

An Overview of
Medicaid Long-Term Care Programs
in New York

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Chapter 5

Medicaid Managed Long-Term Care

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Table of Contents

Program Snapshot		3
Enrollment and Spending		3
Program and Provider Capacity		4
Health Status and Demographics		6
Rules, Regulations, and Administrative Structure		8
Federal Coverage Requirements		8
Covered Services		8
Service Utilization		9
Eligibility — Medical and Financial		10
Access		11
Provider Requirements		12
Payment		12
Quality Monitoring		13
Policy Implications		14
System Simplification		14
Effective Care Management		15
Integration of Medicare and Medicaid Financing		15
Risk-Adjusted Reimbursement		17
Barriers to Access		17
Direct Care Worker Wages		18
Program Oversight		18
References		19

Index of Figures		
Figure 5.1	MMLTC Enrollment and Spending	3
Figure 5.2	Share of Enrollment and Spending in New York City, by Program	4
Figure 5.3	Share of MMLTC Plans and Enrollment in New York City	5
Figure 5.4	Managed LTC Enrollees with Cognitive Impairment	8
Figure 5.5	MMLTC Spending, by Type of Service	10

Index of Tables		
Table 5.1	Average Caseload of MMLTC Plans and LTHHCP Providers	5
Table 5.2	Chronic Medical Conditions Among Managed LTC Enrollees	7
Table 5.3	Managed LTC Enrollees Requiring Help with Activities of Daily Living	7
Table 5.4	MMLTC: Covered Services	9
Table 5.5	MMLTC Plan Payment Rates	13

Program Snapshot

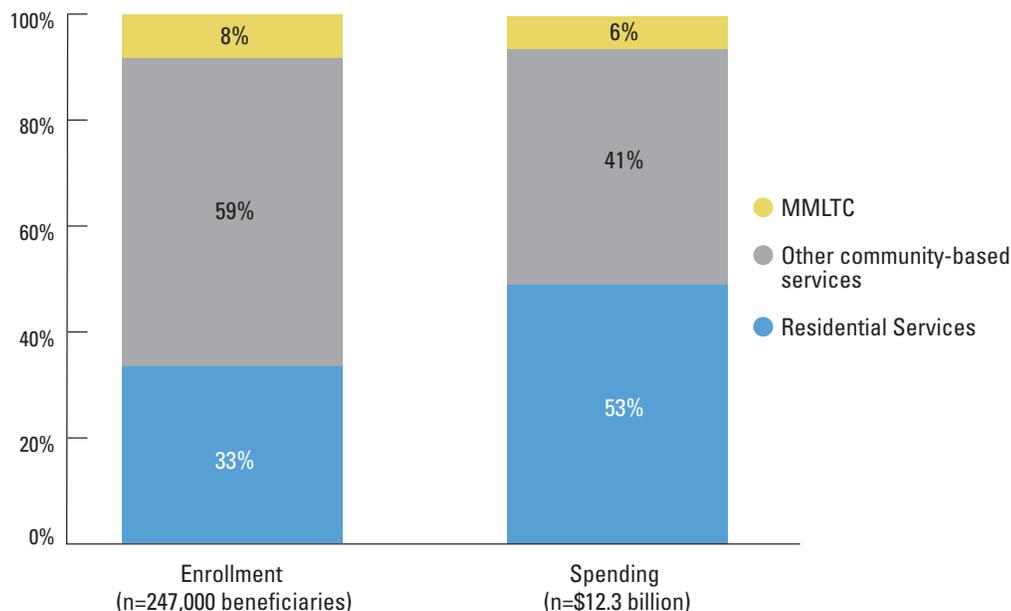
In September 2007, there were approximately 20,000 New Yorkers with nursing home level of care needs enrolled in the state’s Medicaid managed long-term care (MMLTC) program.¹ The program, sometimes referred to as the “Medicaid-only” managed long-term care program to distinguish it from the Program of All-Inclusive Care for the Elderly (PACE), was established in 1997 under the state’s existing authority to provide Medicaid managed care.²

Enrollment and Spending

MMLTC program beneficiaries (enrollees) account for an estimated 8 percent of all Medicaid long-term care beneficiaries.

Medicaid spent roughly \$700 million on the MMLTC program in FFY 2007, approximately 6 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

Figure 5.1
Percentage of MMLTC Enrollment and Spending as a Share of All Medicaid Long-Term Care Programs, 2007



Source: UHF analysis of September 2007 MARS data and FFY 2007 CMS-64.

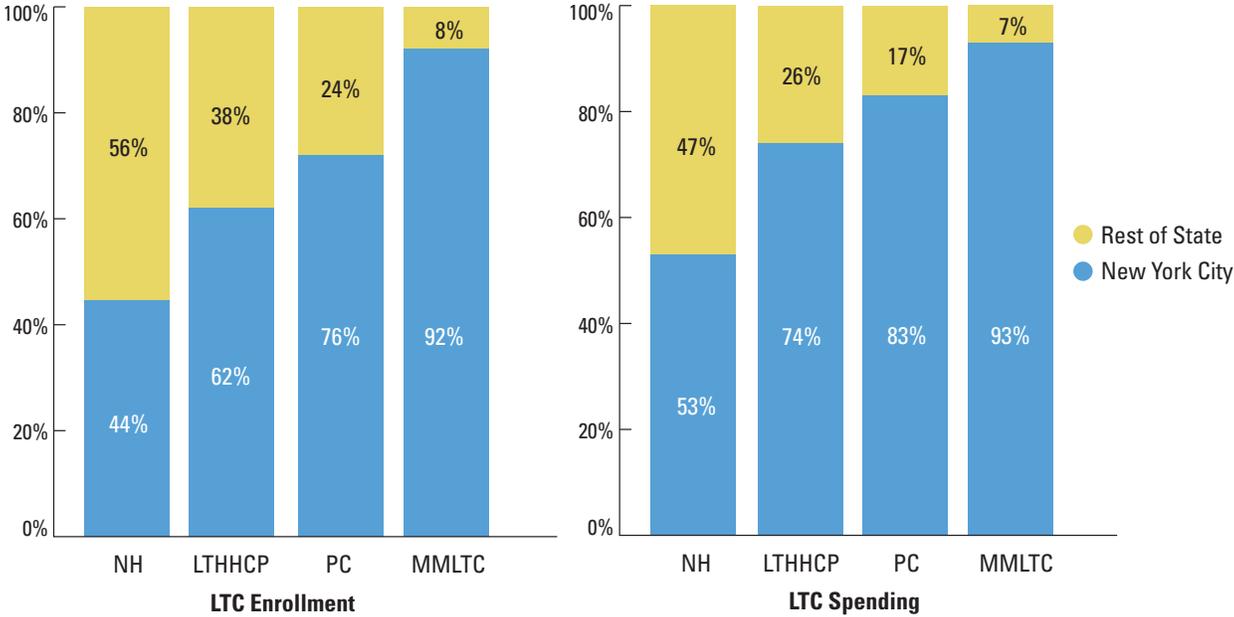
Note: Other community-based services include traditional PC, CHHA, CDPAP, ADHC, TBI, LTHHCP, and PACE programs.

¹ This program portrait is a chapter in *An Overview of Medicaid Long-Term Care Programs in New York* by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. PLEASE NOTE: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, Medicaid Assisted Living Program (ALP), traditional personal care (PC), certified home health care (CHHA), consumer-directed PC (CDPAP), adult day health care (ADHC), the Long-Term Home Health Care Program (LTHHCP), the Traumatic Brain Injury (TBI) waiver program, Medicaid managed long-term care (MMLTC), and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities (OMRDD) or medically fragile children, such as the Care at Home Program. See Technical Notes for a discussion of data sources and research methods.

² The state’s Managed Long-term Care Integration and Finance Act (Chapter 659 of the Laws of 1997) consolidates all managed long-term care demonstrations and plans (including Medicaid managed long-term care and PACE) under one legislative authority.

New York City vs. Rest of State: The vast majority of the state’s MMLTC enrollment (92 percent) and spending (93 percent) is in New York City. This regional distribution of spending and enrollment is consistent with the pattern seen in other community-based programs, though the concentration in New York City is more pronounced. It differs from the enrollment pattern for New York’s nursing homes, in which a larger proportion of enrollment is outside of New York City.

Figure 5.2
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007



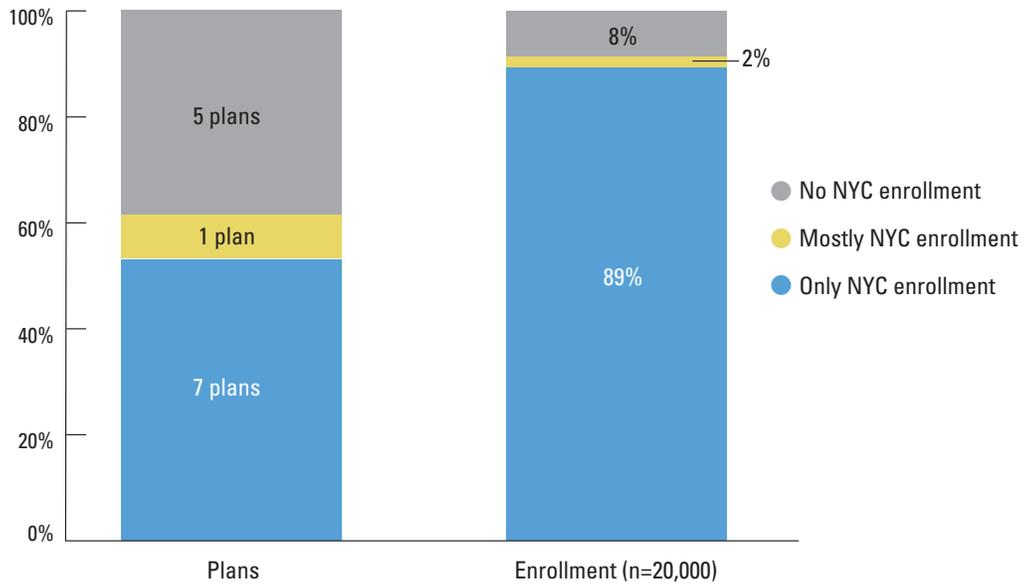
Sources: For nursing homes, LTHHCP, and traditional personal care program: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of September 2007 SDOH Managed Care enrollment data and SDOH Medicaid Managed Care Operating Report (MCOR) data, 12/31/07, provided by the MLTC/PACE Coalition.

Program and Provider Capacity

There are 13 MMLTC plans in New York (September 2007). Seven of the plans operate exclusively in New York City; one operates primarily in the city but has a small number of enrollees in an adjacent county; and five operate exclusively outside of the city. Only three counties outside of the New York City metropolitan area have an MMLTC plan.^{3,4}

³ Metropolitan area includes New York City, Long Island (Nassau and Suffolk counties), and New Rochelle regions (Westchester, Orange, and Rockland counties).
⁴ MMLTC is available in at least 13 counties (Erie, Herkimer, Nassau, Oneida, Orange, Rockland, Suffolk, Westchester, and the five counties in New York City). Plans may expand into additional counties.

Figure 5.3
Share of MMLTC Plans and Enrollment in New York City, September 2007



Source: September 2007 Medicaid managed care statistics, SDOH.
 Note: Percentages are rounded and may not sum to 100%.

Program Size: There is no limit on the number of beneficiaries that an individual MMLTC plan can enroll.⁵ The seven plans with enrollment primarily in New York City are significantly larger than the five plans that operate exclusively outside the city (average enrollment of 2,340 and 310, respectively). This pattern is consistent with the Long-Term Home Health Care Program (LTHHCP), which has smaller programs outside of New York City. Within the City, however, average program enrollment in MMLTC plans is much larger than in LTHHCP providers.

Table 5.1
Average Caseload Size of MMLTC Plans and LTHHCP Providers

	MMLTC Plans	LTHHCP Providers
New York City	2,340 (7 plans)	350 (29 providers)
Both NYC and ROS	420 (1 plan)	700 (11 providers)
Rest of State	310 (5 plans)	100 (69 providers)

Sources: Sept 2007 Medicaid managed care statistics (SDOH) and 2007 LTHHCP census.

⁵ The state's Managed Long-term Care Integration and Financing Act of 1997 authorized up to 37 managed long-term care plans (including MMLTC and PACE plans) for up to 25,000 frail seniors and adults with physical disabilities.

Program Growth: For the last five years, statewide program enrollment has grown by approximately 20 percent per year (New York State Department of Health 2006). However, plans in New York City have grown more rapidly than those in other parts of the state. For example, between September 2003 and September 2007, enrollment in New York City increased by 135 percent, compared to an increase of only 60 percent in the rest of the state.

Workforce: MMLTC plans typically employ nurses and social workers directly. In New York City, plans subcontract with licensed home care service agencies for direct care services (home health aides and personal care aides), but in the rest of the state it is more common for plans to employ their own workers. There is no independent, reliable source of data about turnover rates at the national, state, or local level.⁶

Health Status and Demographics

The figures in this section of the report include enrollees from both the MMLTC and PACE programs.⁷ Enrollment in both programs is limited to individuals with nursing home level of care needs. The vast majority of enrollees receive services in community-based settings. However, a small percentage (an average of 7 percent statewide) are nursing home residents.

The majority of enrollees are frail seniors. Eleven percent are adults (under the age of 65) with physical disabilities; most of these are enrolled in a single plan in New York City. Seventy-six percent of enrollees are female, 62 percent are people of color, and 43 percent speak a primary language other than English.

⁶ National and local estimates of the turnover rates for direct care workers in the home care industry range from 40 to 50 percent (Seavey et al. 2006). PHI reports that in New York City, the turnover rate of the MMLTC program is higher than that of the personal care program, which is estimated to be 11 to 15 percent annually. It reports that in the rest of the state, the turnover rate is comparable to or worse than the national average [Carol Rodat, PHI, personal communication, September 25, 2008]. The contrast to New York City is likely related to labor-management agreements which are standardized and approximately \$2 to \$3 more per hour than the wages paid by the licensed home care services programs with whom the MMLTC plans contract.

⁷ Figures in this section of the report come from the New York State Department of Health Managed Long-Term Care Final Report (2006), which cites December 31, 2005 data. PACE accounted for 16 percent of total MLTC enrollment in December 2005.

Table 5.2
Frequency of Chronic Medical Conditions Among Managed Long-Term Care Enrollees, December 2005

Medical Condition	Percent of Total
Hypertension	82%
Cardiac, Heart Problems	52%
Visual Impairments	44%
Osteoarthritis	42%
Diabetes	40%
Stroke/CVA	23%

Source: New York State Department of Health (28 March 2006). New York State Managed Long-Term Care: Final Report to the Governor and Legislature.

Note: Health status statistics include both MMLTC and PACE enrollees.

Enrollees generally have a number of chronic medical conditions. Out of every 10 enrollees, eight have hypertension; five have cardiac problems; four have visual impairment; four have osteoarthritis; four have diabetes; and two have suffered a stroke. Most enrollees have a combination of these conditions.

Most beneficiaries require help with dressing (89 percent), bathing (93 percent), transferring (72 percent), walking (95 percent), and eating (78 percent). Nearly one-half (46 percent) require some assistance with toileting.⁸ Roughly one-half of enrollees have some degree of cognitive impairment.

Table 5.3
Percentage of Managed Long-Term Care Enrollees Requiring Help with Activities of Daily Living, December 2005

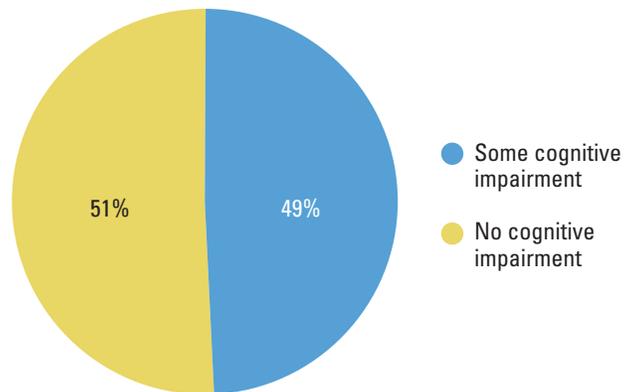
ADL	Extent of Help Required		
	None	Some	Total
Dressing	11%	69%	20%
Bathing	7%	50%	43%
Toileting	54%	26%	20%
Transferring	28%	60%	12%
Walking	5%	94%	1% (bedfast)
Eating	22%	77%	1% (tube feeding)

Source: New York State Department of Health (28 March 2006). NYS Managed Long-Term Care: Final Report to the Governor and Legislature.

Note: Functional status statistics include both MMLTC and PACE enrollees.

⁸ According to the Semi-Annual Assessment of Members (SAAM), transferring is the "ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if member is bedfast." See Eligibility section for a description of the SAAM.

Figure 5.4
Managed Long-Term Care Enrollees with Cognitive Impairment, December 2005



Source: SDOH (March 2006). NYS Managed LTC: Final Report to the Governor and Legislature.
Note: Health status statistics include both MMLTC and PACE enrollees.

Rules, Regulations, and Administrative Structure

Federal Coverage Requirements

Title 19, Section 1932 of the Social Security Act allows states to establish voluntary managed care plans as an alternative to fee-for-service Medicaid. MMLTC plans operate under the state’s authority to regulate managed care plans (Article 44 of the New York Public Health Law).

Covered Services

MMLTC plans are responsible for care management and for several specified services: nursing; personal care and home health aide services; physical, occupational, and speech therapies; and medical equipment and supplies. Plans may also provide services not typically covered by Medicaid, such as medical social services and social day care. Unlike the state’s Long-Term Home Health Care Program, MMLTC plans are required to provide nursing home care, when appropriate and for as long as necessary, as well as dentistry, optometry, and podiatry — services that beneficiaries who have both Medicare and Medicaid coverage (dually eligible) cannot typically access through the federal Medicare program.⁹

⁹ Residents of nursing homes are not eligible to enroll in MMLTC plans, although enrollees who come to need nursing home care may remain enrolled in MMLTC.

**Table 5.4
Medicaid Managed Long-Term Care Program: Covered Services**

Covered Services	Services Coordinated But Not Covered
Care management	Physician services
Nursing	Inpatient/outpatient hospital services
Home health	Rural health clinic services
Personal care	Pharmacy
Homemaking	Laboratory
Housekeeping	Radiology and radiation services
Physical therapy	Chronic renal dialysis
Occupational therapy	Mental health and mental retardation / developmental disability services
Speech pathology	Alcohol and substance abuse services
Respiratory therapy	Family planning services
Audiology	Emergency transportation
Medical supplies & equipment	Other services listed in the state's Medicaid plan
Medical day care	
Social day care	
Nutritional counseling	
Personal emergency response system and other social/environmental supports	
Non-emergency transportation	
Nursing home care *	
Dentistry*	
Optometry*	
Podiatry*	
Assisted living (optional) *	

Note: * Services covered by MMLTC plans but not by the Long-Term Home Health Care Program.

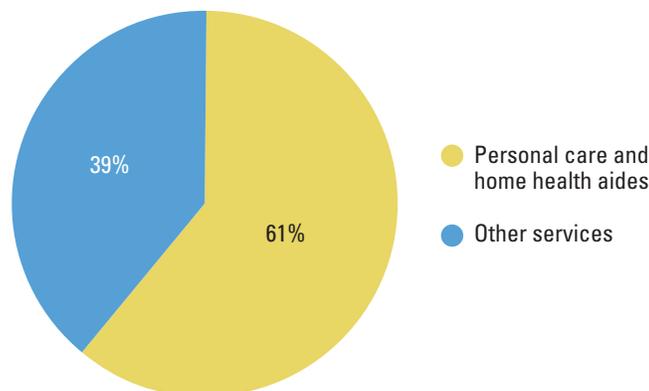
Scope of Care Management Responsibility: MMLTC plans are responsible for managing all the care needs of beneficiaries, regardless of the care setting. If an enrollee is hospitalized or requires nursing home care, the plan remains responsible for managing his or her care and associated costs. Care management caseloads vary in size from plan to plan. Care managers, usually nurses (sometimes social workers), typically have responsibility for managing the care of 25 to 30 beneficiaries (Hokenstad and Haslanger 2004).

Service Utilization

Consistent with service utilization patterns in most long-term care programs that primarily enroll frail seniors and adults with physical disabilities, most service use is attributable to direct care services — hands-on help with activities of daily living and instrumental activities of daily living.

Nearly all enrollees receive direct care services (either personal care or home health aide services). In 2005, New York City plans spent 61 percent of their Medicaid revenue on direct care services.

Figure 5.5
Percentage of MMLTC Spending in New York City, by Type of Service, 2005



Source: American PACE Exchange analysis of NYS Managed LTC Plan Performance, CY 2005.

Eligibility — Medical and Financial

Medical Eligibility: Applicants must be 18 years or older. There are no excluded adult populations. Unlike nursing homes, MMLTC plans can admit enrollees with a primary diagnosis of either a severe and persistent mental illness or an intellectual disability (such as mental retardation or a developmental disability), provided that they meet all other eligibility requirements.¹⁰

Eligibility is limited to individuals who require nursing home level of care as measured by the Semi-Annual Assessment of Members (SAAM).¹¹ Eligibility also requires that the applicant can be safely and appropriately maintained in a home and community-based setting, as indicated by the SAAM and a physician's order. Plans must conduct a comprehensive needs assessment, including the SAAM, at least every 180 days.¹²

The local department of social services is responsible for approving medical eligibility determinations before plan enrollment. New York City's department of social services (HRA) does not make an independent home visit to confirm eligibility and service plans, as it does for the LTHHCP; instead, it reviews the paperwork (SAAM and plan of care)

¹⁰ For more information about eligibility, see Bogart 2007.

¹¹ The SAAM is a chronic care version of the Outcome and Assessment Information Set (OASIS), a tool that is a federally mandated assessment used to determine level of care and reimbursement, and to measure outcomes of care in organizations that are required to comply with Medicare regulations (CHHAs and LTHHCP providers). Applicants must require a nursing home level of care, scoring five or more on the SAAM.

¹² Unlike LTHHCP providers, MMLTC plans are not required by the state to adhere to the Medicare conditions of participation.

submitted by the plan. New enrollments are timed to start at the beginning of each month so as to coincide with monthly payment cycles.

Financial Eligibility: Local departments of social services determine financial eligibility for MMLTC plans using general Medicaid criteria (income no greater than \$8,700 annually and savings no greater than \$13,050) and the additional “home equity limit” criterion that applies only to financial eligibility for long-term care (primary residence valued at no more than \$750,000).¹³

Access

As is the case in most other long-term care programs, MMLTC applicants apply directly from the community to an individual plan. The plan sends a nurse to the applicant’s home to conduct an initial eligibility determination, which includes administering the SAAM. Upon enrollment, plan staff members develop a comprehensive care plan. Plans are required to re-administer the SAAM at least once every 180 days or after any change in an enrollee’s functional status. The local department of social services reviews the SAAM and the plan of care every 180 days.

We were not able to obtain good information about the source of program admissions. However, because the timing of admissions must coincide with the beginning of the month (for billing purposes), plans are not likely to receive as many direct referrals from hospitals as LTHHCP providers do.

Discharge Patterns: Most disenrollments from MMLTC or PACE are due to death or voluntary disenrollments (e.g., moving to another state); a small number were involuntary — i.e., the beneficiary was no longer eligible for the plan (New York State Department of Health 2006). In 2005, there were 968 deaths (an estimated 7 percent of total enrollment). In addition, there were 1,250 disenrollments from the MMLTC and PACE plans combined (an estimated 9 percent of total enrollment).¹⁴ Of these, 78 percent were voluntary and 22 percent were involuntary.¹⁵

¹³ Individuals whose income is higher than the rules allow may qualify for Medicaid through the Spend-Down (Medically Needy) program, which allows applicants with “excess income” (the amount above \$725 per month) attributable to medical expenses to “spend down” to the financial resource limit. [See Chapter 1 and Glossary.]

¹⁴ Total December 2005 enrollment was 11,976 beneficiaries in MMLTC (84 percent) and 2,338 beneficiaries in PACE (16 percent).

¹⁵ More than 90 percent of involuntary disenrollments are initiated by the plan because the enrollee no longer met enrollment criteria for one of the following reasons: the enrollee moved out of the service area, left the service area for more than 60 days, was hospitalized for more than 45 days, failed to pay their Medicaid spend-down surplus, or exhibited such abusive or disruptive behavior that it was “no longer possible for the plans to provide effective and quality services.” Voluntary disenrollments may include issues such as moving outside of the service area, enrollment in another Medicaid joining program, or dissatisfaction with the quality or quantity of services.

Provider Requirements

All program sponsors approved before 2007 were provider-based organizations with expertise in providing home care services rather than insurance companies. However, because they are managed care plans providing Medicaid services, MMLTC plans operate under both the state's insurance regulatory authority and the federal authority to provide managed care alternatives to traditional fee-for-service Medicaid. New plans must be approved by the New York State Insurance Department and the State Department of Health.¹⁶ New York requires plans to have fiscal reserves equal to 5 percent of net premium income.¹⁷ Plans approved as MMLTC providers after 2006 must be sponsored by organizations that are also designated as Special Needs Plans (SNPs) under Medicare. A SNP is a type of Medicare managed care plan (Medicare Advantage) that is designed specifically for beneficiaries with special needs, including institutional residents, dually eligible individuals, and people with severe or disabling chronic conditions.¹⁸ The purpose of this requirement is to locate the responsibility for managing beneficiaries' medical and long-term care needs within a single organization.

Payment

The state's Medicaid program pays each plan a negotiated monthly premium for each enrolled beneficiary. There are different payment amounts for enrollees aged 18–64 years and those 65 and older; in addition there are different payment amounts for those who have Medicare coverage (dually eligible) and those who do not. Unlike nursing home payment, these premiums are not risk-adjusted (case-mix indexed) to account for different levels of functional, cognitive, and clinical need. Before 2006, the state negotiated the monthly premiums for each plan independently based on the prior year's expenditures; an extremely labor-intensive process. The state changed the process: premiums are individually negotiated every other year, and in the intervening years all plans receive a trend factor adjustment (2 percent in 2007) applied to the prior year's rates. There is no specific payment adjustment for additional costs associated with enrollees who have extensive needs, such as those who reside in nursing homes or who require a high level of personal care or costly equipment (Kronick and Llanos 2008).¹⁹

¹⁶ The New York State Insurance Department is responsible for regulating enrollee contracts, premium rates, and fiscal solvency (in consultation with the Department of Health).

¹⁷ Initial solvency requirements are based on the accumulated operating deficit until the projected break-even month. Added to that amount is the calculated escrow deposit account, which is equal to the greater of \$100,000 or 5 percent of the estimated health care expenditures for the calendar year of operations.

¹⁸ Medicare Advantage is available to all Medicare beneficiaries, regardless of their level of disability.

¹⁹ The state's 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 population. The state contracts with an actuarial firm to meet these requirements.

In 2007, the statewide average monthly Medicaid premium for an MMLTC plan was about \$3,600 per member. However, the premiums varied greatly between New York City and the rest of the state, as well as among plans within the same region. The premium for enrollees who do not have Medicare coverage (Medicaid only) is higher than that for those who are dually eligible. Some of the variation among plans in the same region is likely related to the proportion of enrollees with Medicare coverage compared to those without.

Table 5.5
Average Monthly Medicaid Payment Rates for MMLTC Plans, 2007

Region	Average Per Member Per Month Premiums	Range
New York State	\$3,600	\$2,000 - \$5,000
New York City	\$3,600	\$3,000 - \$5,000
Rest of state	\$3,000	\$2,000 - \$4,000

Source: UHF analysis of SDOH Medicaid Managed Care Operating Report data, December 2007, provided by the MLTC/PACE Coalition.

Quality Monitoring

The State Department of Health is accountable for plan performance. Although the state recently restructured and co-located responsibility for most of the long-term care programs (including nursing homes, the LTHHCP, and personal care) within a single division (the Office of Long-Term Care), oversight of the MMLTC and PACE remains the responsibility of the managed care division. Plans are subject to an annual on-site performance review and are required to submit SAAM data and disenrollment statistics semiannually. Failure to meet survey standards can result in sanctions, including suspension of enrollment privileges. There are no specific rewards for good performance. The state does not publicly report outcomes for the MMLTC plans, as it does for LTHHCP providers and nursing homes.

Each plan is required to have an internal quality assurance and performance improvement program and to conduct at least one major quality improvement project per year. Plans are also required to conduct at least one enrollee satisfaction survey each year.

Policy Implications

The Medicaid managed long-term care program plays a fundamental role in meeting the long-term care needs of more than 20,000 New Yorkers each month. Most of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities. Care for this group can be intensive and costly. In FFY 2007, Medicaid spending for the MMLTC program was roughly \$700 million. This section of the report explores some of the challenges facing the program, and identifies critical issues for further research and discussion about how the delivery of long-term care services could be improved.

System Simplification

In the current long-term care system, it is difficult to distinguish among programs that enroll similar populations. For example, MMLTC and the LTHHCP enroll similar populations (both are limited to individuals who have nursing home level of care needs), and although MMLTC provides a slightly broader array of services than the LTHHCP does, most spending in both programs goes toward direct care services. The primary difference between the programs is how they are paid. MMLTC plans are paid a monthly premium for each beneficiary, and they are responsible for meeting beneficiaries' long-term care needs for as long as necessary, including providing nursing home care when appropriate. Meanwhile, LTHHCP providers are paid on a fee-for-service basis, but there is a limit on how much can be spent on each beneficiary.²⁰ If a beneficiary's needs exceed the budget threshold, they may have to disenroll and seek services elsewhere (such as a nursing home, certified home health agency, or through the personal care program).

Given the apparent overlap in target populations, it is important to decide whether to maintain both MMLTC and the LTHHCP as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. Solutions must address regional differences in capacity. MMLTC is primarily a New York City program, and the LTHHCP plays a particularly significant role outside of the city; in some counties it is the primary way for beneficiaries to receive community-based care.

²⁰ The per-beneficiary spending cap in the LTHHCP is equivalent to 75 percent of the average Medicaid nursing home rate in the same county. There are some exceptions to this requirement. [See Chapter 4 for an in-depth look at the Long-Term Home Health Care Program.]

Effective Care Management

Because most long-term care beneficiaries have multiple chronic medical conditions, they typically require a lot of medical services and acute care. Effective care management for people with chronic medical conditions can accomplish many tasks: preventing avoidable events, such as medication errors or urinary tract infections; promoting early treatment to slow functional and cognitive decline; and fostering more effective disease management, such as better glucose monitoring for diabetics. In order to address the full complement of beneficiaries' needs, it will be important to implement strategies that more fully integrate long-term care with the delivery of medical, mental health, and social services.

However, many factors make it difficult to provide care management that effectively balances cost and quality: a shortage of nurses and social workers with the required skills and experience; regulatory requirements whose documentation consumes a substantial amount of the time available to manage beneficiary care; differences in how providers interpret the scope of their care management responsibilities; and gaps in the availability of local services, such as transportation and in-home mental health care. A long-term care reform agenda for New York State should include clear guidelines about expectations for care management services; a strategy for ensuring that the professionals who perform this important role have appropriate skills, training, and supervision; and a strategy for regularly monitoring and evaluating the effectiveness of care management services. Careful consideration should be given to reform solutions that would narrow gaps in the availability of local services.

Integration of Medicare and Medicaid Financing

For dually eligible beneficiaries (those with both Medicaid and Medicare coverage), effective long-term care can save money for both the Medicaid and Medicare programs. For example, a serious fall can permanently impair an individual's ability to walk. Preventing that fall could avert the cost of additional hours of personal care or placement in a nursing home, paid for by Medicaid. The more substantial and immediate savings, however, would accrue to Medicare, by obviating the need for emergency room visits, hospitalizations, and rehabilitation services.

There is continuing interest at both the state and federal level to more fully integrate Medicare and Medicaid financing at the provider or plan level. The Program of All-Inclusive Care for the Elderly (PACE) is widely cited as a successful model of integrated financing and service delivery, but it has been slow to replicate the program (as currently configured) on a broad scale.²¹ Therefore, the state has pursued other strategies. For example, since 2006, the state department of health has required sponsors of new MMLTC plans to also offer Medicare special needs plans (SNPs).²² In addition, the state has recently established a new long-term care program, Medicaid Advantage Plus, which is another managed care option for dually eligible individuals over the age of 18 with nursing home level of care needs.²³ The purpose of the SNP requirement and the new Medicaid Advantage Plus program are similar — to integrate service delivery and to allow the Medicaid program to capture savings that often accrue to Medicare as a result of Medicaid-financed interventions. To capture these Medicare “savings,” it is likely that the Medicaid premiums for these integrated plans will be lower than rates for current MMLTC plans.

There are practical implications related to these changes. For example, the new SNP requirement suggests the need for large organizational sponsors, such as insurance companies, that can assume the financial risks associated with capitated financing and meet the financial reserve requirements. While it does not prohibit organizations with extensive home care experience from applying to sponsor an MMLTC plan, it does make qualification more difficult. MMLTC sponsors are typically organizations with expertise in providing home care services, and therefore have strong connections to other community-based organizations serving frail seniors and adults with physical disabilities. Having strong community relationships is one of the factors that the state department of health has identified as critical to successful program growth (New York State Department of Health 2006). The SNP policy may be difficult for these provider-based organizations to meet. For similar reasons, the requirements for the new Medicaid Advantage Plus program may also be difficult for these provider-based organizations to meet.

²¹ PACE represents a very small share of long-term care enrollment and spending in New York, with slightly more than 3,000 enrolled in December 2007. Providers receive prospective reimbursement from both Medicare and Medicaid and are responsible for all health care as well as long-term care services. The fiscal and regulatory requirements for PACE, such as the capital costs associated with building the required adult day health care system, restrict the number of community providers that can become plans (Hokenstad and Haslanger 2004).

²² See description of SNPs in section on provider requirements. There were 26 SNPs offered in New York in 2008, with total enrollment of 64,940 as of March 2007 (Kaiser State Health Facts). Enrollment in these plans is optional.

²³ In the Medicaid Advantage Plus program, beneficiaries must enroll in the same health plan for most of their Medicare and Medicaid benefits. Plans that participate in the program offer a uniform Medicare Advantage product and a supplemental Medicaid Advantage product, which also covers long-term care services. Enrollment in the plans is optional.

Strategies to more fully integrate Medicare and Medicaid financing will need to consider how best to build on and incorporate the capacity and expertise of current long-term care providers. They may also need to consider how best to foster viable partnerships between the insurance companies that operate SNPs and provider organizations with long-term care expertise.

Risk-Adjusted Payment

From a budgetary perspective, prospective payment approaches have the advantage of more predictability; the state can more effectively project how much it will be spending. MMLTC payment is adjusted by age, but unlike nursing home payments, monthly premiums are not risk-adjusted (case-mix indexed) to account for different levels of functional, cognitive, and clinical need. In practical terms, this means that plans may not have sufficient financial incentives or resources to enroll beneficiaries who are especially frail or have complex medical conditions. Ideally, financial incentives should award plans more resources for enrolling beneficiaries with more complicated needs. A reform agenda should consider a methodology for risk-adjusting Medicaid payment to MMLTC (as well as payments to PACE and Medicaid Advantage Plus plans). More research is needed to address outstanding questions about how best to do this.

Barriers to Access

Many of the personal care program beneficiaries in New York City have needs comparable to those of MMLTC enrollees and would likely benefit from the care management and expanded array of services that MMLTC provides but that the personal care program does not (Hokenstad et al. 2002). In part because of the way they are paid, some plans may not have sufficient financial incentives or resources to enroll people with the most extensive direct care needs. As a result, some of these high-need individuals become enrolled in the personal care program.

A growing body of evidence from similar programs in other states and countries suggests that programs similar to MMLTC are effective in delaying nursing home placements and reducing the number of unnecessary hospitalizations (Saucier and Fox-Grage 2005; Kane and Homyak 2003; Kane et al. 2003; Chatterji et al. 1998; APS Healthcare 2003; Aydede 2003). A reform strategy must take a closer look at the population with nursing home level of care needs in all long-term care programs. Are they receiving the right care, in the right setting, at the right price? More research is needed to determine which of the state's program models are most successful at managing care, for which populations, and at what cost to Medicaid.

Direct Care Worker Wages

It is also important to keep in mind the practical barrier that wage differences present to system reform. Beneficiaries value their relationships with direct care workers. The likelihood of beneficiaries voluntarily switching from one program (such as personal care) to another (such as MMLTC) would be increased if direct care workers were able to remain with them. However, as a result of successful collective bargaining agreements, personal care program workers (home attendants) in New York City earn approximately \$2 to \$3 more per hour than the personal care aides and home health aides who typically provide direct care services in MMLTC and the LTHHCP. Understandably, direct care workers would be reluctant to transfer with beneficiaries if it meant that they would have to accept lower wages and benefits. A workforce strategy should include a socially responsible solution for achieving equity in direct care wages (comparable pay for comparable work) across the long-term care sector. Potential reform strategies, such as achieving administrative savings through program consolidations, may hinge on having flexibility to reassign workers where there are needed most.

Program Oversight

Within the department of health, responsibility for the MMLTC program and the other long-term care programs are not located in the same office. Oversight responsibility for long-term care programs is divided between the Office of Health Insurance Programs (for managed long-term care) and the Office of Long-Term Care. There will need to be a concerted effort to promote consistency in long-term care policy and regulation.

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