



New York Association of Homes & Services for the Aging

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Public Hearing Testimony

## Managed Long-Term Care Demonstration Program

**Submitted to:**

**Assembly Committee on Health  
Richard N. Gottfried, Chair**

**Presented by:**

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On behalf of the New York State Association of Homes and Services for the Aging (NYAHS), I thank you for the opportunity to comment on the Managed Long Term Care Demonstration program. My name is Darius Kirstein and I am a Senior Policy Analyst with NYAHS, a statewide organization of socially responsible, community-benefit organizations dedicated to providing high quality health care, housing, and community services to the elderly and people with special needs.

Founded in 1961, NYAHS is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care. NYAHS members include nursing homes, senior housing providers, adult care facilities, home care and other community services providers, continuing care retirement communities, assisted living providers as well as managed long term care plans. NYAHS's nearly 650 members serve an estimated 500,000 New Yorkers of all ages annually.

Not-for-profit organizations were among the first sponsors of formalized home and community-based programs for the aged and disabled. They have been on the cutting edge of home and community-based care from the very first Medicaid waiver programs to the innovative managed long term care demonstration programs being discussed today. NYAHS members have embraced the concept of care in the least restrictive, most appropriate setting, and are helping to build a continuing care system characterized by comprehensive, coordinated services tailored to the needs of the individual.

Studies and surveys have shown that most seniors prefer to remain in their homes as long as possible. New York state has recognized this and has been a national leader in providing community-based care. The question is how to best extend this community-based care to those whose intense health care needs make them difficult and expensive to serve. Managed long term care has been offering one promising answer.

## **Background**

Statewide, managed long term care (MLTC) plans care for nearly 14,000 nursing home eligible persons. Enrollees are primarily frail seniors who receive coordinated care at home and in day centers allowing them to remain in their homes as long as possible. MLTC plans receive a fixed amount per month for each enrollee that they use to directly provide or purchase needed care and services.

The two primary models in the state are Medicaid-only (i.e., partial capitation) plans and the Programs of All Inclusive Care for the Elderly (PACE). PACE is a permanent provider class in the Medicare program and is included as a service in New York's Medicaid State Plan.

Medicaid-only plans are a mix of programs established pursuant to a Commonwealth Fund-supported demonstration program and plans established through legislative designations that stem from the Long Term Care Integration and Finance Act (Chapter 659 of the Laws of 1997). This legislation aimed to consolidate legislative authority for all managed long term care programs in the state and capped enrollment at 50,000 individuals.

Medicaid-only plans contract directly with the state to provide or arrange all necessary continuing care services and coordinate and arrange primary and acute care services for nursing home eligible people living in the community. These plans receive a fixed ("capitated") monthly Medicaid payment for each enrollee with which the plan must provide all needed continuing care services as well as care coordination. There are 11 Medicaid-only plans operating in the state. While these plans serve primarily seniors, six do enroll persons as young as 21.

PACE is a national MLTC model that combines capitated payments from both Medicaid and Medicare to care for nursing home eligible seniors in the community. PACE plans must provide comprehensive and coordinated continuing care and acute care services to their enrollees. Care is centered around a day center, which contains a clinic and is where primary care, personal care and therapy is provided. Services are provided in the home as well. While there are currently four PACE plans in New York, several organizations operating Medicaid-only plans are working towards becoming or adding a PACE plan. PACE enrollees must be at least 55 years old.

The primary difference between the two models is in funding streams and care responsibilities. PACE plans are financially responsible for all primary, acute and long term health care needs of their participants as well as any support services necessary to enable the participant to remain in the community. Medicaid-only plans must pay for or provide continuing care services and supports while arranging hospital and primary care services, which are paid for on a fee-for-service basis. The PACE model is structured around the day center while Medicaid-only plans have more flexibility in organizing services to meet enrollee needs. Both models include an interdisciplinary team approach to care planning, with nurses often in the role of care coordinator.

Of the 11 Medicaid-only plans, six serve all or parts of New York City, one serves Long Island, one serves Erie county, one serves Oneida and Herkimer counties and two serve Orange and Rockland counties. Currently operating PACE plans are located in Rochester, Syracuse and Schenectady, and the fourth serves New York City and Westchester. The table below shows the distribution of the 14,000 enrollees by plan type and geography.

Distribution of MLTC Plans and Enrollees, October 2005					
	ALL	PACE	MLTC	NYC	NON-NYC
Total Plans	15	4	11	7*	8
Enrollees	13,854	2,285	10,315	11,834	2,020
Percent of Total	100%	16.5%	74.5%	85.4%	14.6%

\*One plan serves NYC and Westchester

### **Success of the Program**

NYAHSa has long argued that fragmentation of care and payment sources results in service gaps that are especially problematic for frail seniors and other vulnerable individuals. We have advocated for care models that stress care coordination, provide comprehensive services and promote integration of payment sources to help ensure that the level and amount of care a senior or person with special needs receives is based on need rather than the dictates of the program for which they are eligible.

MLTC plans provide the type of coordinated care likely to result in optimal health outcomes. Importantly, this type of coordination helps to fill the gaps experienced by the dually eligible population, whose care can often become fragmented due to service availability and eligibility issues. These gaps can lead to deteriorating health, increased costs and elevated risk of institutional placement.

Studies done on managed long term care nationally and in New York indicate that the MLTC plans have been successful as a clinical care model and that client satisfaction is high. The Department of Health (DOH) notes this in the *New York State Managed Care Interim Report* to the governor and Legislature. The rate of nursing home placement among this frail, nursing home eligible population is low, showing that they are meeting their mission of helping enrollees maintain their independence. Disenrollment rates for this voluntary program are low. Two evaluations of PACE have found it to have good clinical outcomes and to successfully reduce hospitalizations. A third evaluation is nearing completion.

Available evidence suggests that MLTC plans are also cost effective. All enrollees require nursing home level of care and most are dually eligible for both Medicare and Medicaid. In New York, dually eligible individuals represent only 15 percent of Medicaid enrollees but account for 45 percent of the state's Medicaid spending. Nationally, over 40 percent suffer from a cognitive or mental impairment. They are a group that is difficult and expensive to serve, yet the national average hospitalization rate for PACE participants mirrors the rate for all Medicare beneficiaries, a much broader group that is significantly less frail on average than the MLTC population.

Medicaid payments to MLTC plans are limited to what Medicaid would pay for care of similar populations in other care settings, which incorporates guaranteed savings or at least cost-neutrality into the program. The lack of a uniform assessment tool across various institutional and community-based programs makes it difficult to get an exact cost comparison for serving similar populations in different settings. However, the capitated rates MLTC plans receive are far lower than average regional nursing home rates. So when a Medicaid-only plan is able to return several people per month from the nursing home to the community and serve them at a monthly cost of \$3,200 instead of \$7,000, the Medicaid savings to the state and local governments are real.

Along with this, managed long term care aligns financial incentives with desired outcomes. Plans do not receive more money by providing more services. Rather, they have a genuine incentive to provide sufficient, targeted, appropriate care to keep the person as healthy and as independent as possible. If a plan fails to do this successfully, it must use additional resources to meet the enrollee's needs as his/her health deteriorates, ultimately bearing the cost of nursing home care when it becomes impossible to provide care safely in the home.

To meet the future desires of individuals for independence and realize New York's stated commitment to community-based care, the future of long term care may rest largely on the availability of appropriate housing coupled with necessary supports and health care services delivered in the community. It is time to stop viewing community-based care and MLTC plans as alternative models and demonstrations and start viewing them as the appropriate standard of care that they are for the populations they target. MLTC plans work. It is time to make the program authorization permanent.

## **Expanding the Program**

Along with making it permanent, access to this program should be increased in areas of the state currently not served by MLTC plans. Although the bulk of the current managed long term care activity is in the downstate area where population is most dense, efforts should be made to expand it into areas not currently served by the program. Congress has just funded a multi-state initiative, spearheaded by the National PACE Association, for expanding PACE into rural areas. This initiative is the culmination of several years of development work and will help demonstrate the feasibility of managed long term care in smaller markets.

An effective partnership between DOH and plans will facilitate their growth and increase opportunities for New Yorkers to benefit from the program. And although the 2005-06 State Budget authorizes additional plans, there should be a method through which organizations willing to serve areas currently without access to managed long term care could be considered for provider designation.

As the program is renewed and further expanded, we urge that care be taken to ensure that New Yorkers have continued access to MLTC plans operated by provider-based organizations. With a few exceptions, such as Evercare, which specializes in coordinated senior care, the bulk of managed long term care nationwide is offered by provider-based organizations. All 15 plans operating in New York are provider-based. It is provider-based organizations that have the track record of providing cost-effective managed long term care to frail individuals with good clinical outcomes and with high enrollee satisfaction.

This is not to say that non-provider based organizations should not participate. One of the strengths of the MLTC program is that it allows a variety of different models to be established. However, it is important to keep in mind that potential enrollees are frail and often have multiple, complex needs. If 40 percent of all dually eligible individuals have cognitive impairments, the proportion is likely to be even higher for those who are dually eligible and require nursing home level care. Continuity and stability are crucial for these individuals. Assessing the needs, monitoring the progress and communicating with cognitively impaired persons are specialized skills.

Organizations that operate MLTC plans have honed these skills. They include some of the most diverse and innovative continuing care organizations in the state. Most of these organizations

have established track records of providing multiple levels of care for the elderly and people with special needs, such as senior housing, adult day health care, assisted living, acute care, skilled nursing and rehabilitation. Some provide additional services such as meals on wheels or homemaker services. These organizations have years of in-depth experience in meeting the varied, complex needs of their residents and clients.

Provider-based managed long term care may be uniquely qualified to develop care innovations because of providers' familiarity with senior health issues. Providers have embraced the MLTC model because it finally provides a funding stream for items and services that are instrumental in keeping seniors in the community, but that neither mainstream Medicaid nor Medicare covers.

For example, one organization pays to outfit an enrollee's home with ceiling rails that transport the person. This allows the enrollee, a multiple sclerosis patient, unprecedented mobility and independence while helping to reduce required aide time. The same plan pays for wander-guards that enable a cognitively impaired enrollee to live safely at home. These examples are from a Long Island plan, but similar stories could be told by most plans. These plans are attuned to the needs of frail individuals and able to apply or invent strategies to address them. With demographic trends pointing to the continuing decline in the number of caregivers relative to those needing care, technology and environmental adaptations must play a greater support role where appropriate. The state has recognized this in the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) initiative included in the 2005-06 State Budget, which should facilitate this type of hands-on innovation that provider-based MLTC plans offer.

Although the 1997 legislation envisioned consolidating legislative authority for all MLTC plans, including PACE, under section 4403-f of Public Health Law, the authority of the four operating PACE programs appropriately stems from legislation that individually authorized each program. Extension or modification to section 4403-f of Public Health Law should recognize the differences between Medicaid-only plans, which are part of a state program, and PACE plans, which have permanent provider status in the Medicare program and, as such, are subject to federal oversight and extensive consumer protections. Minimizing duplicative regulation would decrease the administrative burden for both the programs and state regulators. Medicare Part D will further differentiate Medicaid-only plans from PACE plans. While Medicaid-only plans will no longer provide prescription drugs, PACE plans will be operating as Medicare Advantage prescription drug plans (PDPs) for their participants.

A key challenge for the state in this resurgence of interest in utilizing managed care to organize health care for seniors and other vulnerable populations is to ensure that it regulates each plan type appropriately to its function. The Medicare Modernization Act has attracted managed care organizations (MCOs) back to Medicare managed care (now known as Medicare Part C, or Medicare Advantage) and created Medicare Advantage Special Needs Plans that will begin serving targeted special needs populations in 2006. The state has begun enrolling seniors into mainstream Medicaid managed care, contingent on their enrollment into a companion Medicare Advantage plan. Mandatory managed care enrollment for Supplemental Security Income (SSI) recipients--primarily individuals with disabilities--is being phased-in in New York City. If done well, managed care can result in more coordinated, more appropriate care and lead to better health outcomes. If done poorly, it can result in inappropriate service rationing, confusion and a backlash against managed care that could undermine the achievements of the MLTC program. For vulnerable seniors, the stakes are high, making it important to do it right.

### **MLTC and Long Term Care Reform**

New York has reemphasized its commitment to community-based care. Various continuing care reform initiatives are underway. These include the Nursing Home Transition and Diversion Waiver, LTC Point-of-Entry, the nursing home rightsizing demonstration, reforms to the Medicaid program and increased focus on patient-centered care. The MLTC program exemplifies many of the goals of these initiatives. It is crucial that MLTC be appropriately incorporated into these initiatives without unnecessarily duplicating the services or creating barriers to enrollment.

The MLTC program is an effective nursing home transition and diversion program. Plans are not only delaying and preventing institutional placements, but are bringing people out of institutional settings and providing them with the array of services that make it possible for them to live in their own homes.

The MLTC program also operates as an effective point-of-entry to all necessary services, both continuing and acute care. Once a person has enrolled in a plan, the assessment and care planning take into consideration all of the services he or she needs that may otherwise require the person to seek information from multiple sources and apply with multiple programs or providers. It can also be a way of providing the enrollee with the quantity and type of continuing care

services tailored to meet his or her needs, without having to navigate waiting lists or confront artificial limits or other barriers.

This is especially beneficial during transition periods such as discharge from hospitals, which is both the time when health care needs are greatest and when people are the most vulnerable. Even when appropriate community-based services are available, transitions from one level of care to another increase the danger that a person may experience significant decline in health and independence because they are unable to access necessary services in a timely manner.

Managed long term care is an excellent example of community-based care, proving that it can be done for even the most care-intensive individuals. It incorporates the principles of the U.S. Supreme Court's *Olmstead* decision by promoting opportunities for New Yorkers to live in the most integrated, appropriate settings. It is also a good example of patient-centered care, promotes innovation and is an important research laboratory for quality initiatives, since the responsibility for measurable outcomes rests primarily with a single entity.

### **Operational Issues**

While the state continues to face many challenges in implementing the complex MLTC program, it has overcome many of them to create an excellent program. Only Arizona has more people benefiting from managed long term care than New York. However, there are some concerns that are common to many plans that we hope DOH continues to address. The rate setting process remains a cumbersome negotiation that is grounded in each plan's cost report. This is inconsistent with the concept of managed care and differs from the approach all other states take in setting the Medicaid portion of the PACE rate, which is usually pegged to a percentage of Medicaid costs incurred for comparable populations.

The adequacy of the reimbursement rate is also a source of common concern. The type of arbitrary rate freeze imposed on plans from April to October of this year is unreasonable, especially after a lengthy rate negotiation process. Upstate plans are particularly financially vulnerable, and the state should continue to recognize and address the needs of smaller plans if managed long term care is to be offered outside of the largest urban centers in the state. As Medicare is phasing in a frailty adjuster in their rate setting, New York has moved away from any acuity-based adjustment to the Medicaid portion of managed long term care rates. Some local social services districts are hesitant to make referrals to MLTC programs.

Plans also face ever increasing reporting requirements, with no additional funding for staff or equipment to meet these requirements. There are no avenues to appeal these and other changes and, as a result, plans are sometimes placed in an unenviable “take it or leave it” position if they disagree with the state’s determinations. We are hopeful that these concerns will be addressed going forward.

MLTC is the optimal way to serve frail individuals and we are eager to work with you to ensure the continued success and growth of this excellent program. Making the program stronger will serve the state well and can only improve the quality of life for thousands of New Yorkers.

On behalf of NYAHSA, I would like to again thank you for the opportunity to provide these comments and invite committee members to use our organization as a resource. We are ready to help in any way that we can as you consider these important issues.