

NYS Department of Health

MANAGED LONG TERM CARE MANDATORY ENROLLMENT (MRT #90)

REPORT TO THE GOVERNOR AND LEGISLATURE
SEPTEMBER 2012

Redesigning
THE MEDICAID PROGRAM



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Executive Summary

Purpose

The New York State Department of Health respectfully submits this first biannual report to the Governor of the State of New York, Temporary President of the Senate, The Speaker of the Assembly, Chair of the Senate Standing Committee on Health and the Medicaid Managed Care Advisory Review Panel. This report complies with Section 4403-f(7)(b) of Public Health Law, detailing the initial programmatic impact of implementing mandatory enrollment in Managed Long Term Care Plans (MLTC Plans) for a targeted population and selected service areas. The initial report is to be provided by September 2012 and shall be submitted by each February and September thereafter.

The report is required to include information regarding : enrollee satisfaction with care coordination/case management services and timeliness of care; service utilization including changes in the level, type, hours, frequency and providers of services; enrollment, including auto-assignments by plan; quality; and continuity of care for recipients as they move into MLTC Plans.

Notification to the targeted population began in July 2012 with auto-assignment not to commence until November 2012, therefore this initial report will focus on the evolution of the mandatory enrollment process. The report defines the characteristics of the mandatory population, the types of Managed Long Term Care Plans available to recipients, the role of the Enrollment Broker (New York Medicaid Choice), the notification process, and the anticipated scheduled rollout of the mandatory initiative.

Background

In January 2011 Governor Andrew M. Cuomo established the Medicaid Redesign Team (MRT) which was comprised of a variety of stakeholders and experts in the health care industry to work cooperatively to reform New York State's health care system and reduce costs. The MRT worked in two phases. Phase 1 provided a blueprint for lowering Medicaid spending in State fiscal year 2011-12 by \$2.3 billion. Phase 1 was completed in February 2011 when the MRT submitted an initial report in line with the Governor's Medicaid spending target contained in his 2011-2012 budget. The report included 79 recommendations to redesign and restructure the Medicaid program by bringing efficiencies and by generating better health outcomes for patients. The Legislature, as part of the budget process, approved 78 of the 79

recommendations it considered; these initiatives are now being implemented, including mandatory managed long term care (MRT #90).

In Phase 2, to address additional issues and to monitor the implementation of key recommendations enacted in Phase 1, the MRT divided into 10 work groups, including one on Managed Long Term Care and Waiver Redesign. As part of their commitment to community inclusiveness, the groups provided 175 additional stakeholders the opportunity to participate in the MRT process. The workgroup completed its efforts on October 28, 2011 which launched the activities of the Department.

1115 Waiver Amendment

In May 2012, the New York State Department of Health (NYSDOH) submitted an amendment to the Centers for Medicare and Medicaid Services (CMS) to both the Partnership Plan and F-SHRP Medicaid Section 1115 Demonstration waivers. The amendment requires all dual-eligible individuals (persons in receipt of both Medicare and Medicaid) aged 21 or older and who are in need of community-based long term care services for more than 120 days to be mandatorily enrolled into Managed Long Term Care Plans (MLTCPs) or Care Coordination Models (CCMs).

NYSDOH received written approval to fully implement the mandatory initiative and auto-assignment on August 31, 2012.

Expansion of MLTC Plans

To meet the goals of MRT #90, the moratorium on certifying new MLTC Plans was lifted to support additional capacity to accommodate the anticipated increased enrollment into Managed Long Term Care Plans (MLTCPs) over the next 3-5 years. Through August 2012, the NYSDOH has received over twenty five Certificate of Authority applications to operate a MLTCP. Existing plans were encouraged to consider expanding their geographic service areas to include additional counties and the NYSDOH has received approximately fourteen service area expansion applications. Additionally, in an effort to diversify their product offerings, a number of existing plans have also submitted applications to add other models of long-term care such as Medicaid Advantage Plus (MAP) and Medicaid Advantage (MA).

Program Evaluation

Currently there are approximately 55,000 Medicaid recipients enrolled statewide in one of three models of MLTCPs: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus Plans (MAP); and, partially capitated Medicaid Managed Long Term Care Plans (Medicaid MLTCP). After the full phase-in of mandatory enrollment statewide, it is estimated by

the end of year 2014 that over 100,000 Medicaid recipients will be enrolled in some type of Managed Long Term Care Plan.

Several sources for data collection have been identified that will enable: the assessment of member satisfaction; review and comparison in changes in levels of service utilization; determination of the number of new enrollments by plan; establishment and evaluation of quality measures related to the range of services provided by the plans and evaluate plans' adherence to the NYSDOHs continuity of care policy.

Introduction

The New York State Department of Health (NYSDOH) respectfully submits this first biannual report to the Governor of the State of New York, Temporary President of the Senate, The Speaker of the Assembly, Chair of the Senate Standing Committee on Health and the Medicaid Managed Care Advisory Review Panel. This report complies with Chapter 59 of the Laws of 2011 in detailing the initial programmatic impact of implementing mandatory enrollment in Managed Long Term Care Plans for a targeted population and selected service areas. The report is required to include information on: enrollee satisfaction with care coordination/case management services and timeliness of care; service utilization including changes in the level, type, hours, frequency and providers of services; enrollment, including auto-assignments by plan; quality; and, continuity of care for recipients as they move into MLTC Plans.

The report defines the characteristics of the mandatory population, the types of Managed Long Term Care Plans available to recipients, the role of the Enrollment Broker (New York Medicaid Choice), the notification process, and the anticipated scheduled rollout of the mandatory initiative.

With issuance of Executive Order #5, Governor Andrew M. Cuomo established the Medicaid Redesign Team (MRT) in January 2011, bringing together a group of health care stakeholders, experts and advocates from throughout New York State. The goals of the MRT were to improve overall health system quality and efficiency, streamline and focus health care administrative and financial structures, and reduce Medicaid costs while emphasizing the delivery of well-managed, cost effective quality health services.

In February 2011, the MRT completed a Phase I initiative which included seventy-nine (79) recommendations to redesign and restructure the Medicaid program. Seventy-eight (78) recommendations were approved by the Legislature as part of the year's enacted budget and are currently in various stages of implementation. These recommendations included the required change to managed long term care. The Phase I initiatives met the Governor's Medicaid budget target, introduced significant structural reforms, and achieved savings without limiting recipient eligibility.

Efficient, high-quality, sustainable health care requires effective care management and a delivery system which integrates and coordinates patient care. As a component of a fully integrated care management system, Medicaid Redesign Team Proposal #90 and 2011 budget legislation requires the mandatory transition and enrollment of certain community based long term care services recipients into Managed Long Term Care Plans (MLTCPs) or Care Coordination Models (CCMs). To meet the goals of MRT #90, the moratorium on certifying new MLTCPs was lifted to allow capacity to expand. Fee-for-service long term care service programs i.e; the Personal Care Program, the Long Term Home Health Care Program (LTHHCP) and Certified Home Health Agencies consumers will be transitioned. New York State currently

operates three models of MLTCPs: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus Plans; and, partially capitated Managed Long Term Care Plans.

Partially capitated Managed Long Term Care Plans provide long-term (personal care, home health) and ancillary (transportation, dental, rehabilitative therapies) health care services with an integrated care management component; PACE provides comprehensive primary, acute and long-term care in a day center setting and in the home; Medicaid Advantage Plus Plans, with enrollment in a companion Medicare Advantage Plan, include comprehensive acute, primary and long-term care services.

All models of MLTCPs and CCMs provide community based long term care services, nursing home care and many ancillary services, including person-centered, individualized care management.

The mandatory enrollment initiative impacts Dual Eligible recipients (individuals who are eligible for both Medicaid and Medicare), aged 21 and over, who are in need of community based long term care services for over 120 days, excluding at this time the following groups:

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury Waiver participants;
- Nursing Home residents;
- Assistant Living Program participants;
- Dual eligible individuals who do not require community based long term care services.

Community based long term care services include home health care, personal care, adult day health care and private duty nursing.

In addition to those individuals who must enroll, the following populations may voluntarily enroll:

- Dual eligible individuals, age 18-20, in need of community based long term care services for over 120 days and assessed as nursing home eligible.
- Non-dual eligible individuals, age 18 and older assessed as nursing home eligible and in need of community based long term care services for over 120 days.

The NYSDOH has received verbal approval from the Centers for Medicare and Medicaid Services (CMS) to initiate distribution of the mandatory enrollment notifications starting in Manhattan. NYSDOH received final approval to fully implement the mandatory initiative and auto-assignment from CMS on August 31, 2012 with initial auto-assignments starting in November 2012.

The Enrollment Broker is New York Medicaid Choice (NYMC), in consultation with the SDOH, has developed notification letters, brochures and informational material which will assist

individuals to make an informed choice of plans. The initial mailings provided recipients with a notification letter regarding the upcoming change in long term care service delivery, a description of the three types of MLTCPs available (PACE, Partial Cap and Medicaid Advantage Plus) along with a listing of plan names, service area and contact numbers, and, an informational brochure.

Mandatory enrollment is scheduled to begin in New York City and will roll-out to other counties according to the following schedule:

Phase I: New York City – New Service Clients

September 17, 2012: Dual Eligible recipients, new to service, fitting the mandatory population definition, and residing in New York City (New York, Bronx, Kings, Queens and Richmond counties) will be identified for enrollment and referred to the Enrollment Broker for information, assistance and enrollment activities. New to service means a first-time Medicaid recipient or a current Medicaid recipient applying to receive or deemed to require community based long-term care services.

The Enrollment Broker can answer questions about the enrollment process and, if requested by the recipient, will provide assistance in contacting a plan (if the recipient expresses interest in a particular plan the New York Medicaid Choice Consumer Service Representative will “warm transfer” the recipient to a Member Services representative at that Plan). The intent is to encourage recipients to choose a plan which meets their needs rather than be auto-assigned to a plan after 60 days.

Recipients in the mandatory population can choose to enroll in a Partially Capitated MLTCP, a PACE, or a Medicaid Advantage Plus (if they meet eligibility standards). If the recipient does not choose a Plan, the recipient will be auto assigned to a Partial Cap MLTCP (due to inability to auto-assign to Medicare).

The plan will conduct an assessment within 30 days of contact or referral to determine if the recipient is eligible for community based long term care. The plan transmits the enrollment information to the New York Medicaid Choice, the Enrollment Broker, who confirms by mail the enrollment with the consumer.

Phase I: New York City – Clients Already Receiving Service

For recipients already receiving community based long term care services, enrollment into a plan will be phased-in by service type by borough and by zip code. Recipients first receive an announcement letter to let them know Medicaid is changing how services are going to be provided with information about plans and access to NYMC. At least 60 days prior to auto-

assignment, these same consumers receive a second mailing with notification that they must make a plan selection. This mailing contains an information brochure and a plan list.

Recipients will have 60 days to choose a plan or be auto-assigned based on the following notification and enrollment schedule:

- **July 2012:** Notification of Personal Care cases in New York County begins with notifications of change in service.
- **August 2012:** Enrollment of Personal Care cases in New York County continues.
- **September 2012:** Enrollment of Personal Care cases in New York County continues; enrollment of Personal Care cases in Bronx County begins;
- **October 2012:** Enrollment of Personal Care a cases in New York and Bronx Counties continues; enrollment of Personal Care cases in Kings County begins.
- **November 2012:** Continue enrollment of Personal Care and initiate Consumer Directed Personal Assistance Program cases in New York, Bronx and Kings Counties. Initiate CDPAP Citywide for new enrollees.
- **December 2012:** Continue enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in New York, Bronx and Kings Counties; enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in Queens and Richmond Counties begins.
- **January 2013:** Initiate enrollments city-wide of Long Term Home Health Care Program, Adult Day Health Care Program, private duty nursing cases and home health over 120 days not already enrolled under Personal Care transition.
- **February 2013 and continuing until all clients in service are enrolled:** Continue enrollment of Personal Care, Consumer Directed Personal Assistance Program, home health over 120 days, Adult Day Health Care Program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties.

As plan capacity is established, enrollment of dually eligible community based long term care service recipients is anticipated as follows:

- **Phase II:** Nassau, Suffolk and Westchester Counties anticipated January 2013.
- **Phase III:** Rockland and Orange Counties anticipated June 2013.
- **Phase IV:** Albany, Erie, Onondaga and Monroe Counties anticipated December 2013.
- **Phase V:** Other counties meeting capacity anticipated June 2014.

The transition of Long Term Home Health Care Program participants is dependent on Federal Approval of a 1915(c) waiver amendment. That amendment is under review at this writing.

The final phase of MRT #90 will include enrollment of previously excluded Dual Eligible groups contingent on development of appropriate programs and resources. These previously excluded groups are listed below.

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury Waiver participants;
- Nursing Home residents;
- Assisted Living Program participants;
- Dual Eligibles who do not require community based long term care services.

Recipient Satisfaction - Care Coordination/Case Management

Consumer satisfaction is a key indicator of the quality of care provided by the managed long-term care plans. As Medicaid recipients migrate from fee-for-service community based long-term care to managed long-term care under mandatory enrollment, the Department intends to assess recipient satisfaction with their care coordination and case management on an ongoing basis. Data will be collected from the following sources:

- Plan – administered consumer survey data;
- Telephone surveys conducted by New York’s Enrollment Broker – NYMC;
- Grievance and appeal data collected by the plans and submitted to the Department quarterly;
- Statewide random sample survey by 3rd party under contract with NYSDOH.

Every plan must conduct at least one consumer satisfaction survey of its enrollees each year. Most plans perform an annual survey of all enrollees, while several conduct surveys more frequently (semi-annually and/or quarterly) on a sample of enrollees. In addition to surveying members, plans survey family members to get their input as well. The NYSDOH administered survey is completed every 2 years and is currently being prepared for 2012, results will be available in 2013. Results of the 2010 survey are included as Appendix A or can be found at http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_plan_member_satisfaction_survey.pdf.

New York’s Enrollment Broker – NYMC will conduct telephone surveys to evaluate recipients enrollment experience, case management satisfaction and continuity of care. The surveys will be conducted every two months and will include a sample size of 10% of enrollments. Telephone surveys will be conducted for all recipients that do not choose a plan and are auto-

assigned by NYMC. NYMC will compile the results of the surveys and provide quarterly reports to the NYSDOH.

Grievance and appeals are another source of data for assessing experience. Plans are required to maintain grievance logs and to use the data they collect as part of their quality improvement process. They are required to report the data they collect to the NYSDOH on a quarterly basis. The NYSDOH will evaluate the data on an ongoing basis to gauge overall consumer satisfaction.

Service Utilization

Plans are required to file Operating Reports and Medicaid Encounter Data to the NYSDOH on a quarterly and annual basis. The Managed Long Term Care Medicaid Managed Care Operating Report (MLTC MMCOR) contains cost, service utilization and financial performance data. The Medicaid Encounter Data System (MEDS) is an electronic medium that allows plans to report patient level service utilization. Plans are also required to collect and report to the NYSDOH information on enrollees' level of functional and cognitive impairment, behaviors and clinical diagnosis. This information is collected at enrollment and then semiannually thereafter. The data is collected using the Semi-Annual Assessment of Members (SAAM) instrument.

Using the various source of data identified above, the NYSDOH will be able to assess and compare changes in level of care, hour and frequency of recipients previously receiving long-term care services on a fee-for-service basis. The NYSDOH will track the service utilization of a sample of enrollees for six months following enrollment into a plan. This data will then be compared to the recipient's service utilization while receiving personal care on a fee-for-service basis.

Enrollment

Enrollment has steadily increased over the past eight years from approximately 10,000 in 2004 to just over 57,800 in August 2012 with the number of plans nearly doubling from 16 to over 30 plans. The majority of enrollment is in partially capitated managed long-term care plans and highly concentrated in New York City. Enrollment is expected to accelerate as MRT 90 is implemented with an estimated 24,000 recipients enrolled during the first phase of implementation.

New York's Enrollment Broker, NYMC will track the auto assignment rates of plans in each phase of the mandatory rollout. The NYSDOH produces a monthly Medicaid Managed Care

Enrollment Report for recipients enrolled in both Mainstream Managed Care and Managed Long Term Care. The report tracks the number of recipients enrolled by plan; county and product line and reports a twelve month trend. These data allow the NYSDOH to monitor managed long-term care enrollment growth and plan auto assignment rates.

Quality

The NYSDOH has been collecting and utilizing quality performance measurement data for traditional Medicaid managed care plans since 1994. The NYSDOH is scheduled to release the first Managed Long Term Care Annual Report by December 2012. In 2010, a draft report was presented to MLTC plans for input regarding content. The NYSDOH expects that this report will be published annually and will continue to evolve with input from consumers and the health care industry. This report will contain quality performance measures based upon the semi-annual assessment of enrollee's health and functional status. Quality performance measures such as falls, annual flu immunization and oral medication management are presented, as well as performance over time measures that track stability or improvement in activities of daily living (ADLs), incontinence, and other outcomes of interest over a given time period.

As New York transitions from the current assessment tool to the Uniform Assessment System – New York (UAS-NY), it is anticipated that the quality performance measurement set for the managed long term care population will expand to additional domains.

Continuity of Care

MLTCPs must ensure that individuals transitioning from Medicaid fee-for-service have continuity of the long term care services they are currently receiving. The following are the requirements the MLTCPs must meet. Other counties will become mandatory in accordance with the phase-in timetable discussed previously. Any additional county-specific requirements for continuity of care will be released as other counties become mandatory. For the purpose of this policy, long term care services include Personal Care, Long Term Home Health Care Program, Home Health Care over 120 days, Adult Day Health Care, and Private Duty Nursing.

The first group being transitioned into MLTC in New York City is the population in receipt of Personal Care. New York City plans are required to contract with Home Attendant Vendors contracted to the Human Resources Administration (HRA). This will enable Personal Care recipients to retain their current aide while transitioning from the Personal Care fee-for-service program. The plan must pay the vendor the published rate paid by HRA. There is no requirement for a plan to contract with a vendor that is not willing to accept the HRA rate.

If the MLTCP does not have a contract with an enrolling person's Home Attendant vendor, the plan must make every effort to maintain the relationship between the person's worker and the member. Pursuant to Section 4403-f (11)(d) the participant being transitioned may elect to continue their current care until the next comprehensive assessment of the MLTC plan which is

typically within 30 days of initiating enrollment, however due to CMS requirements the continuity of care requirement adopted is 60 days or until an assessment, whichever is later.

Plans are required to submit a plan identifying the mechanisms that will be used to assure continuity of care for new enrollees that are transitioning from long term care services other than personal care. These transition plans are approved by the Department of Health in order for the plan to accept auto assignments. This policy will be effective from July 1, 2012 to March 31, 2013.

The telephone surveys conducted by NYMC will contain specific questions relating to the recipients continuity of care and will allow the Department to measure the rate at which recipients are able to maintain their relationship with their personal care aide or home attendant.

Future Activities

Due to CMS approval as of August 31, 2012, there will be more specific data available for review and analysis in the next report (February 2013).