

New York State's Medicaid-only Managed Long-Term Care Program

This policy brief describes an innovative model of managed long-term care (MLTC) in New York State (NYS) that serves Medicaid eligible adults at a nursing home level of impairment, most of whom are also eligible for Medicare. The ten MLTC plans discussed here are capitated to provide all Medicaid-funded long-term care (LTC) benefits. Plans are also responsible for coordinating primary and acute care services covered by Medicare. This MLTC model is currently offered by ten diverse organizations throughout the state and serves over 4,500 voluntary participants. It is the newest of the four MLTC models operating in NYS (see Table 1).

Why New York State needs MLTC

New York State has a large population at risk for LTC – it has the third highest proportion of over-65s in the nation, with over one in five of them eligible for the Medicaid program. It also spends the most, by far, on LTC services, paying out nearly three times the national per capita average for persons over 65.² The State's support for a range of LTC service options has meant that the proportion of State LTC expenditures that goes toward community-

based, rather than institutional care is the fourth highest in the nation.³

The newest MLTC initiative, discussed in this policy brief, is part of the State's long-standing commitment to provide a range of community-based services and supports to Medicaid-eligible persons in need of LTC.⁴ In addition to increasing choices and improving client outcomes, MLTC is intended to contain Medicaid costs and provide, through capitation, an incentive to deliver care in a cost-effective manner (see Figure 1).

TABLE 1: MLTC MODELS IN NYS

Model	Services included in the capitation rate	Number of plans under development	Number of operational plans
➔ Medicaid-only MLTC	Medicaid LTC services	14	10
Program for All-Inclusive Care for the Elderly (PACE)	All Medicare and Medicaid services	4	4
Social and Health Maintenance Organization (SHMO)	Enriched package of Medicare services	1	1
Senior Health Plus ¹	All Medicare and Medicaid services	1	0

Figure 1: Goals of the MLTC demonstration⁵

- Increase choices for long term care clients and their families
- Increase client satisfaction through a more flexible delivery system
- Improve the health status outcomes of clients
- Foster independence and improve or delay declines in functioning
- Provide services in a cost-effective manner by using capitation

What the State did

NYS's Medicaid-only MLTC efforts began in the early 1990s, when it received a grant from The Commonwealth Fund to support development of a capitated LTC demonstration program.⁶ A first round of participating organizations was recruited in 1996. Then in 1997, the State legislature passed the Long Term Care Integration and Finance Act, which established MLTC as a new type of managed care organization, integrated all MLTC demonstrations under one legislative and regulatory authority, and authorized the Department of Health to approve 24 additional MLTC plans. This legislation provides a State framework for the full integration of financing and service delivery for beneficiaries who are dually eligible for Medicare and Medicaid.

The ten Medicaid-only MLTC plans that are currently up and running, listed in Table 3, represent a mix of geographic locations and types of sponsoring organizations; they include plans resulting from the Commonwealth Demonstration, and the 1997 legislation. The plans are capitated to provide a rich package of LTC benefits – see Figure 2 – to individuals at a nursing home level of care. (Figure 3 shows the State's eligibility criteria.) In addition, plans are responsible for coordinating services not

¹ Formerly known as the Monroe County Continuing Care Network, Senior Health Plus plans to provide integrated care to three groups of over-65 year olds: healthy individuals, frail, community-dwelling individuals, and nursing home residents. Capitation will be risk-adjusted and members may choose from an open panel of providers.

² Burwell, B. (2001). Medicaid Long-Term Care Expenditures in Fiscal Year 2000. *The Gerontologist*, 40 (5): 687-691.

in the benefit package, including Medicare services such as physician services, inpatient care, diagnostic procedures, and short-term nursing home care. Although the plans are not financially responsible for members' primary and acute medical care, they do have a broad responsibility for the health and well-being of their members.

How does New York State's approach compare to other approaches?

First, the NYS Medicaid-only MLTC model differs from PACE or SHMO by focusing on the capitation of LTC only. While this model, like PACE and SHMO, requires plans to coordinate acute care services, it does not require plans to pay for or provide them. Consequently, members of Medicaid-only MLTC plans need not give up their existing primary care providers when they enroll. Second, the

Figure 2: Program Benefits

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| <ul style="list-style-type: none">• Care coordination• Case management of covered services• Home health care*• Rehabilitation therapies*• Adult day services• Home-delivered meals• Personal care• Chore services• Personal Emergency Response Systems• Medications• Dental care | <ul style="list-style-type: none">• Durable medical equipment and supplies*• Optometry and eyeglasses• Podiatry*• Audiology and hearing aids• Transportation for medical appointments• Respiratory therapy• Environmental modifications• Nursing home*• Assisted living (optional) |
|--|--|

Plans are also responsible for coordinating all non-covered services, including physician services, inpatient care, emergency room services, ambulance services, and diagnostic and lab procedures.

* Plan pays if not covered by Medicare

Figure 3: Program eligibility

Participants targeted are persons who:

- Are Medicaid-eligible*
- Meet state criteria for a nursing home level of care
- Reside in the community at enrollment
- Require long term care for more than 120 days
- Are aged 21 or older.

* Until January 1, 2001, participants were required to be dually eligible for both Medicare and Medicaid.

NYS Medicaid-only model allows a variety of service delivery models to be developed, rather than prescribing one way to deliver services.

The NYS Medicaid-only MLTC model also differs from other states' efforts to develop Medicaid-only MLTC. Table 2 compares the NYS model to Medicaid-only models developed by Arizona⁷ and Wisconsin. Arizona's model is statewide and capitates a broader range of services, while Wisconsin's Family Care program provides a range of benefits that is closer to that offered by the NYS model.

All three of these states have broadly similar goals. They aim to use organizations outside government to manage plans and work toward "full integration" – integrating financing for LTC services with that of other health services. However, among these states, only New York relies solely on organizations outside government to manage the capitation amount. Arizona and Wisconsin currently rely heavily on counties to run their plans, although Arizona has recently required plans statewide to undergo competitive bidding for contracts, and Wisconsin aims to allow outside organizations to take over operation of plans from 2003. The goal of fully integrating the financing of acute and LTC has also suffered setbacks in all three states – with the exception of PACE, which states continue to support, and Wisconsin's Partnership Project.⁸

TABLE 2: SELECTED STATES'

	Arizona
Program name	Arizona Long-Term Care System
Benefits capitated	The full range of acute, mental health, and LTC services paid for by Medicaid.
Waiver of federal Medicaid requirements?	1115 waiver
Eligibility	Medicaid eligible individuals requiring a nursing home level of care. People with developmental disability receive services from a specialized plan.
Rank among states in per capita spending on HCBS⁹	26th
Voluntary?	No
State-wide?	Yes
Status	Operating since 1989
Enrollment (approx.) As of Nov. 2001	18,933
Nature of MLTC plans	County-run organizations currently manage the capitation payment for three-quarters of participants. One for-profit and one not-for-profit plan manage the remainder. In a few areas, there is competition among plans.

³ Murtaugh, C.M., Sparer, M.S., Feldman, P.H., Lee, J.S., Basch, A., Sherlock, A., Clark, A.L. (1999). *State Strategies for Allocating Resources to Home and Community-Based Care*. New York, NY: The Center for Home Care Policy and Research, Visiting Nurse Service of NY.

⁴ In addition to programs listed in Table 1, these include the Long Term Home Health Care Program ("Nursing Home Without Walls") and Community Nursing Organizations, a federal demonstration.

⁵ New York State Department of Social Services. (1996). *Evaluated Medicaid Long Term Care Capitation Program Request for Proposals*. Albany, NY: Author.

⁶ This was formally known as New York's Evaluated Medicaid Long-Term Care Capitation Program. The Fund also supported a limited evaluation, published as Liu, K., Long S.K., Storeygard M., Lockshin A. (May, 2001). *Integrating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York*. New York: The Commonwealth Fund.

MEDICAID-ONLY MLTC PROGRAMS

New York	Wisconsin
Evaluated Medicaid Long-Term Care Capitation Program	Family Care
All Medicaid LTC services, plus prescription drugs, podiatry, dentistry, audiology, and optometry.	All Medicaid LTC services, plus home and community-based waiver services. Physician, medications, dental and in-patient hospital NOT included.
None required	Combination 1915 b/c waiver
Medicaid eligible individuals over 21 years of age requiring a nursing home level of care.	Medicaid eligible individuals over 18 years of age meeting certain functional and financial requirements.
1st	9th
Yes	Yes ¹⁰
No – legislative approval exists for more plans, however	No – expansion is dependent on legislative approval
Operating since 1998	First plan began operation in February 2000
4,500	4,373
The plans' sponsoring organizations differ widely in kind; six of the eleven counties and New York City boroughs offering MLTC provide a choice of plans.	Five counties run Care Management Organizations, which administer and manage the capitation payment, and nine run Disability and Aging Resource Centers, which provide information and assistance. No competition among plans currently exists.

How plans have implemented the NYS model of Medicaid-only MLTC

The most striking feature of the NYS model of Medicaid-only MLTC is the variety of organizations that are operating plans and the resulting differences among plans.

- Plans come from a wide array of sponsoring organizations, from integrated health systems to nursing homes.
- They are located in different geographical settings. While most plans are based in urban and suburban settings, one plan includes a rural area among those it serves.
- Some plans can provide most services through their sponsoring organizations, while others build networks through contracts with unaffiliated organizations. Some have developed certain provider types, such as adult day services, from scratch.
- Plans differ in scale, depending on the goals and resources of the sponsoring organization.
- Plans operate a variety of care management models, defining “teams” differently. Some plans separate out care management from service delivery, while some use nurse case managers who also provide hands-on care.

However, plans have a number of elements in common.

- All plans are experienced in serving their target population and all but one are not-for-profit.
- All plans have had to invest substantial resources in start-up and agree that building the management, regulatory compliance, and information systems appropriate for managed care is a significant challenge.
- Lastly, all plans emphasize the importance of psychological and social factors in the lives of people needing Medicaid LTC services and the importance of addressing these needs when developing a service delivery model.

⁷ Arizona operates its long-term care program under a demonstration grant outside the Medicaid program.

⁸ The Wisconsin Partnership Project serves 1,210 Medicaid-eligible individuals at a nursing-home level of care (as of December 2001) and aims to deliver integrated services. Providers receive capitated payments from Medicaid and, in the case of dual eligibles, from Medicare. Its four providers include a PACE site.

⁹ HCBS stands for home and community-based LTC services. Kitchener M., Carrillo H., Harrington C. (2001). *An analysis of state variation in the growth of Medicaid home and community-based services*. San Francisco, CA: Department of Social and Behavioral Sciences, University of California, San Francisco.

¹⁰ However, Family Care is the only way to access home and community-based waiver services.

TABLE 3: MLTC PLANS IN NEW YORK STATE¹¹

Name	Sponsoring organization	Area served ¹²	Startup date	Eligibility	Enrollment Dec. '01	Contact information
ORIGINAL DEMONSTRATION PLANS						
Broadlawn Health Partners	<i>Integrated health system</i> – Winthrop South Nassau Univ. Health System and the Catholic Health System Long Island	<i>Suburban</i> – Nassau County (population over 65 = 197,132)	February '99	21+ (91% are 65+)	172	Diane Dias, Administrator 399 County Line Road Amityville, NY 11701 631-608-5630
Co-op Care	<i>Nursing home</i> – Hebrew Hospital Home	<i>Urban</i> – The Bronx (population over 65 = 129,717)	August '98	21+ (89% are 65+)	397	Maura Bordas, Administrator for Community Programs 2117 Williamsbridge Road Bronx, NY 10461 718-239-6626
Partners in Community Care	<i>Hospital and managed care plan joint venture</i> – A limited liability corporation established by the Good Samaritan Hospital and the Better Health Plan	<i>Suburban</i> – Orange and Rockland counties (population over 65 = 66,776)	January '99	21+	82	Arnold Green, Administrator Good Samaritan Hospital 255 Lafayette Avenue, Room 245 Suffern Ny 10901 1-800-688-7422
Senior Network Health LLC	<i>Integrated health system</i> – Mohawk Valley Network	<i>Rural and suburban</i> – Oneida County (population over 65 = 38,226)	October '98	65+	188	Deborah Maciewicz, Director of Clinical Services, Box 4215 Utica, New York 13504-4215 315-738-6054
VNS CHOICE	<i>Home health agency</i> – The Visiting Nurse Service of NY	<i>Urban</i> – All NYC boroughs (population over 65 = 938,546)	January '98	65+	2,509	Holly Michaels Fisher Vice President/Executive Director 5 Penn Plaza, 11th Floor New York, NY 10001-1810 212-290-4858
PLANS AUTHORIZED UNDER THE 1997 LONG TERM CARE FINANCE ACT						
GUILDNET	<i>Nonprofit service provider</i> – Jewish Guild for the Blind	<i>Urban and suburban</i> – All NYC boroughs except Staten Island (population over 65 = 890,440)	July '00	21+ (90% are blind or visually impaired, about 75% over 65)	628	Geri Taylor, Exec. Vice President 15 W. 65th Street New York, NY 10023-6694 212-769-7851
HomeFirst	<i>Integrated health system</i> – Metropolitan Jewish Health System	<i>Urban</i> – Brooklyn (population over 65 = 279,572)	July '00	65+	209	Christopher Palmieri, Administrator 6323 7th Avenue Brooklyn, NY 11220 718-630-2560
Independence Care System	<i>Home health care agency</i> – Cooperative Home Care Associates	<i>Urban</i> – The Bronx and Manhattan	April '00	21+ (1% is 65+)	294	Rick Surpin, President 257 Park Avenue So, 2nd Floor New York, NY 10010-7304 212-584-2500
PRE-PACE PLANS¹³						
Health Advantage Plan	<i>Multiservice provider</i> – Arden Hill Senior Health System	<i>Suburban</i> – Orange (population over 65 = 33,577)	December '00	55+	27	Maureen Coughlin, Administrator 6 Harriman Drive Goshen, NY 10924 845-291-8323
Senior Health Partners	<i>Collaboration</i> – Mt. Sinai Hospital, Jewish Home and Hospital, Metropolitan Council on Jewish Poverty	<i>Urban</i> – Northern Manhattan (population over 65 for all of Manhattan = 194,869)	June '01	55+	46	Christine Klotz, President 149 West 105th Street, #3E New York, NY 10025 212-870-4610

¹¹ Four other plans received approval, but have not yet been implemented.

¹² Population figures are for 1998, from the US Bureau of the Census: Internet Release September 15, 1999. Compiled by the New York State Department for the Aging.

¹³ The only difference between pre-PACE plans and the other Medicaid-only MLTC plans is their intent to become fully integrated PACE sites and their need to work toward meeting the additional PACE requirements. The benefit package, eligibility requirements, and regulatory regime are identical.

Figure 4: Advantages of the NYS MLTC model

For consumers

- Allows members to maintain existing arrangements for primary and acute care
- Coordinates non-covered services, thus integrating service delivery
- Provides a choice of different service delivery options

For plans

- Allows plans to build on their existing areas of expertise and develop different ways of delivering services
- Has the demonstrated potential to grow quickly and serve a large number of participants

For the state

- The model's flexibility encourages the development of plans and infrastructure by widely differing organizations
- Because no waiver is required, the need for states to strike complicated agreements with the federal government is minimized

Implications

The model of MLTC described here has important advantages for consumers, plans, and the State. (See Figure 4.) These include flexibility, feasibility, and the potential for improved care for members. Flexibility is shown by the plans' variety: they differ widely in resources, service delivery approaches, and target populations, demonstrating the advantages of these differences and resulting in more choice for LTC beneficiaries. Flexibility also benefits members by allowing them to keep their primary care providers and existing network of specialists—features that increase member satisfaction and promote continuity of care. Another advantage of the model for consumers is the requirement that plans coordinate the full range of long-term, primary and acute care services, making the system easier to navigate and improving quality of care.

The NY State MLTC model's flexibility also makes it feasible for widely differing organizations to become MLTC plans. Very different organizations can build on their existing infrastructure, areas of expertise, and accustomed modes of service delivery to develop their own version of MLTC. In addition, timely implementation results from the focus on Medicaid services and benefits, which eliminates the need for a federal waiver. Although many of the MLTC plans continue to see the full integration of Medicaid and Medicare financing and services as an important goal, the knowledge and experience they have gained in implementing Medicaid-only MLTC serves as an important building block toward that longer-term goal. Thus, this model encourages experimentation, yielding important lessons for the future of LTC.

THIS POLICY BRIEF WAS PREPARED BY
PAMELA NADASH

Center for Home Care Policy & Research



VISITING NURSE SERVICE OF NEW YORK

107 EAST 70TH STREET NEW YORK, NEW YORK 10021

PH. 212.794.6300 FAX 212.794.6610

www.vnsny.org/research