, information on the number of and reasons for disenrollments requested by enrollees from the plans can be a potentially useful indicator of consumer satisfaction.

Disenrollment data are submitted by the plans to the Department at six (6) month intervals. The disenrollment data fall into two (2) general categories: number of individuals who voluntarily left the plan (and the reasons for their disenrollment) and individuals who were involuntarily disenrolled (number and reasons). Information on deaths is collected as well.

Voluntary disenrollments account for 79% of total disenrollments. The most frequent reason (53%) for voluntary disenrollment was the enrollee's decision to leave the plan because he or she did not like the restricted panel of providers (an intrinsic feature of managed care). The second most common reason (18%) for disenrollment was a move by the enrollee outside of the plan's service area. Six percent (6%) of voluntary disenrollments were related to enrollee dissatisfaction with the quality or quantity of care provided. Other reasons, such as the enrollee not wanting to pay a spenddown amount, overall dislike of the plan, etc., accounted for the remaining voluntary disenrollment reasons (23%).

The disenrollment rate due to deaths for all plans is 4.9%.

In certain instances, the plan (subject to the approval of the LDSS) or the LDSS can determine that disenrollment of a participant is necessary. This action, known as an "involuntary disenrollment", may occur when an enrollee moves outside of the service area, or requires care in a hospital, mental health or drug/alcohol facility for more than 45 days etc. Less than half of the plans reported involuntary disenrollments during study period. In the six (6) plans in which involuntary disenrollment occurred, these disenrollments accounted for only 50 disenrollments (about 20% of all total disenrollments). The most common reason for involuntary disenrollment was the enrollee's need for inpatient hospitalization exceeding 45 days, which renders the individual ineligible for continued participation in a partially-capitated managed long-term care plan. The second most frequent reason for involuntary disenrollment was the participant's move outside of the plan's service area.

12. NEW YORK STATE INSURANCE DEPARTMENT ROLE IN MANAGED LONG-TERM CARE

Section 4403-f 4. of the New York State Public Health Law (PHL) identifies the role of the Superintendent of Insurance in the regulation of managed long-term care plans (MLTCPs). That role includes regulation of enrollee contracts, premium rates and fiscal solvency. The Superintendent consults with the Commissioner of Health (Commissioner) as set forth in Section 4403-f regarding fiscal solvency issues. The Superintendent determines premium rates for plans, except where Section 4403-f indicates the Commissioner establishes payment rates for services provided to enrollees eligible under Title XIX of the federal Social Security Act (Medicaid). Where the Commissioner establishes Medicaid payment rates, the Commissioner must consult with the Superintendent. The Superintendent regulates enrollee contracts in close coordination with the Commissioner because the plans enroll Medicaid; Medicare and private pay populations⁸. The Superintendent (along with the Commissioner and Director of the State Office for the Aging) also has a role in regulating plan marketing materials pursuant to Section 4403-f 7. (c)(ii) of the PHL.

Solvency

The Superintendent has developed specific financial solvency requirements for plans pursuant to Section 4403-f 4. of the PHL. The financial solvency requirements are based upon the coverage arrangements that will be offered to the population to be served by the plan; that is:

1. a “partially-capitated” plan which serves a population composed of individuals covered by Medicaid solely for the services mandated for a plan (these do not include hospital and/or medical coverage); or
2. a “fully-capitated” plan which covers hospital and/or medical services as well as the services mandated by statute for the plan (i.e., a PACE).

The financial solvency requirements are based upon the plan’s financial projections submitted to the Commissioner for the determination of the capitation premium for the plan. These financial projections are used to determine the initial solvency requirement. Solvency is calculated as follows.

1. The accumulated operating deficit until the “break even” month is determined.
2. To that amount, the Superintendent adds the calculated escrow deposit account according to the requirements of 10 NYCRR Part 98-1.11 (e) (regulations of the Department of Health). The escrow

⁸ There is a limit of ten (10) private pay enrollees in a managed long-term care plan.

account is based upon the projected medical expenses for the plan's first year of operations. If the plan is fully capitated, the escrow deposit account amounts to 5% of the first year expenses. If the plan is partially-capitated, the escrow deposit account amounts to 2.5% of the projected first year medical expenses.

A majority of the approved plans have been able to meet the financial solvency requirements. It appears that those managed long-term care plans that have sponsoring organizations with a significant population which would benefit from the services of the affiliated MLTCP have an advantage in being financially successful over those that do not. Plans without a readily available pool of potential membership must sometimes expend significant marketing expenses to obtain new members.

In some instances it took effort to school MLTCP management about the need to maintain adequate capitalization to cover underwriting risk. Some plans were accustomed as providers to receiving Medicaid fee-for-service reimbursements as a service provider, and were not familiar with their new role as a managed care organization assuming underwriting risk. However, the plans can be credited for their efforts at understanding and accepting the financial solvency criteria established by the Insurance Department.

Enrollee Contracts

All managed long-term care plan members receive enrollee contracts. This document sets forth the rights and obligations of the plan and its members.

The Superintendent reviews the proposed contract and provides comments to the Department of Health when the enrollee population consists solely of persons eligible for Medicaid. However, in certain instances, a plan wants to allow a small population not eligible for Medicaid to pay full premium for coverage. In that circumstance, the Insurance Department has approved appropriate changes in the form of an addendum to the basic enrollee Medicaid contract.

The Insurance Department reviews enrollee handbooks and contracts and marketing materials to ensure that they reflect accurate, factual, clear and consistent language. The reviews also focus issues related to enrollment of private pay individuals.

Rates

Pursuant to Section 4403-f 8. of the PHL, the Insurance Department has consulted with the Department of Health in the formulation of the Medicaid rate capitation methodology (Medicaid rate methodology) applied to the MLTCPs. In September 1999, staff from the Departments of Insurance and Health met with staff from interested plans about the Medicaid rate methodology. Issues discussed (and subsequently included the data base

used for the Medicaid rate methodology) included the components to be used in developing the Medicaid rate methodology, specifics of the rates for new plans and a work plan under which existing MLTCPs would transition to the Medicaid rate methodology.

As previously noted, some plans requested the ability to enroll a small number of participants not eligible for Medicaid who would pay full premium for coverage (a maximum of 10 “private pay” enrollees is permitted in a MLTCP). The premium to be paid by this private pay population requires approval by the Insurance Department. The Insurance Department had reviewed private pay rate submissions for four (4) plans as of November 2002, and had approved private pay rates for all four (4) plans.

Marketing Materials

Pursuant to Section 4403-f 7. (c)(ii) of the PHL, the Insurance Department reviews plan marketing materials received from the Department of Health, which coordinates comments not only from the Insurance Department, but from the State Office for the Aging as well.

During the Insurance Department’s review of some plan marketing materials, issues about their accuracy or appropriateness (in relation to the enrollee contract language) have been identified and comments to that effect provided to the Department of Health, noting the enrollee contract is the legally binding document between the plan and the enrollee. Consequently, the enrollee contract must serve as the template for the accuracy of marketing materials, and the plan is legally obligated to provide the benefits as set forth in the enrollee contract.

Other Activities

Pursuant to Section 4403-f 6. (e)(f) of the PHL, the Insurance Department has entered into eleven (11) written agreements with approved managed long-term care plans about matters regulated by the Superintendent. These written agreements identify certain Insurance Law statutory sections to which the plans must adhere. An example of such a statutory section is Section 308 that requires provision by the plan of special reports to the Superintendent when necessary. Another example is Section 3224-a that requires cooperation by the plan with the Superintendent to resolve consumer complaints according to a Section 3224-a timeframe (where applicable). Further examples of Insurance Law statutory sections include the possibility of a Section 1307 loan for a plan, either for initial capitalization purposes or upon a determination of impairment, and the applicability of Insurance Law Article 74 concerning rehabilitation or liquidation when necessary.

Since the enactment in 1997 of The Long-term Care Integration and Finance Act, the Insurance Department has participated in numerous meetings and conference calls. These meetings and calls involved several plans or those

entities interested in becoming managed long-term care plans. The Insurance Department was present to discuss the requirements of Section 4403-f of the PHL with respect to matters regulated by the Superintendent of Insurance. Participation in these meetings and calls (including calls with federal staff, individual plans and organizations seeking to become MLTCPs), as well as document review, has consumed a significant portion of Insurance Department staff time.

Conclusion

Since Chapter 659 of the Laws of 1997 was enacted, the Insurance Department has effectively implemented its defined role under Section 4403-f of the PHL in the regulation of managed long-term care plans.

The Insurance Department notes that progress has been made since 1997 with respect to the regulation of solvency, enrollee contracts, premium rates and marketing materials. The plans thus far have come to recognize the need for Insurance Department involvement in the statutory areas which it regulates, and have adjusted their operation to meet the standards of Insurance Department review.

In addition, the Insurance Department has established an excellent working relationship with the Department of Health, the lead agency in the regulation of these plans. This relationship has been modeled on the other areas of health insurance jointly regulated by the two Departments.

13. RECOMMENDATIONS AND FUTURE ACTIVITIES

The following are recommendations regarding the State's managed long-term care program as it moves forward, based on the operational experience of the fifteen (15) managed long-term care plans approved to date, and the factors that affect their success.

- **Enrollment growth and administrative efficiency must improve.**
 - In order to be viable long-term care plans, existing plans need to achieve greater administrative efficiency. While many plans have made important strides in reducing administrative costs on a per member per month basis, further efficiencies are necessary to ensure plan viability on an ongoing basis and cost-effectiveness for the State.
 - Local departments of social services (LDSS) are critical to enable expanded enrollment and must be appropriately staffed to support increasing MLTC enrollment. The potential for simplifying the enrollment process also needs to be considered.

- **DMS-1 assessment tool and scoring process must be improved.**

The feasibility of improving the DMS-1 assessment and scoring procedures needs to be explored in order to make it a more reliable tool for assessing both patient and financial risk. Options in this area could include refining the DMS-1 instrument to include additional or improved assessment questions, and replacing the instrument, in total or in part, with other nationally used assessment tools.

- **Data reporting and accuracy must improve.**

Managed long-term care plans must improve their MIS and cost reporting capabilities, and they should begin to report recipient-level encounter information to the Department, consistent with other managed care plans. This will enhance the Department's ability to monitor the quality and appropriateness of service delivery, improve the rate setting process, and to assess the effectiveness of care planning strategies. In the near future, the Department expects to modify its automated systems to accommodate the submission of individual client-specific encounter data from managed long-term care plans, which will provide a more efficient way for plans to submit data on service utilization to the Department.

- **DOH monitoring activities must continue and be enhanced.**

The Department must continue its efforts to enhance its oversight and monitoring of MLTCPs. These long-term plans represent a new model of service delivery and financing, and new approaches to provider monitoring

are required. The development of the monitoring framework began with adapting existing methods (e.g., from those used in the oversight of home care agencies, managed care plans, etc.) for use with the MLTCPs. The Department will continue this process, refining existing models of regulatory oversight to meet the particular needs of the managed long-term care plans.

- **The strengths and weaknesses of full vs. partial plan models must continue to be evaluated.**

The respective effectiveness of the two existing MLTC models must be evaluated, including:

- assessment of the clinical success and cost-effectiveness of varying care management approaches;
- continued evaluation of whether certain population groups (i.e., severely disabled) can be effectively served through either of these models;
- analysis of the relative cost-effectiveness of full versus partial capitation managed long-term models and the appropriateness of their respective benefit packages. The availability of Medicare capitation revenues for the dually eligible enrollee population may emerge as an important factor in ensuring financial viability of MLTC plans.
- continued analysis of the long-term ability of small plans, whether fully or partially-capitated, to function successfully under a risk model.

- **New federal regulations must be implemented and their impact assessed.**

New federal regulations governing Medicaid managed care plans, including New York State managed long-term care plans (excluding PACE organizations), require plan compliance by August 2003. Previously MLTCPs were exempted from some aspects of the federal managed care requirements because of their status as partially-capitated plans. However, the new regulations are extensive and cover partially-capitated plans as well as more comprehensive managed care entities. Consequently, the Department must assess the impact of the new regulations on both State and plan operations.

- **The Department must continue to work with MLTCPs on improving care management.**

In addition to the lack of integration of primary care physician services in the partially-capitated care model, the Department has identified other issues with some plans' successful implementation of care management processes and procedures. While certain plans have demonstrated excellent care management capabilities, others need to improve their care management abilities. There are specific care management concerns about some plans ability to develop appropriate care plans to meet both enrollee clinical and non-clinical needs and ongoing monitoring of service delivery effectiveness and the need for continuation of services.

To address this issue, the Department will continue to work closely with the plans that need improvement, providing necessary technical assistance and guidance.

- **Most of the MLTCPs are partially capitated. Benefit carve-outs can create undesirable incentives and can limit cost-effectiveness. The Department will need to assess the appropriateness of the benefit package for partially capitated plans and make modifications as necessary.**

The role of the primary care physician in the partially-capitated plans must be explored. In the partially-capitated plan, physician services are currently excluded from the benefit package. This exclusion poses some problems for plans, insofar as an individual's enrollment depends on willingness of the prospective enrollee's primary care physician to cooperate and coordinate care with the plan. Once an individual is enrolled, the plan's ability to appropriately manage care is contingent on the primary care physician's continued willingness to cooperate.

ATTACHMENT
Managed Long-term Care Plans in New York State
2003

Name/Sponsor	Address/Phone #	Service Area by County	Age Requirements	Payment Accepted
Comprehensive Care Management (Beth Abraham Family of Health Services) PACE	612 Allerton Avenue Bronx, New York 10457 1-877-226-8500 718-515-8600	Bronx, New York (Manhattan), Westchester, Kings (Brooklyn)	55 and over	Medicaid Medicare Private Pay
Independent Living for Seniors (Via Health) PACE	2066 Hudson Avenue Rochester, New York 14617 585-922-2800	Monroe (not all of county)	55 and over	Medicaid Medicare Private Pay
Eddy Senior Care (Northeast Health) PACE	504 State Street Schenectady, New York 12305 518-382-3290	Schenectady (not all of county)	55 and over	Medicaid Medicare Private Pay
Independent Living Services of Central New York, Inc. (Loretto Rest Nursing Home, Inc.) PACE	Sally Coyne Center for Independence 100 Malta Lane North Syracuse, New York 13212 1-877-208-5285 315-452-5739	Onondaga	55 and over	Medicaid Medicare Private Pay

Name/Sponsor	Address/Phone #	Service Area by County	Age Requirements	Payment Accepted
Elant Choice (Elant, Inc.) Partially Capitated MLTCP	6 Harriman Drive Goshen, New York 10924 1-877-255-3678	Orange	55 and over	Medicaid Private Pay
Senior Health Partners (Mt. Sinai Hospital, Jewish Home and Hospital for the Aged, Metropolitan Coordinating Council on Jewish Poverty) Partially Capitated MLTCP	149 West 105 th Street Suite 3E New York, New York 10025 1-800-633-9717 212-870-4610	Upper New York County (Manhattan, north of 59 th Street)	55 and over	Medicaid Private Pay
GuildNet (The Jewish Guild for the Blind) Partially Capitated MLTCP	15 West 65 th Street 4 th Floor New York, New York 10023-6694 1-800-932-4703 212-769-7855	Bronx, Kings (Brooklyn), New York (Manhattan), Queens	21 and over	Medicaid
VNS CHOICE (Visiting Nurse Services of New York) Partially Capitated MLTCP	5 Penn Plaza 11 th Floor New York, New York 10001 1-888-867-6555 212-290-4858	Bronx	21 and over	Medicaid

Name/Sponsor	Address/Phone #	Service Area by County	Age Requirements	Payment Accepted
Co-Op Plan (Hebrew Hospital Home) Partially Capitated MLTCP	3677 East Tremont Avenue Bronx, New York 10465 1-888-830-5620 718-678-1622	Bronx	21 and over	Medicaid
Senior Network Health, LLC (Mohawk Valley Network, Inc.) Partially Capitated MLTCP	P.O. Box 4215 430 Court Street, 2 nd Floor Utica, New York 13504 1-888-355-4764 315-738-6050	Oneida Herkimer	65 and over	Medicaid
Partners in Community Care (Good Samaritan Hospital) Partially Capitated MLTCP	255 Lafayette Avenue Room 332 Suffern, New York 10901 1-888-688-7422 845-368-5930	Orange Rockland	21 and over	Medicaid
Health Partners of New York (f/k/a Broadlawn) Winthrop South Nassau Catholic Health System East Partially Capitated MLTCP	Carone Hall 399 County Line Road Amityville, New York 11701 516-336-2000	Nassau	21 and over	Medicaid

Name/Sponsor	Address/Phone #	Service Area by County	Age Requirements	Payment Accepted
Independence Care System (Cooperative Home Care Associates) Partially Capitated MLTCP	257 Park Avenue, South 2 nd Floor New York, New York 10010-7304 1-877-427-2525 212-584-2500	Bronx, New York (Manhattan)	21 and over	Medicaid
Total Aging in Place Program (Weinberg Campus, Inc.) Partially Capitated MLTCP	461 John James Audubon Parkway Amherst, New York 14228 (716-250-3100)	Erie (not all of county)	55 and over	Medicaid Private Pay
HomeFirst, Inc. (Metropolitan Jewish Health System) Partially Capitated MLTCP	6323 Seventh Avenue Brooklyn, New York 11220 1-877-427-1119	Kings (Brooklyn) New York (Manhattan)	65 and over	Medicaid

