Medicaid Managed Long-Term Care in New York Part I

By David Kronenberg and David Silva

David Kronenberg

David Silva

This is the first part of a two-part article regarding Managed Long-Term Care (MLTC) in New York State. In this first part we will provide an overview of MLTC, including the statutory and regulatory authority, payment mechanism, services covered, and assessment process. The second part of the article will examine due process rights for MLTC enrollees and provide some strategy and advocacy tips as well as discuss some recent Fair Hearing Decisions regarding MLTC programs.

I. What Is Managed Long-Term Care?

Managed Long-Term Care is one of the dozen different programs through which the New York State Medicaid program pays for long-term care in both residential and community settings.[1] MLTC is different from other types of long-term care in that it is financed by capitated payments to managed care organizations to provide home care and other medical services. The other difference (at least vis-à-vis Personal Care Assistance and Certified Home Health Agency) is that MLTC includes care management and integrated care delivery.

The Social Security Act authorizes states to develop managed care plans as an alternative to fee-for service Medicaid.[2] The Long-Term Care Integration and Financing Act of 1997[3] amended Article 44 of the New York Public Health Law to establish a demonstration project for the integration of long-term care service delivery and alternative financing through MLTC plans.[4] The legislature's goals for MLTC were to prevent or delay the onset of chronic medical conditions, reduce utilization of the health care system, and decrease fragmentation of care for the consumer, while simultaneously avoiding the high cost of care in an institutional setting.[5]

Enrollment in a MLTC plan is voluntary. Like an HMO, the MLTC plan only pays for services rendered by medical providers who contract with the MLTC plan. Medicaid does not pay for each service covered by a MLTC plan. Instead, Medicaid pays a fixed monthly amount per member, with the expectation that some members need only minimal services while others require much more. In theory, the MLTC plan is adequately reimbursed for the cost of providing care to all of its members, even if the payment for each individual member may be either excessive or inadequate relative to that member's medical costs. This is known as spreading the risk. The payments to the providers can be either fully capitated (all payments to the provider are capitated) or partly capitated (the providers bill some services as fee for service).

One concern about this type of health care delivery system is that the capitated payment creates an inherent conflict between providing necessary quality care and worrying about the bottom line. This conflict creates an incentive for MLTC plans to avoid enrolling individuals with greater medical needs ("cherry-picking"), and to reduce or deny coverage of expensive services. However, Federal law requires that Medicaid managed care plans make services available to the same extent they are available to recipients of fee-for-service Medicaid,[6] and Federal regulations prohibit "cherry-picking."[7]

The MLTC plans listed at the end of this article are fully or partly funded by Medicaid. There are other capitated Medicare long-term care programs, such as ElderPlan (Social HMO in Brooklyn).[8]

There are two models of MLTC: the fully capitated Program for All-Inclusive Care for the Elderly (PACE) and the partially capitated Medicaid Managed Long-Term Care (MMLTC) plans.

II. Program for All-Inclusive Care for the Elderly

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission.[9] Enrollment in a PACE is voluntary. The objective of these programs is to provide a fully integrated package of care for seniors while allowing enrollees greater independence by avoiding institutionalization. Both Medicare and Medicaid pay for PACE services on a capitated basis. Medicare recipients who are not

eligible for Medicaid may participate in a PACE by paying a monthly premium equal to the Medicaid capitation amount, but members are never required to pay any Medicare or Medicaid cost-sharing.[10] PACE plans require their members to use PACE physicians and providers. PACE members are not allowed to go "out of plan" to receive services. An interdisciplinary team develops care plans for each member and provides ongoing care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member.[11] Most participants are dually eligible for Medicare and Medicaid, with a small number of consumers in only one or the other.

Maintaining enrollees' social and environmental health is also a key component of PACE. Some social and environment services not normally reimbursed by Medicaid and Medicare may be included in an enrollee's care plan. Services covered under PACE include:

- care management and coordination
- inpatient and outpatient hospital services
- primary and preventive care
- adult day care (medical and social)
- meals
- nutrition services
- ambulance and non-emergency transportation
- audiology
- dentistry
- home health and personal care
- radiology / laboratory
- prescription / non-prescription drugs
- podiatry
- physical, speech and occupational therapies
- respiratory therapy
- medical equipment and supplies
- orthotics / prosthetics
- personal emergency response systems (PERS)
- nursing home services (subject to Institutional Medicaid eligibility)
- other social and environmental supports[12]

Medicaid eligibility for PACE (as with all Managed Long-Term Care) is Community Coverage with Community-Based Long-Term Care, meaning that applicants are only required to document their assets as of the month of application, rather than being subject to a look-back period as with Institutional Medicaid.[13] However, spousal impoverishment protections do apply to PACE enrollees.[14]

Currently there are five PACE sites that operate in New York. Each of these programs has a contract with the New York State Department of Health (DOH). A copy of the Model Contract for a PACE can be viewed at the DOH Web site.[15] Although New York has the highest PACE enrollment of any state,[16] enrollment in PACE is much lower than almost any other long-term care program in New York. Only about 3,000 individuals are enrolled in PACE in New York, compared with about 20,000 in partially capitated MMLTC plans, 24,000 in Long-Term Home Health Care Programs (aka the Lombardi waiver), 41,000 receiving services from a Certified Home Health Agency (CHHA), and 57,000 receiving Personal Care Assistance.[17] There is currently only one PACE site serving the NYC area (see table on following pages).

III. Medicaid Managed Long-Term Care Plans

Partially capitated Medicaid Managed Long-Term Care (MMLTC), as distinguished from the fully capitated PACE, is the dominant form of managed long-term care in New York. Currently, there are 13 MMLTC plans operating in New York State, nine of which operate in New York City (see table below). A copy of the model contract for MMLTC plans can be found at the DOH Web site.[18]

Enrollment in an MMLTC plan is voluntary.[19] A client may enroll directly with a plan. A client must enroll from the community but must be eligible for nursing home level of care based on a score of five or higher on an assessment tool called the Semi-Annual Assessment of Members (SAAM).[20] At the time of enrollment, the client must be able to live in the community. However, if the member comes to require nursing home care after enrollment in an MMLTC, he or she may remain in their plan, and the MMLTC plan would cover his or her nursing home care (subject to approval for Institutional Medicaid).

Medicaid funding is partial, meaning that some Medicaid services, including most primary medical care, are not included in the capitation rate and are Fee For Service (FFS). However, the MMLTC plan is responsible for coordinating all services, even those not included in the capitation rate. The following services are included in capitation and may only be provided by providers affiliated with the MMLTC plan. Therefore, it is imperative for an enrollee to understand that Medicaid will not pay for these services if the provider is not in the plan or a referral from a plan provider is not obtained:

- Care management and medical social services
- Home care—nursing, home health aide, personal care, occupational, speech and physical therapies
- Optometry / eyeglasses
- Dental services
- Rehabilitation therapies, respiratory therapy
- Audiology and hearing aids, prostheses, and orthotics
- Nutrition
- Podiatry
- Non-emergency transportation for medical care
- Home-delivered meals and / or meals in a day care center or other group setting
- Medical equipment and supplies
- Social day care or Adult Day Health Care
- Social / environmental supports (chore services, home modifications)
- Personal Emergency Response System (PERS)
- Nursing home—covered by MMLTC, but institutional budgeting and transfer penalty rules apply[21]
- Prescription and non-prescription drugs[22]

Individual MLTC plans may cover other services as well. Be sure to check with the plan's member handbook if a prospective member is concerned about keeping his or her old providers for the following services. If the plan does not cover them, then client may continue to obtain the services out of plan using his or her Medicaid or Medicare card. The following are some services that are not required to be covered by the partial MMLTC capitation, but which the plan may opt to cover, and which all plans must coordinate:

- Inpatient hospital stays
- Primary care, specialists, outpatient clinics
- Lab tests, x-ray, radiology
- Dialysis
- Emergency transportation
- Mental health and substance abuse services

A client may disenroll effective the first of the following month and transition to personal care (home attendant) or CHHA care. The local Department of Social Services must process the disenrollment. If a client disenrolls, the MMLTC plan must continue services until disenrollment takes place. The MMLTC plan must also help transfer to other long-term care services.

Additional Federal regulations governing managed care plans were promulgated in 2002.[23] The State may impose sanctions on a MMLTC plan for charging enrollees premiums or other charges that are higher than those charged under the Medicaid program.[24] It is also sanctionable to discriminate among enrollees on the basis of their health status or need for health care services.[25]

New York State regulations governing MLTC plans were issued in 2005, when the demonstration project expired and plans were required to obtain Certificates of Authority from DOH to continue operation.[26] MMLTC plans are subject to oversight both by DOH and the New York Department of Insurance. All marketing activity by a MMLTC plan must be reviewed by DOH to ensure it complies with applicable regulations and the plan's contract.

In addition to the Federal statutory requirement that MMLTC plans make services available to the same extent they are available to recipients of fee-for-service Medicaid, the Model Contract also includes this clause: "Managed care organizations may not define covered services more restrictively than the Medicaid Program."[27]

MMLTC plans use the SAAM for all service assessments—including for personal care assistance—rather than the familiar physician's order, nurse's assessment, social assessment, and independent medical review required for fee-for-service personal care assessments.[28] As a result, it may be difficult for advocates to determine whether a MMLTC member's personal care authorization is procedurally or substantively adequate, for example, when preparing for a Fair Hearing. Although the SAAM is approved by DOH, it appears to contradict the regulations governing personal care assessments in terms of the facts collected, the weight given to those facts, and the qualifications of the individuals conducting the various parts of the assessment.[29] However, at least one Fair Hearing Decision has held that the requirements for personal care assessments under the fee-for-service system apply with equal force to MMLTC plans, a result that comports with authorities cited above.[30] It remains to be seen whether and how the apparent conflict between the SAAM and personal care regulations will be reconciled in practice.

Stay tuned for Part Two of this series, where we will go into more depth about MMLTC assessments, fair hearing strategies, and due process protections.

Managed Long-Term Care Enrollment by Program, Plan, and County[31]

Plan Sponsor	Age Limit	County	Enrollment
PACE Plans (Fully Capitated)			
Comprehensive Care Management (Beth Abraham Family of Health Services) 612 Allerton Ave. Bronx, NY 10467 (877) 226-8500 http://comprehensivecaremanagement.com	55+	Nassau NYC except Staten Isl. Suffolk Westchester Total	7 2,234 59 172 *2,472*
Eddy Senior Care (Northeast Health) 504 State St. Schenectady, NY12305 (518) 382-3290 http://nehealth.com	55+	Schenectady	102
Independent Living For Seniors (Rochester General Health System) 2066 Hudson Ave. Rochester, NY 14617 (585) 922-2800 http://independentlivingforseniors.com	55+	Monroe	265
PACE CNY (Loretto Rest Nursing Home, Inc.) Sally Coyne Center for Independence 100 Malta La. North Syracuse, NY 13212 (877) 208-5284 http://pacecny.org	55+	Chautauqua Onondaga Total	1 325 326
Total Senior Care 519 N. Union St. Olean, NY 14760 (866) 939-8613 http://totalseniorcare.net	55+	Cattaraugus	22
Total PACE (fully capitated) enrollees			**3,187**
MLTC Plans (partially capitated)			
Amerigroup 21 Penn Plaza New York, NY 10001 (800) 600-4441 http://myamerigroup.com	18+	NYC all boroughs	632
CCM Select (Beth Abraham Family of Health Services) 612 Allerton Ave. Bronx, NY 10467 (877) 226-8500 http://comprehensivecaremanagement.com	18+	NYC except Staten Isl. Westchester *Total*	1,371 20 *1,391*

Plan Sponsor	Age Limit	County	Enrollment
Elant Choice 46 Harriman Dr. Goshen, NY 10924 (877) 255-4678 http://elant.org	18+	Orange Rockland Dutchess Ulster Total	107 34 0 0 *141*
Guildnet (Jewish Guild for the Blind) 15 W. 65th St. 4th Fl. New York, NY 10023 (800) 932-4703 http://jgb.org	18+	Nassau NYC except Staten Isl. Suffolk Total	467 5,652 278 *6,397*
HHH Choices (Hebrew Home & Hospital) 2100 Bartow Ave. #310 Bronx, NY 10475 (888) 830-5620 http://hhhinc.org	18+	NYC Bronx only	767
Homefirst 6323 Seventh Ave. Brooklyn, NY 11220 (718) 759-4510 http://mjhs.org	18+	NYC all boroughs	3,374
Independence Care Systems 257 Park Ave. S. 2nd fl. New York, NY 10010 (212) 584-2500 http://icsny.org	18+	Bronx, Bklyn, Manh.	1,414
Fidelis Care At Home (Fidelis Care) 400 Rella Blvd., Ste. 211 Suffern, NY 10901 (800) 688-7422 http://fideliscareny.org	18+	Orange Rockland *Total*	175 130 *305*
Senior Health Partners (Mt. Sinai Hospital, Jewish Home and Hospital, Metropolitan Council on Jewish Poverty) 149 W. 105th St. New York, NY 10025 (800) 633-9717 http://shpny.org/	55+	NYC except Staten Isl.	1,754
Senior Network Health (Mohawk Valley Network, Inc.) 2521 Sunset Ave. Utica, NY 13502 (888) 355-4764 http://www.mvnhealth.com	18+	Herkimer Oneida Total	44 340 *384*

Plan Sponsor	Age Limit	County	Enrollment
Total Aging In Place Program (Weinberg Campus, Inc.) 461 John J. Audubon Pkwy Amherst, NY 14228 (866) 882-8185 http://totalaginginplaceprogram.com	55+	Erie	142
VNS Choice (Visiting Nurse Service of NY) 1250 Broadway, 11th Fl. New York, NY 10001 (888) 867-6555 http://vnschoice.org/	18+	NYC all boroughs	7,570
Wellcare 11 W. 19th St. New York, NY 10011 (866) 661-1232 http://wellcare.com	18+	NYC except Staten Isl.	494
Total MLTC (partially capitated) enrollees			**24,765**
Total Managed Long-Term Care enrollees			**27,952**

Endnotes

1. Overviews, statutory and regulatory authority for the other Medicaid home care programs are posted at Selfhelp Community Services, Inc., The Various Types of Medicaid Home Care in New York State (Oct. 21, 2009), *at* http://wnylc.com/health/entry/41/.
2. 42 U.S.C. § 1396u–2 (establishing the "State option to use managed care").
3. 1997 N.Y. Laws ch. 659.
4. N.Y. Public Health Law § 4403-f (PHL).
5. 1997 N.Y. Laws ch. 659, § 81.
6. 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.210(a)(2) and (a)(4)(i).
7. 42 C.F.R. § 438.700(b)(3).
8. A list of the MLTC plans operating in New York State can be found at the end of this article and *at* http://tinyurl.com/YJONYBL.
9. PACE was established by the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4802(a)(3) (codified at 42 U.S.C. § 1396u-4). *See also* 42 U.S.C. § 1395eee; 42 C.F.R. pt. 460.
10. N.Y. Dep't of Health, New York State Managed Long-Term Care: Final Report to the Governor and Legislature 5 (2006), *at* http://tinyurl.com/YJYFAE8.
11. N.Y. Dep't of Health, About Managed Long Term Care (2006), *at* http://tinyurl.com/YGSDWLL.
12. *Id.;* PHL § 4403-f(10).
13. N.Y.C. Human Res. Admin., Resource Attestation and Documentation Chart (2007), *available at* http://wnylc.com/health/download/28/.
14. N.Y. Dep't of Health, *Evans v. Wing and DeBuono et al.*, GIS 01 MA/037 (November 20, 2001), *at* http://tinyurl.com/YLRPM4W. *See also* N.Y. Dep't of Health, Medicaid Reference Guide, Glossary at x (November 2007), *available at* http://tinyurl.com/YF5ODGQ (defining Institutionalized Spouse to include a person who is receiving services under a PACE).
15. N.Y. Dep't of Health, Program for All Inclusive Care of the Elderly (PACE): Model Contract (2007) *at* http://tinyurl.com/YKB664K.
16. *See supra* note 10.
17. Alene Hokenstad et al., United Hospital Fund, An Overview of Medicaid Long-Term Care Programs in New York 9 (2009), *at* http://www.uhfnyc.org/publications/880507.
18. N.Y. Dep't of Health, 2007 MLTC Model Contract (2007), *at* http://tinyurl.com/YGU4QL2.
19. This policy is different than regular Medicaid Managed Care, which is now mandatory for most Medicaid beneficiaries in certain counties (including NYC). With the exception of those who have both Medicare and Medicaid, those with a spend-down, and certain other categories, all Medicaid applicants are required to enroll in a managed care plan to deliver their Medicaid benefits. Because most elderly clients have Medicare, they are exempt from the requirement to join a Medicaid Managed Care plan. *See* N.Y. Dep't of Health, Comparison of New York State Public Managed Care Programs (2008), *at* http://tinyurl.com/YZGNT49.
20. *See supra* note 17 at 10. It is a modified version of the Outcome and Assessment Information Set (OASIS) used by CHHAs and Lombardi programs to comply with Medicare reimbursement rules. *Id.* The SAAM is not required by law, but is one of the reporting requirements included in the MLTC Model Contract (*see supra* note 18 at 35 & 38).
21. If members transferred assets in look-back period, they must be involuntarily disenrolled if nursing home services are more than a full calendar month.
22. *See supra* note 17 at 9; note 18 Appendix G.
23. 42 C.F.R. pt. 438.
24. *Id.* at § 438.700(b)(2).
25. *Id.* at § 438.700(b)(3).
26. 10 N.Y.C.R.R. pt. 98.

27. *See supra* note 6; note 18 Appendix J (which incorporates by reference the description and scope of services contained in the eMedNY Provider Manuals). The Provider Manuals are *available at* http://www.emedny.org/ProviderManuals/index.html.

28. Advocates in New York City will recognize these forms by the beloved designations M-11q, M-27r, M-11s and LMD, respectively.

29. 18 N.Y.C.R.R. § 505.14.

30. *In re T.T.*, Fair Hearing No. 5136483H (N.Y. Dep't of Health, May 29, 2009), *available at* http://onlineresources.wnylc.net (must register to access Fair Hearing Database).

31. N.Y. Dep't of Health, Managed Long-Term Care Plan Directory (August 2009), *at* http://tinyurl.com/YJONYBL; Monthly Medicaid Managed Care Enrollment Report (October 2009), *at* http://tinyurl.com/YJOQMNH.

David I. Kronenberg is a partner in the law firm of Goldfarb Abrandt Salzman & Kutzin LLP concentrating in plans for long term care, asset protection, estate plans, supplemental needs trusts, real estate, cooperatives, and the rights of the elderly and disabled. He received his J.D. from New York Law School in 2001.

David Silva is the Assistant Director of the Evelyn Frank Legal Resources Program at Selfhelp Community Services, Inc. in New York City. He received his J.D. from Cardozo School of Law in 2005.