Coalition to Protect the Rights of New York's Dually Eligible

New York's 2012 Managed Long Term Care Report: An Incomplete Picture

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EXECUTIVE SUMMARY

The *Coalition to Protect the Rights of New York's Dually Eligible* is a coalition of consumer advocates focused on protecting the rights of some of the most vulnerable in our communities – elderly or disabled Medicare recipients who also meet the income threshold for Medicaid, also referred to as the dually eligible. Currently, this population is being enrolled into Managed Long Term Care (MLTC) in New York City, Long Island, and Westchester with expansion planned upstate. Additionally in 2014, contingent on Federal approval, this same population will be enrolled into new health insurance plans that provide dually eligible New Yorkers with their Medicare and Medicaid benefits. As such it is critical to ensure that private health plan performance metrics are collected by the State, analyzed and distilled by the State, and presented to dually eligible beneficiaries so they are able to make informed choices about their health care.

To this end, the State Legislature enacted a reporting requirement to ensure that MLTC plans provide required services and that consumers have the information they need to make meaningful choices between plans. Specifically, Section 4403-f(7)(b)(vii)of the Public Health Law requires the Commissioner of Health to issue biannual reports on enrollee satisfaction, service utilization, enrollment data, quality data, and continuity of care. The reports must be published on the New York State Department of Health's (the Department's) website and formatted to allow consumers to make comparisons between plans.

Although the Department recently released the 2012 Managed Long Term Care Report (2012 MLTC Report)[1] we believe it does not provide the full spectrum of information that beneficiaries need to make informed health care choices. More specifically, we believe that improvement in the following areas is needed to comply with the Public Health Law:

A. ***Enrollee Satisfaction*** – **The report must contain all of IPRO's findings, not simply the most positive.** The 2012 Report presents the most favorable findings of consumer surveys, but fails

[1] Report dated December 2012 posted at http://www.health.ny.gov/publications/3389_2012.pdf. [Hereafter referred to as "2012 MTLC Report" or "the Report"]

to mention less positive but important findings from IPRO's report, including the fact that higher need respondents in poorer health were significantly more likely to raise concerns about services than those in good health.

B. *Service Utilization Data* – **To facilitate informed choice, the report must include both assessment and utilization data, and raw data must be distilled by the Department.** The 2012 Report did not include much of the data that plans are required to report to the Department and did not analyze the data or draw meaningful conclusions from the metrics. Quarterly Managed Medicaid Cost and Operating Reports (MMCOR) data available to the Department includes the medical loss ratio (percentage of premium spent on medical care compared to administrative expenses), plan spending in different care settings, amount of capitation rate spent on administrative expenses compared to services, the types, level and cost of various services provided to members, the number of members receiving different types of services or no services, and a variety of other elements which should be subject to regression analysis to determine important correlations.

C. *Enrollment data* – **The report must include information about disenrollment, such as the number of members who sought disenrollment, reasons for disenrollment and the number of members involuntarily disenrolled from plans. In future reports, information about auto-enrollment must also be included.**

D. ***Quality data*** **– The report must include additional information related to health outcomes, including how service utilization correlates with incidences of falls and the number of members with skin breakdowns (bedsores).**

E. ***Continuity of care*** **– Data about coverage disruptions or gaps in coverage as beneficiaries transition into managed care should be included in the report.** This data point will be even more critical in future years as more New Yorkers are enrolled into MLTC plans. Additionally, the 2012 Report also does not report on Plans' compliance with the Americans with Disabilities Act (ADA), a central component of a successful long term care program for the consumer's perspective.

F. ***Comparisons between plans*** **– Both the existing data in the report and the additional data we've identified for inclusion in the report must be presented in a way that allows beneficiaries to make meaningful comparison between plans.**

The data and analysis that are missing from the 2012 Report are critical for assessing health disparities and compliance with the community integration mandate in *Olmstead v. L.C.*, 527 U.S. 581 (1999), as well as monitoring health plan compliance and providing beneficiaries with the information and tools to make meaningful choices. **As such, the *Coalition to Protect the Rights of New York's Dually Eligible* requests that a supplemental report be prepared immediately and that new quality and consumer survey measures be employed, as detailed in the following analysis**. Because of the importance of the report to beneficiaries, we also ask that stakeholders including beneficiary advocates have the opportunity to comment on the reports in advance of their public release. We believe this is particularly critical and time sensitive, because over the next six months tens of thousands of dually eligible New Yorkers will enroll into MLTC plans.

BACKGROUND

Assessing the current landscape of Managed Long Term Care (MLTC) is critical to provide direction to the State as it prepares to expand the program statewide and develop the Fully Integrated Duals Advantage Program (FIDA) to include the full range of health care and long term care support services for dual eligibles. As these programs are developed and expanded, there are three key goals of interest to the Coalition to Protect the Rights of New York's Dually Eligible:

1) Provide beneficiaries with tools to facilitate meaningful choices and enrollment into the appropriate health option;
2) Ensure that there is State oversight and monitoring of health plans providing care to this particularly vulnerable group; and
3) Ensure plan compliance with addressing health disparities and achieving community integration as mandated under *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Analysis of demographic, performance, and utilization data is central to each of these goals.

The Legislature enacted a reporting requirement in the MLTC program. Section 4403-f(7)(b)(vii) of the Public Health Law provides:

> (1) The commissioner shall report biannually on the implementation of this subdivision. The reports shall include, but not be limited to:
>
> > (A) Satisfaction of enrollees with care coordination/case management; timeliness of care;
> > (B) Service utilization data including changes in the level, hours, frequency, and types of services and providers;
> > (C) Enrollment data, including auto-assignment rates by plan;
> > (D) Quality data; and
> > (E) Continuity of care for participants as they move to managed long term care, with respect to community based and nursing home populations…
>
> (2) The commissioner shall publish the report on the department's website….
> The initial report shall be provided by September first, 2012. The reports shall be made available by each February first, and September first thereafter. Such reports shall be formatted to allow comparisons between plans.

The Reporting Period Encompasses Voluntary Enrollment Only

It is important to keep in mind at the outset that the 2012 Managed Long Term Care Report (the 2012 Report) is based on information gathered at a time when enrollment in MLTC was voluntary. Total enrollment was significantly lower during the voluntary period than it is now. As the program becomes mandatory enrollment numbers are expected to climb as the mandatory program expands to include additional service types and geographic areas.

The SAAM data used for the report is from the second half of 2011, at the end of which there were 45,194 people enrolled statewide in three types of Plans (MLTC, MAP, and PACE). The consumer survey was conducted in the Spring of 2011 based on enrollees who had six months of continuous enrollment in 2010. In December 2010, there were a total of 32,264 in all three types of Plans statewide, which increased from 30,781 in July 2010. Enrollment has more than doubled since then, as shown here.

Total MLTC enrollment in New York City (partial capitation only)[2]

Dec-10	Dec-11	Feb-12	Jun-12	Sept- 12	Oct-12	Nov-12	Dec-12
32,264	39,487	42,684	45,634	50,760	54,947	59,102	63,873

AREAS THAT REQUIRE IMPROVEMENT IN THE 2012 REPORT

As more states begin offering managed long term care, and as managed care is expanded here in New York, the need for improved measures and reporting of outcomes and quality is being recognized. Many of the traditional quality measures used in traditional managed care for primary care do not sufficiently capture quality and outcomes in MLTC. In a mandatory environment, accurate quality measures become even more crucial.

Below are some of the areas that the 2012 Report does not address, which includes, incomplete data sources, inadequate correlation of data, and lack of information on compliance with the Americans with Disabilities Act (ADA). We strongly believe that the collecting and public reporting of this information is vital as tens of thousands of more vulnerable New Yorkers are required to enroll in these health plans over the next six months. We ask that the State produce a supplemental report to resolve to ensure that a complete and accurate tool is available to beneficiaries and their advocates.

(A) Selective reporting of member satisfaction survey

The 2012 Report omits many of the troublesome findings from the consumer satisfaction survey, *IPRO Managed Long Term Care Plan Member Satisfaction Survey Report.*[3] Most significantly, the IPRO report finds that “Table 18 shows that the odds of a high plan rating are higher for those who are in good health.” (IPRO report, pg. 26) This finding raises concerns about the delivery of quality care to the higher-need members, in particular the higher-need members who are now mandated to shift from the fee-for-service Medicaid personal care program and long-term home health care program, where many have had stable home care services for chronic health conditions, into an MLTC plan.

[2] Data obtained from NYS DOH Monthly Medicaid Managed Care Enrollment Reports at http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/.

[3] IPRO Report dated September 2011 is posted at http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_plan_member_satisfaction_survey.pdf.

Addition IPRO findings not mentioned in the 2012 Report, but should be included in an amended report, include:

1. Access to routine appointments

a. Only 42% of respondents in 2011 who were 65+ years old reported that they had timely access to routine eye care appointments, which is significantly lower than what was observed in 2007 (50%) (IPRO report pg. 15).
b. A significant percentage of respondents (across all Plan types) reported that they are unable to schedule appointments with their regular doctor or PCP in a timely manner (within 30 days), and even lower percentages were reported for dentists, eye care, and foot doctors. Moreover, IPRO noted a declining trend in these percentages since 2007 (Tables 7, 12, 27). Percentages were somewhat higher for PACE and MAP respondents, but all three Plan types reflect room for improvement. Also, respondents who were of poor health status in 2011 were significantly less likely to report that they had timely access to routine appointments with providers than the same cohort in 2007 (Table 16). Another finding was that Caucasian respondents were significantly more likely to report more favorably with regard to routine appointments than any other race group (IPRO report pg. 34).

2. Access to urgent needs

For urgent needs, a significant number of respondents indicated that same day appointments are not possible with any of these providers (Tables 8, 28, IPRO report pg. 34).

3. Quality of services

a. Respondents continue to rate the quality of dental services lower than other highly utilized services (Tables 5, 25, IPRO report pg. 33). 29.5% of MLTC members and 28.3% of all plan members responding reported poor or fair quality dental care (IPRO report pg. 39).
b. PACE members responded more favorably than partially capitated members with regard to the quality of certain services, such as medical supplies/equipment, social workers (IPRO report pg. 34).

4. Timeliness of care and services

A significantly lower percentage of partially capitated respondents rated care manager and visiting nurse services as always/usually on time in 2011 than in 2007 (Tables 11, 26, IPRO report pg. 35). Among MLTC respondents, 54.5% stated that their care manager was always on time in 2007 but only 46.1% in 2011. In all Plans, 52.9% stated that their care manager was always on time in 2007 but only 46.6% in 2011. Among MLTC respondents, 57.4% stated that their regular visiting nurse was always on time in 2007 but only 48.8% in

2011. In all Plans, 56% stated that their nurse was always on time in 2007 but only 50.2% in 2011 (IPRO report pg. 45).

5. On-time appointments

% of Member Survey Responses "Sometimes" Or "Never" On Time

	MLTC		ALL PLANS (MAP, PACE, MLTC)	
	2007	2011	2007	2011
Trans. To Day Center	32.7%	39.1%	25.9%	31.1%
Trans from Day Center	32.2%	41.2%	25.7%	31.4%
Trans to MD	26.5%	29.9%	24.7%	28.2%
Trans from MD	27.4%	34.0%	26.5%	31.4%
Regular Visiting Nurse	21.6%	28.5%	21.1%	27.3%
Care Manager	21%	28.1%	21.1%	27.0%

IPRO Consumer Satisfaction Survey at pages 45, 47-48

6. Barriers based on language, race, or ethnicity

a. There were some observed language differences for some of the ratings, as discussed in the Comparisons by Primary Language section of the report. English speaking members were more likely than non-English speaking members (i.e. Spanish, Chinese) to give a positive rating with regard to the quality of certain services, such as medical supplies/equipment, eye care, social workers, dentists, physical therapists.
b. English speaking members were also more likely to respond more favorably with regard to access to routine appointments with regular doctors, eye care providers, and dentists than non-English speaking members (i.e. Spanish, Chinese). It would appear that language barriers may be playing a role in consumer satisfaction and timely access to services.
c. Table 19 (IPRO report pg. 35) shows that race/ethnicity and health status had a significant effect on the quality of care score, after adjusting for all the independent variables:
    - Hispanics and Asians gave lower ratings for quality of care than Caucasian respondents.
    - Current health status is positively associated with quality of care rating (IPRO report pg. 26).

7. Plan responsiveness and ability to be involved in care plan

a. Only 51.3% of MLTC members and 52.5% of all respondents (including MAP, PACE) always felt they were "involved in making decisions about plan of care" (IPRO report pg. 36).
b. Only 51.7% of MLTC members and 53.45% of all respondents (including MAP, PACE) always felt the Plan explains services clearly (IPRO report pg. 36).

c. Only 52.8% of MLTC members and 55.5% of all(including MAP, PACE) who called the Plan with a question or for help always felt that they were able to speak to a person quickly (IPRO report pg. 36).
d. 28.2% of all MLTC members responding and 28.7 of all respondents statewide (including MAP, PACE) reported making a complaint or grievance with their Plan. Of these, 40.5% of MLTC members and 44.6% of all Plan members were always satisfied with the Plan's response (IPRO report pg. 37).

8. Additional Survey Topics are Required

The IPRO survey added four new questions from the original survey designed in 2007. These four new questions were around medication management and advance directives. While relevant, there are additional questions that would be meaningful, especially for MLTC Plans that are partially capitated (i.e. do not provide primary and acute health care services). Some example of the measures that should be captured in future IPRO surveys, or other enrollee satisfaction surveys, include:

a. Consumer choice. The only question included in this area was "Are you involved in making decisions about your plan of care?" (IPRO report pg. 55). 78% said they were always or usually involved (IPRO report pg. 8). Additional questions on consumer choice should include:

- Did the consumer have the opportunity to make choices about which services to receive? (e.g. adult day care vs. home care, nursing facility vs. home care, home-delivered or home-prepared meals vs. congregate meals);
- Did the consumer have the opportunity to make choices about which providers would provide the services?
- Did the consumer have the opportunity to contest a decision by the Plan to provide or deny a particular service or a particular amount of service? (While notice of such decisions is legally required, testing the consumer's awareness of appeal rights is still critical.)
- To what extent does the consumer perceive that the Plan makes support available with everyday activities when needed, including participation in work, school, religious, social, or community activities the consumer chooses to participate in.

b. **Timeliness of Plan actions**. The IPRO survey asks if an aide, nurse, care manager arrives promptly, and measures timeliness of obtaining medical appointments, etc. However, it does not measure how long it takes for the Plan to review a new request for services or a request for an increase in the amount of services, or how long it takes for newly approved services to start.

c. **Complaints**. The 2012 Report provides an incomplete picture regarding the nature of consumer complaints, grievances and appeals, which is a fundamental measure of consumer satisfaction. The IPRO survey fails to drill down to identify the reason for and nature of complaints filed and the data that is provided fails to allow for plan comparison.

- The 2012 Report fails to review, catalogue or analyze complaints filed with the State DOH by consumers or their representatives about Plans,
- The 2012 Report states that 28.2% of all MLTC members responding and 28.7% of all respondents statewide (including MAP, PACE) reported making a complaint or grievance with their Plan. However, no analysis of the reasons for the complaints and outcome of investigations is provided. Nor is there , any means to allow comparisons between Plans, as required by PHL 4403-f(7)(b)(viii)(2).
- Plans are required to document the receipt and disposition of each grievance or complaint, and retain these records for not less than three years (10 NYCRR § 98-1.14(d)). The content of these should also be analyzed and included in the 2012 Report.
- Similarly, the 2012 Report should include the number of Fair Hearings requested, the issues raised in these hearings, and the disposition of the hearings. More than half reported dissatisfaction with the Plan's response to a complaint (IPRO report p. 37), yet the reasons for this dissatisfaction are not probed or reported further.
- As required by the Public Health Law, data on complaints and grievances must by tied to specific plans in order to allow for comparison between Plans.

d. **Measurements of person-centeredness**.

Many states are seeing the value of shifting away from exclusively medical model measures to include social and person-directed measures for a more holistic approach. These types of questions should assess whether consumer needs and wants are met. It is not enough for a clinical assessment of needs, but also an evaluation of the person's full life, such as whether Plans provide supports to maintain community involvement. These factors should also be assessed for changes over time.

Standard reporting measures should be supplemented by more specialized measures in the critical areas of person-centered planning, screening for poor health literacy, beneficiary autonomy, and community supports.[4] Data collected from plans in these areas could include:

- Plan reports on person centered care coordination/care management to include team staffing, member contacts, health literacy screening, provider participation and related outcomes.[5]
- The degree of member participation in person-centered planning.[6]

[4] Cited as the measures most needed to fill critical gaps in: *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Measure Applications Partnership, Final Report to HHS, June, 2012.
[5] Pennsylvania has incorporated such reports into its monitoring efforts for Medicaid MCOs. See Kaiser Commission on Medicaid and the Uninsured, *Current and Emerging Issues in Medicaid Risk-based Managed Care: Insights from an Expert Roundtable*, September, 2012.
[6] Developed by the Commission on Accreditation of Rehabilitation Facilities and suggested in Appendix H, p. 82, of *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*, Measure Applications Partnership, Final Report to HHS, June, 2012.

- The level of unmet need v. satisfaction with community supports for members and member care-givers.[7]
- Assessment measures, which could likely draw upon elements of the new Uniform Assessment System and should include plan responses to risks and unmet need.[8]
- Outcomes related to collaboration and communication across provider settings or lack thereof (negative markers to include transfers without complete records, lack of hospitalization notifications, contraindicated medications).[9]

New York State should explore measures in use by other states for the MLTC population. For example, Wisconsin uses "Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES)" that assesses degree to which member agrees with statements such as:

- I decide where and with whom I live.
- I make decisions regarding my supports and services.
- I decide how I spend my day.
- I have relationships with family and friends I care about, and have the support.
- I do things that are important to me.
- I am involved in my community.
- My life is stable.
- I am respected and treated fairly.
- I have privacy.
- I have the best possible health.
- I feel safe.
- I am free from abuse and neglect.

The Council on Quality Leadership (CQL) uses Personal Outcome Measures uses similar tools targeted at people with intellectual and developmental disabilities. The following are not the questions asked, but rather some of the targets for measurements:

- People are connected to natural support networks.
- People are safe.
- People have the best possible health.
- People exercise rights.
- People are treated fairly.
- People are free from abuse and neglect.
- People experience continuity and security.
- People choose where and with whom they live
- People are respected.

[7] *Id.*, p. 84.
[8] *Id.*
[9] *Id.,* p. 9.

New York should also modify existing consumer surveys to incorporate survey methods for members with behavioral health needs and capture critical information about quality of life for those using long term services and supports. Survey information should be supplemented with the use of focus groups to pull in information from higher risk consumers.

(B) Incomplete Utilization Data Reporting

1. **MMCOR Reports.** The 2012 MLTC Report relies on two sources of data: Assessment data from the SAAM assessment tool and consumer satisfaction survey data from IPRO. While these two sources are important, additional data points must be included and analyzed. All Plans report cost and utilization data to the State Department of Health in quarterly Managed Medicaid Cost and Operating Reports (MMCOR) reports.[10] Analysis of this data is vital for a more complete evaluation of MLTC, MAP and PACE Plans.

   Among the vast information available from the MMCOR that are not included in the 2012 Report include:

   a. **Medical-Loss Ratio and *Olmstead* Data.** How much of the monthly capitation rate is spent by Plans on each of various services, care management, administrative salary and other overhead, and profit? Of services, how much is spent on community-based versus institutional services? MMCOR data obtained through a Freedom of Information request for 2011 revealed that out of thirteen partially capitated MLTC plans operating in 2011, only five had Medical Loss Ratios of 80 percent or more, and five had MLRs below 75 percent.[11]

   b. **Utilization of services.** How much of the various services in the benefit package are the Plans providing? For example, the Plans report the number of "member months" in which member receives various amounts of personal care or home health services, reported in tiers such as 700+ hours/month, less than 80 hours/month, and five tiers in between. Our own analysis of 2010 MMCOR data revealed a wide disparity among Plans in the amount of home care provided.[12] A more holistic analysis by the Department could provide insight into these disparities and identify any systemic needs or gaps. Plans also report number of days of adult day care, number of podiatry visits, etc.

   c. **Variation of services and combinations of services.** MMCOR data include the number and percentage of members receiving adult day health care only, or adult day health care plus personal care, or nursing facility only, etc.

[10] These reports are required by regulation. 10 NYCRR § 98-1.16(f)-(g),(l).

[11] Summaries of some of the 2011 MMCOR data are attached hereto, Appendix C. Also see 2010 summary of MMCOR data at http://www.wnylc.com/health/afile/169/326/. The 2011 data shows that for three plans, more than ten percent of the capitation premiums were spent on nursing home care. See Appendix D attached hereto.

[12] http://www.wnylc.com/health/afile/169/324/

d. **Correlation between MMCOR and SAAM. A regression** analysis should correlate the MMCOR data on utilization of home care and other services provided with SAAM factors such as demographics, health acuity and other SAAM data, race/ethnicity, activities of daily living, living arrangements (% of members living alone – 2012 Report pg. 23), and the capitation rates. For example, do plans providing a more home care report fewer falls or emergency hospital admissions?
   - The Report lists the "average" SAAM scores for each plan. (Table 3, page 18). However, the average scores do not tell the full story of the needs of the high-need outliers, and whether and how the plans are meeting those needs. The 2011 MMCOR data shows that of the 13 partially capitated MLTC plans then operating, only three provided personal or home health aide services in the amount of more than 700 hours per month in more than one percent of the "member months" in which home care was provided. Yet the average SAAM scores of the plans providing high hours were the same as those that were not. Moreover, some plans that were not providing high hours of home care had more members that spent the entire last quarter of 2011 in a nursing home. This could suggest excessive use of nursing home care for high-need members. See Appendices A and B attached hereto.

e. **Nursing facility utilization.** The 2012 Report states that 2.2% of total population of MLTC, MAP and PACE was admitted to a nursing facility during the last half of 2011, and provides a breakdown of the reasons for admission (62.6% for therapy services or respite care – presumably temporary; 34.3% for permanent placement, 4.6% were "unsafe at home," and .6% for hospice care (2012 Report pg. 37).

   - **Length of stay** – No information is provided such as average length of stay in a nursing facility within a calendar year, though this is available in the MMCOR data (number/ percentage of members in a nursing facility during an entire quarter varies markedly among Plans).[13] In 2011, MMCOR data show three out of 13 partially capitated MLTC plans had 4 percent or more of their residents admitted to nursing homes for the entire last quarter. See Appendix B attached hereto.

   - **Member residents -** The number of members in a nursing facility at any one time appears to be higher than the 2.2% reported. In the IPRO survey, 4.8% of all MLTC/MAP/PACE members who responded stated they lived in a nursing home (IPRO report, pg. 52).

   - **"Unsafe at home" -** There was no determined correlation provided between the 38.9% enrollees placed permanently or who were "unsafe at home" with the amount and type of services provided by the Plans. If a Plan provides relatively little home care but places relatively more members in a nursing facility, this raises a flag as to over-utilization of nursing home care. The

[13] See 2010 data posted at http://www.wnylc.com/health/afile/169/325/

allegation that one is "unsafe at home" has long been a pretext for denying community-based services to people who may simply need more services to remain in the community.

- **Transitions -** The 2012 Report did not include data on the number of members who enrolled from nursing facilities and transitioned to the community. Plans should report percentage of MLTC members who were long-term residents of nursing facilities at the time they enrolled in the Plan and then transitioned to the community during the measurement period. Incentives should be provided for Plans to enroll nursing home residents and transition them to community living.[14]

- **Permanent placement -** The 2012 Report should include data on the number permanently placed in nursing facilities, broken down by the three types of Plans, and then by individual Plans, as is done for other data in the Report (see, example at Table 10, pg 36). Not only is this information extremely useful to MLTC recipients, but it is a requirement in the Public Health Law § 4403-f(7)(b)(viii)(2) that calls for clear information about which Plans have a higher rate of nursing facility utilization. Again, more data on nursing home usage and length of stay is available in MMCOR and should be cross walked to the 2012 Report.

- **Disenrollments –** It is important to see the percentage of those who were disenrolled by a Plan because of or after placement in a nursing facility. The 2012 Report stresses several times that including skilled nursing facility services in the capitation payment provides a financial incentive for the Plans to keep their members healthy and living in the community (pg. 3). However, because nursing facility services are still available through Medicaid on a fee-for-service basis, it is possible for a member to disenroll from a Plan when placed in a nursing facility, and switch to fee-for-service payment. Consumers have pointed out that this could provide incentives for MLTC Plans to avoid the cost of caring for high-need members by limiting the size of their nursing facility networks to a small number. As a result, the consumer disenrolls from the plan – ostensibly to use an out-of-network nursing home. If the right protections and incentives are not established costs could be shifted from the MLTC Plan onto the State Medicaid fee-for-service program.[15] For this reason, consumer advocates have called for a requirement that plan networks include any nursing home that meets certain specified standards.

2. **Other Important Utilization Data**

[14] This is one of many recommendations made in *: Incentives for Community-Based Services and Supports in Medicaid Managed Long Term Care: -- Consumer Advocate Recommendations for New York State*, March 23, 2012: http://wnylc.com/health/download/304/

[15] Ibid.

a. **Assistive Technology.** All Plans, including partially capitated MLTC Plans, are responsible for assessing the need for and providing durable medical equipment and other assistive technologies and supplies. Reporting is needed of the Plans' use of assistive technologies that help individuals maintain independence at home and integration in the community.

   Assistive technologies should include a full spectrum of mobility, communications, and cognitive tools. These devices, and training in their use, should include but not be limited to wheeled mobility equipment, walkers, canes, emergency response systems, and telehealth. These have been shown to assist with activities of daily living and instrumental activities of daily living. The degree to which Plans promptly repair damaged equipment, provide replacements while equipment is repaired should also be measured and reported.

b. **Timeliness of Plan assessment and initiation of services.** While the IPRO Survey, described above, gives the consumers' perception of whether the Plans timely deliver care, the 2012 Report fails to give the Plans' own data on the length of time between a member or provider's request for services and the Plan's determination, and then the time frame of the initiation of services. Similarly, it is also important to know the length of time before responding to a member's request for a referral for dental care, podiatry, or other specialty services, and the waiting time for the appointment.

(C) Incomplete Disenrollment Data

The 2012 Report did not provide data on disenrollments. As mentioned under a voluntary program, consumers could disenroll from MLTC and transfer to a variety of other long term service programs, such as fee-for-service personal care and consumer directed personal assistance, certified home health, the Lombardi long term home health care program, and various other waivers. In addition, Plans were permitted to disenroll members on limited grounds, such as nonpayment of the "spend-down." The 2012 Report does not include data showing disenrollment rates and the reasons for disenrollment. For those permanently placed in nursing facilities, the 2012 Report does not indicate whether they remained in the Plans while in the nursing home, which is a covered service in the benefit package, or whether the individuals disenrolled voluntarily, MMCOR data includes the number disenrolled in each quarter and should be included in the Report. Lastly, since the program was voluntary during the reporting period, there is no auto-assignment data. Although we recognize that is not available to include in the amended 2012 Report, we ask that this data point be queued up for future reports.

(D) Incomplete Health Maintenance, Outcome, Quality of Care Data

1. **The four measures used for Plan Performance are not analyzed to the degree which would allow a reader to ascertain quality.** The four measures used in the 2012 Report (p. 24 et. Seq.) to describe performance in quality of life, effectiveness of care and emergent care are described as follows:

a. Percentage of members who received an **influenza vaccination** in the past year.
b. The risk-adjusted percentage of members who are independently managing **oral medication**.
c. The risk-adjusted percentage of members who had one or more **falls** in the past 6 months. A higher percentage indicates greater care needs of the population.
d. The risk-adjusted **percentage of members who received emergent care** in the hospital. A higher percentage indicates greater care needs of the population.Two of the four measures, flu immunizations and management of oral medication, are essentially irrelevant to assessment of MLTC performance .

Flu Immunization Status – MLTC plans do not cover primary care so, unlike mainstream managed care plans, are not responsible for immunizations. It is misleading to compare MLTC plans on this measure with PACE and Medicaid Advantage Plus plans, since the PACE and MAP plans are fully capitated and do cover immunizations. Even if immunizations were within the MLTC plans' service package, they are not helpful in measuring the primary goal of MLTC, which is to provide long term care to assist in basic daily life activities.

Similarly, the percentage of members who independently manage oral medication is not particularly relevant to this population of beneficiaries. Whether an individual can or cannot manage oral medication is a factor that the plan should take into account in designing their plan of care. But it is not an aptitude that would be expected to improve with good care management – it is a function of the cognitive, mental and physical status of the individual.

The third measure – percentage of members who needed Hospital Emergent Care, is relevant to plan performance as it could show the plan's failure to provide home care or other services that could prevent falls and other accidents. The 2012 Report states that this measure is risk adjusted based on prognosis and SAAM index, presumably to differentiate those emergencies that were inevitable because of the individual's prognosis, and those that might have been prevented with adequate care management and services at home. The 2012 Report does not, however, fully explain how risk adjustment was done.

The fourth measure – percentage with falls in last 6 months – is clearly important for long-term care plans. As the 2012 Report states, "A higher percentage indicates greater care needs of the population." (p. 25). The percentage of members – including short-term and permanently placed nursing home residents - who had one or more falls in the past 6 months is risk adjusted, but further explanation is needed on how this was done (2012 Report p. 25-26, 51), and more analysis is needed.

For example, The 2012 Report fails to correlate the number of falls leading to a hospital admission with MMCOR data on the amount of home care and other services provided by the plan. If a higher number of falls indicates greater care needs, it is a glaring omission to leave out any data on how much home care and other services each plan provides. Burns, lacerations, and other accidents should similarly be reported. The 2012 Report states that 9.7% of the initial hospital admissions for the 8.3% of members admitted at least once to the hospital during the last 6 months of 2011 were for falls, defined to include other

accidents at home. Table 11 (page 37). It is not clear whether this "other accidents" category includes burns.

2. **Additional measures are needed to measure plan performance and quality.**

   a. **Skin breakdowns** – There is **no data on presence of skin breakdown** (a/k/a decubitus conditions, bedsores) and change in a skin breakdown condition over time – improvement, deterioration, or onset of new condition. In a program focused on long term care this measure is a more important marker than flu immunization. Consequently, this is an appropriate measure for the "Performance over Time" Measurement (see below). All MLTC members, including nursing facility residents, who had a decubitus condition observed during the preceding measurement period, should have one of following outcomes reported for the current measurement period: (1) an improvement in the condition, (2) the same condition or (3) deterioration of condition (to include any required hospitalization for the condition).
   b. **Timeliness of care and Plan responsiveness to request -** The 2012 Report includes only limited information on member satisfaction with timeliness of care, but no information on actual Plan performance in delivering timely care**.** It would be helpful if the State were conducting or arranging for "secret shopper" surveys of Plans to ascertain ability to talk to a member services representative by phone, the waiting time for a callback, or the waiting time for an initial assessment to be made for a new enrollee. These results should be tracked and reported.
   c. **Number of members the plan enabled to return to the community from an institutional placement.**
   d. Number of members who were able to **enroll in or remain in school**, or who were able to **obtain a job or continue working**.
   e. Many **other measures** are being developed nationally, discussed above, at pp. 8-10.

3. "**Performance Over Time" measurements need improvement** – We commend the attempt to measure the extent to which members in a plan show stability of or improvement in their ability to perform Activities of Daily Living (ADLS) over a one-year or 6-month period. (2012 Report pp. 27-32). Given that many members have chronic conditions that are degenerative or, at best, will not improve, we question any expectation that the ability to perform ADLS would improve with care management. Still, there are ways that effectiveness of plans' support for ADLs could be measured.

   a. **Incontinence** – The 2012 Report states the percentage of members "who remained stable or improved in presence of incontinence or catheter need" and in the frequency of incontinence over the follow-up period. 2012 Report pp. 31-32. This measure conflates too broad a population to be descriptive. An individual who used a catheter through the entire 12 months is characterized as "stable." A person, who used adult diapers consistently throughout the 12 months, rather than being provided with an aide to assist with toileting, would also be seen as "stable." A more complete measure would differentiate those who were "stable" in maintaining an ability to use a toilet or commode, with or without assistance, from those who remained fully incontinent with reliance on a catheter or adult diapers. Correlation between assistance with toileting and continence and the MMCOR service utilization data should be made.

- **Exclusion of members in nursing homes from Performance Over Time measures** – The 2012 Report states that "assessments performed in nursing homes were removed from these models since a full assessment is not completed when the member is in this location." (2012 Report at 52). We believe, however, that the inclusion of this population in this measure is critical. The plans are still responsible for the care of their members while they are in nursing homes. If the members' ability to perform ADLs, their continence, incidence of falls or skin breakdown, deteriorates while in a nursing home, this must be measured and they must be held accountable.
- **Daily tasks over time -** One suggestion to assess performance over time would be to identify the number and percentage whose need for assistance doing basic daily tasks during the measurement period has increased from the last period. For example, the need for help going to the bathroom or feeding oneself, and the degree of need progressing from verbal cueing to hands-on physical assistance.

(E) No Information Regarding Continuity or Compliance with the Americans with Disabilities Act (ADA)

As noted earlier, mandatory enrollment falls outside of the period covered by the 2012 Report. Still each plan's historical success in avoiding gaps in care for participants as they voluntarily moved into managed long term care is of central importance to consumers and should have been included in the 2012 Report. This measure will be even more critical for future reports that collect information about gaps in care in a mandatory environment. Helping members avoid the loss of aides is one of the fundamental measures of successful care management in the program.

The 2012 Report also does not report on Plans' compliance with the Americans with Disabilities Act (ADA), a central component of a successful long term care program for the consumer's perspective.

Some of the ADA related contractual requirements for Plans include:

- Identify enrollees with disabilities in order to provide reasonable accommodations that are necessary to avoid discrimination.
- Give notice of how disability is defined with examples of disabilities that include functional limitations (e.g. trouble standing, ongoing sadness, difficulty with reading).
- Let people know what kinds of accommodations are available (providing examples that are nonexclusive).
- Ensure that personnel are trained to provide accommodations.
- Include a network of providers with accessible practices.
- Ensure that people with disabilities know that they may file ADA compliance-related complaints with the HHS Office of Civil Rights.

An analysis recently completed by the Center for Independence of the Disabled NY (CIDNY) found MLTC Plans out of compliance with the aforementioned ADA requirements.[16] CIDNY analyzed 18 MLTC Plans. The findings include:

- One in three plans does not provide evidence that they identify people with disabilities;
- None of the 18 plans has a procedure for identifying and recording requests for accommodations for people with disabilities or the disposition of those requests;
- Only two of the 18 plans provide notice to enrollees of the right to reasonable accommodations—it is limited to hearing and vision-related disabilities.
- Not one plan provides detailed guidance on how to request a reasonable accommodation, how and when the request will be addressed and by whom.
- No plans provide accommodations for people with psychiatric disabilities, or mention learning disabilities or intellectual disabilities.
- Plans list a very narrow spectrum of accommodations and do not indicate that the accommodations listed are nonexclusive.
- Not one of the managed long-term care plans trains its employees on the policies and specific procedures for ADA compliance of the managed long-term care plan.
- No plan gives notice of the right to complain to the U.S. Department of Health and Human Services Office of Civil Rights.

The State should, in collaboration with the disability rights community:

- Designate party within the State that holds the responsibility for compliance activities
- Regularly update ADA compliance guidelines that contain clear and detailed guidance on baselines for compliance
- Provide a model compliance plan and member handbook language
- Educate Department of Health personnel regarding federal civil rights law compliance
- Provide or require plans to obtain training for grievance and appeal personnel, member services personnel, case managers and other relevant personnel to receive training on the ADA, compliance plan requirements and disability literacy.

Additional recommendations can be found in CIDNY's report.

(F) Insufficient Plan-by-Plan Comparisons

We know that one of the most important tools for beneficiaries making health care choices is an understandable plan comparison guide. This needs is recognized by PHL 4403-f(7)(b)(viii)(2), which states, "Such reports shall be formatted to allow comparisons between plans." Unfortunately, as noted in addition to the utilization data, which is not included in the report, many of the measures that are reported do not allow for comparison. While some information

[16] Letter to Mark Kissinger, Dep. Commissioner NYS DOH, dated Oct. 5, 2012, from Susan Dooha, Exec. Director, CIDNY, posted at http://tinyurl.com/CIDNY-MLTC-ADA, referencing Chart Comparing MLTC ADA Plan Compliance, posted at http://tinyurl.com/CIDNY-MLTC-ADA-chart-xls.

is given in a Plan-by-Plan comparison, other information is grouped by the three types of Plans – MLTC, MAP, and PACE and some metrics are provided as a single statewide figure.

To ensure that consumers can draw meaningful comparisons and that the report meets the requirements of the law, all of the information listed above should be provided.

CONCLUSION

An analysis Department of Health's 2012 Managed Long-Term Care Report finds that additional key measures, data, and regression must be included both as a matter of law and to meet the needs of a growing MLTC program and developing FIDA demonstration. . We respectfully request that a supplemental report, which is reviewed in advance by advocates and other stakeholders, be issued immediately and that new quality measures be incorporated going forward as recommended in this paper.

Steering Committee, *Coalition to Protect the Rights of New York's Dually Eligible*

Center for Disability Rights – Center for Independence of the Disabled NY
Community Service Society of NY – Empire Justice Center – Legal Aid Society
Medicare Rights Center – New York Association on Independent Living
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ATTACHMENTS

1. Excerpt – Table 3 of 2012 Managed Long-Term Care Report, NYS Dept. of Health, December 2012, posted at http://www.health.ny.gov/publications/3389_2012.pdf (pp. 17 – 19).

Appendix A: MLTC Plans (Partial Capitation) by Hours of Personal Care & Home Health Aide Services Provided – 2011, based on NYS DOH MMCOR 2011 Data.

Appendix B: Percentage of MLTC Enrollees in Nursing Home for Entire 4Th Quarter of 2011, based on MMCOR 2011 Data.

Appendix C: Percentage of PMPM Premium Revenue Spent on Medical Care (MEDICAL-LOSS RATIO), Care Management, Allowed and Non-Allowed Administrative Expenses, with Net Profit (Income) or Loss as % o Premium Revenue -- Partially Capitated MLTC Plans – 2011

Appendix D: Percentage of 2011 PMPM Premium Spent on Medical Services – MLTC Plans NYS - based on 2011 MMCOR DATA – listed in order of percentage spent on Nursing Home care

2011 MMCOR data obtained through Freedom of Information Law request from NYS Dept. of Health

Overall Functioning and Activities of Daily Living

- **Overall Functioning:** The SAAM Index is a composite measure of Activities of Daily Living, Incontinence and Cognitive Functioning. Average score on a scale of 0-51. Zero represents the highest level of functioning.
- **Ambulation:** Member's ability to walk on various surfaces. Average score on a scale of 0-6. Zero represents the highest level of functioning.
- **Bathing:** Member's ability to bathe him/herself independently. Average score on a scale of 0-5. Zero represents the highest level of functioning.
- **Transferring:** Member's ability to move from a seated position to another location. Average score on a scale of 0-6. Zero represents the highest level of functioning.
- **Dressing Upper Body/Dressing Lower Body:** Member's ability to dress their upper and lower bodies. Average score on a scale of 0-3. Zero represents the highest level of functioning.
- **Toileting:** Member's ability to use the bathroom or bedside commode. Average score on a scale of 0-4. Zero represents the highest level of functioning.
- **Feeding/Eating:** Member's ability to feed oneself. (Does not include meal preparation.) Average score on a 0-5 scale. Zero represents the highest level of functioning.

Table 3
Overall Functioning and Activities of Daily Living

Health Plan	Overall Functioning	Activities of Daily Living		
	SAAM Index	Ambulation (0-6)	Bathing (0-5)	Transferring (0-6)
Partial Capitation Plans				
Centerlight Healthcare Select MLTC	16	2.0	2.3	1.5
Elant Choice	16	2.4	2.4	1.4
ElderServe Health, Inc.	15	1.8	2.4	1.2
Fidelis Care at Home	14	2.0	2.2	0.8
GuildNet	19	2.5	2.7	1.7
HHH Choices Health Plan, LLC	14	1.8	2.4	1.1
HealthPlus, an Amerigroup Company MLTC	16	2.3	2.6	1.4
HomeFirst	17	2.4	2.4	1.7
Independence Care System	17	2.9	2.5	1.9
Senior Health Partners A Healthfirst Company	17	2.1	2.3	1.7
Senior Network Health, LLC	15	2.3	2.4	1.9
Total Aging In Place Program	14	2.2	2.2	1.4
VNSNY CHOICE Managed Long Term Care	16	2.3	2.6	1.4
Wellcare Advocate MLTC	13	2.1	2.1	1.1
PACE Organizations				
ArchCare Senior Life	15	2.1	2.2	1.3
Catholic Health – LIFE	14	2.2	2.2	1.0
Centerlight Healthcare PACE	16	2.1	2.5	1.5
Complete Senior Care	SS	SS	SS	SS
Eddy Senior Care	19	2.7	3.1	1.7
Independent Living for Seniors	18	2.4	2.7	1.4
PACE CNY	16	2.4	2.3	1.5
Total Senior Care, Inc.	13	1.9	2.4	0.8
Medicaid Advantage Plus (MAP)				
Elderplan, Inc.	17	2.5	2.5	1.7
Fidelis Medicaid Advantage Plus	15	2.1	2.2	1.4
Guildnet Gold	16	2.3	2.4	1.4
HIP MAP – MLTC	13	2.1	2.4	1.1
HealthPlus, an Amerigroup Company MAP	SS	SS	SS	SS
Senior Whole Health of New York MAP	12	2.1	2.0	1.1
VNSNY CHOICE Total	15	2.1	2.5	1.4
Wellcare Advocate Complete	15	2.3	2.3	1.4
STATEWIDE	**16**	**2.3**	**2.5**	**1.5**

SS = Sample size too small to report

***Table 3** (Continued)*

Overall Functioning and Activities of Daily Living

Health Plan	Activities of Daily Living			
	Dress Upper Body (0-3)	Dress Lower Body (0-3)	Toileting (0-4)	Feeding/ Eating (0-5)
Partial Capitation Plans				
Centerlight Healthcare Select MLTC	1.6	1.9	0.8	0.7
Elant Choice	1.1	1.3	0.8	0.6
ElderServe Health, Inc.	1.5	1.8	0.7	0.4
Fidelis Care at Home	0.9	1.1	0.4	0.6
GuildNet	1.8	2.0	1.0	1.0
HHH Choices Health Plan, LLC	1.7	2.1	0.6	0.5
HealthPlus, an Amerigroup Company MLTC	1.7	2.0	0.9	0.6
HomeFirst	1.7	2.1	0.7	0.8
Independence Care System	1.7	2.1	1.1	0.7
Senior Health Partners A Healthfirst Company	1.6	1.9	0.6	0.5
Senior Network Health, LLC	0.7	1.1	0.3	0.5
Total Aging In Place Program	1.0	1.4	0.6	0.5
VNSNY CHOICE Managed Long Term Care	1.6	2.1	0.8	0.8
Wellcare Advocate MLTC	1.3	1.9	0.4	0.3
PACE Organizations				
ArchCare Senior Life	1.3	1.5	0.9	0.7
Catholic Health – LIFE	0.8	1.2	0.6	0.4
Centerlight Healthcare PACE	1.6	1.8	0.8	0.5
Complete Senior Care	SS	SS	SS	SS
Eddy Senior Care	1.6	1.9	1.3	0.6
Independent Living for Seniors	1.2	1.6	0.9	0.7
PACE CNY	1.0	1.1	0.6	0.5
Total Senior Care, Inc.	0.7	1.1	0.7	0.3
Medicaid Advantage Plus (MAP)				
Elderplan, Inc.	1.7	2.1	0.7	0.8
Fidelis Medicaid Advantage Plus	1.2	1.5	0.7	0.6
Guildnet Gold	1.7	1.7	0.7	1.0
HIP MAP – MLTC	1.4	1.8	0.5	0.3
HealthPlus, an Amerigroup Company MAP	SS	SS	SS	SS
Senior Whole Health of New York MAP	0.4	0.6	0.2	0.2
VNSNY CHOICE Total	1.6	2.0	0.8	0.8
Wellcare Advocate Complete	1.4	2.0	0.6	0.6
STATEWIDE	**1.6**	**1.9**	**0.8**	**0.7**

SS = Sample size too small to report

Appendix A:

MLTC Plans (Partial Capitation) by Hours of Personal Care & Home Health Aide Services Provided – CY 2011

Based on NYS DOH MMCOR 2011 Data.

MLTC Plans (Partial Capitation) by Hours of Personal Care & Home Health Aide Services Provided – 2011
(In order of highest percentage of cases > 480)(All solely NYC unless otherwise indicated)

	A Total enrolled Dec. 2011	**B** Total Member Months* with PCA or HHA	**C** Total # members receiving PCA or HHA but no NH**	% of member months in which Personal care or Home Health care provided in certain ranges of Hours per Month						
				700+ hr/mo.	**480-699 hr/mo**	**320-479 hrs/mo.**	**240-319 hr/mo.**	**160-239 hrs/mo.**	**80-159 hr/mo.**	**1-79 hr/mo.**
GuildNet *(NYC, Nassau, Suffolk)*	7,281	55,845	6,048	7.2%	3.3%	5.8%	10.0%	19.7%	35.1%	18.9%
Independence Care System	1,943	21,197	1,931	6.2%	2.7%	8.4%	9.6%	21.0%	27.7%	24.3%
AMERIGROUP/ HealthPlus	1,389	12,825	1,359	1.8%	1.5%	5.5%	7.2%	17.2%	26.4%	40.4%
HomeFirst (Elderplan)	4,744	48,514	4,589	0.9%	0.5%	12.3%	8.9%	17.9%	38.1%	21.4%
HHH Choices	1,248	12,829	1,024	0.9%	0.4%	2.3%	8.4%	22.3%	44.4%	21.3%
ElderServe (*NYC, Nassau Suffolk, Westchester)*	3,378	13,215	3,223	0.4%	0.5%	4.9%	9.0%	19.4%	26.8%	39.0%
VNS Choice	9,768	102,828	9,038	0.3%	0.2%	3.7%	9.2%	20.4%	40.5%	25.7%
Senior Health Partners (Healthfirst)	3,340	34,756	2,894	0.2%	0.2%	6.4%	8.0%	15.4%	32.4%	37.5%
Senior Network Health *(Herkimer, Oneida)*	386	3,823	235	0.0%	0.3%	0.0%	0.0%	0.0%	2.3%	97.4%
CenterLight Select *(NYC, Westchester)*	3,407	25,789	2,955	0.1%	0.2%	10.1%	12.5%	20.4%	26.6%	30.0%
Wellcare Advocate	1,887	26,822	1,716	0.1%	0.0%	0.5%	1.7%	7.3%	36.1%	54.4%
Fidelis Care at Home *(Orange, Rockland)*	433	4,402	373	0.0%	0.0%	0.7%	2.7%	8.2%	23.4%	64.9%
Elant Choice *(Orange, Rockland)*	172	1,957	134	0.0%	0.0%	0.0%	0.5%	0.0%	6.7%	92.7%

COL B - "Member Month" = month in which plan reported providing a member with Personal Care or Home Health aide services. Since many members do not receive these services for an entire calendar year, this figure is more accurate than stating the total number of members who received the specified amount of hours.

COL C - Actual total number of members who received PCA and/or Home health care at any time during year, but not Nursing home care, as eported by plans. If every member received these services 12 months/year, Col C would be Col B divided by 12. If Col. C figure is much larger than Col. B divided by 12, it means that many members received home care for shorter periods within year.

PACE Plans (Full Capitation) by Hours of Personal Care & Home Health Aide Services Provided – 2011										
	A Total enrollment Dec. 2011[i]	**B** Total Member Months with PCA or HHA	**C** Total Members receiving PCA or HHA**	% of member months in which Personal care or Home Health care provided in certain ranges of Hours per Month						
				700+ hr/mo.	**480-699 hr/mo**	**320-479 hrs/mo.**	**240-319 hr/mo.**	**160-239 hrs/mo.**	**80-159 hr/mo.**	**1-79 hr/mo.**
ArchCare Senior Life NYC	189	2,097	175	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Catholic Health-LIFE Erie	72	429	36	0.0%	0.0%	1.9%	1.2%	0.0%	10.0%	86.9%
Complete Senior Care Niagara	19	54	5	0.0%	0.0%	0.0%	0.0%	0.0%	7.4%	92.6%
CenterLight PACE NYC, Nassau, Suffolk, Westchester	2,877	28,345	2,362	0.1%	0.2%	9.2%	10.3%	19.6%	26.6%	34.0%
Eddy Senior Care Albany, Schenectady	112	1,534	128	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Independent Living for Seniors Monroe	289	2,432	203	0.0%	0.0%	0.0%	0.0%	0.7%	54.5%	44.7%
PACE CNY (Loretto) Chautauqua, Onondoga, Oswego	401	4,280	357	0.0%	0.0%	0.0%	0.0%	0.0%	2.9%	100.0%
Total Senior Care Allegany, Cattaraugus	77	618	52	0.0%	0.0%	0.0%	0.0%	0.0%	5.5%	94.5%

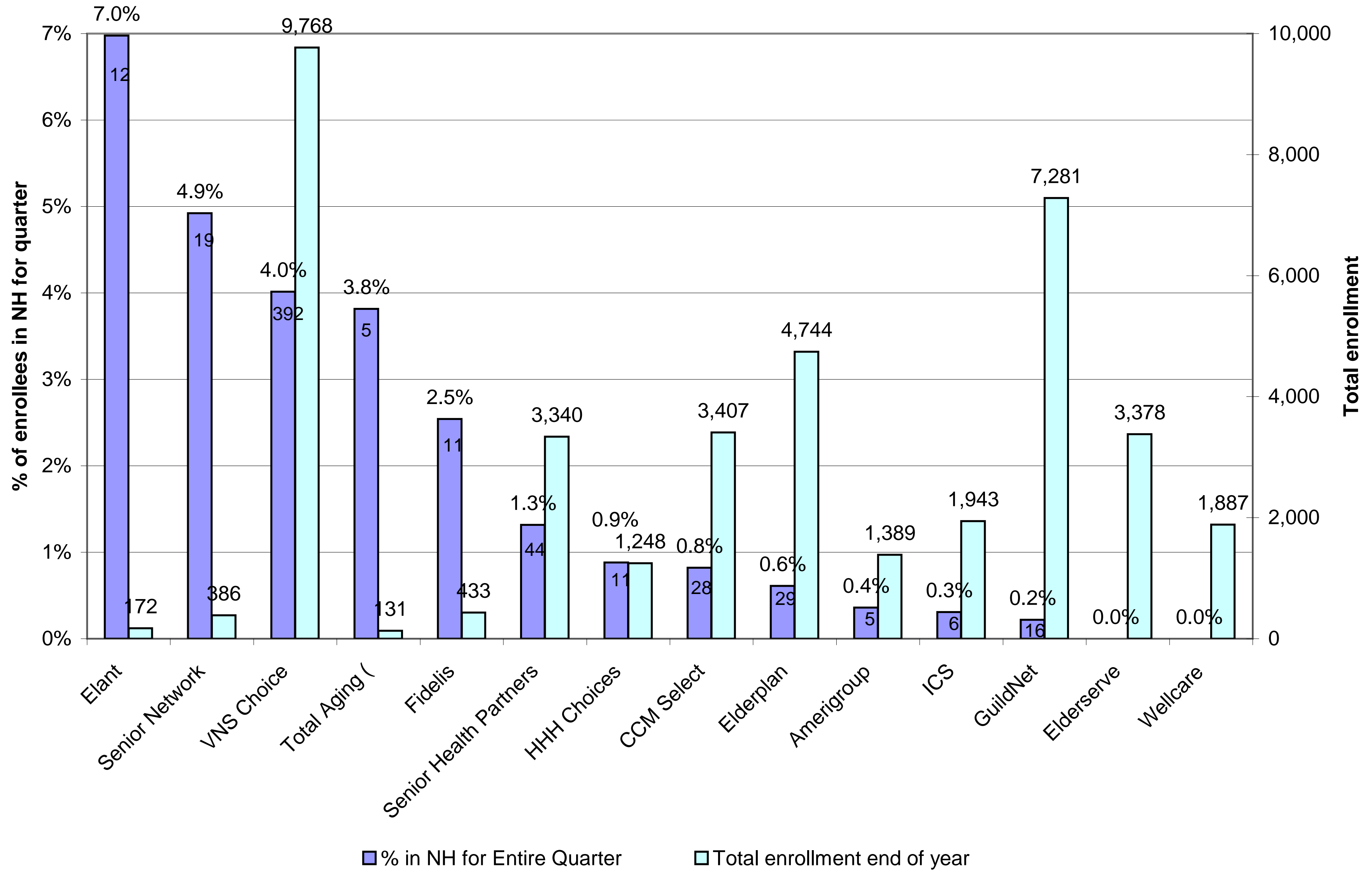
[i] PACE enrollment Figures as of Dec. 2011 from NYS DOH Managed Care Enrollment report, at http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. All other data in this chart from NYS DOH MMCOR data for 2011, Exh. A5 and A6, obtained through FOIL.

COL. C – Unlike MLTC table, Col. C is Col B. figure divided by 12, reflecting maximum number of members who received PCS or HHA services -- if each received services 12 months during the year.

Appendix B:

Percentage of MLTC Enrollees in Nursing Home for Entire 4th Quarter of 2011

based on NYS DOH MMCOR 2011 Data



Source: DOH MMCOR Data 2011

* Numbers on dark bars indicate # of enrollees in NH for whole quarter

Appendix C:

Percentage of PMPM Premium Revenue Spent on Medical Care (MEDICAL-LOSS RATIO), Care Management, Allowed and Non-Allowed Administrative Expenses, with Net Profit (Income) or Loss as % o Premium Revenue

Partially Capitated MLTC Plans – 2011

Percentage of PMPM Premium Revenue Spent on Medical Care, Care Management, Allowed and Non-Allowed Administrative Expenses, with Net Profit (Income) or Loss as % o Premium Revenue
Partially Capitated MLTC Plans – 2011

Plan	Counties (2011)	Enroll-ment Dec. '11	Total Premium Revenue PMPM	Percentage of PMPM Premium Revenue spent on:					Premium Income/ Loss as % of Premium Revenue after non-allowed Admin. Expenses
				A Medical expenses (Medical/ loss ratio)	**B** Care Mgt.	**C** Allowed Admin. Expenses	**TOTAL** A, B, C	**D** Non-allowed Admin. Expenses	
AMERIGROUP MLTC	NYC	1389	3,305.15	91.5%	5.6%	14.6%	111.7%	0.8%	-12.5%
CenterLight Select	NYC, Westchester	3407	3,791.61	89.1%	6.1%	8.1%	103.2%	0.9%	-4.3%
Elant Choice	Orange, Rockland	172	2,973.69	64.3%	3.2%	18.9%	86.4%	0.0%	13.6%
HomeFirst (Elderplan)	NYC	4744	3,578.93	80.8%	1.4%	14.2%	96.4%	0.8%	2.8%
ElderServ e	NYC, Nassau, Suffolk, Westchester	3378	3,765.02	74.0%	5.2%	13.7%	93.0%	0.7%	6.3%
Fidelis Care at Home	Orange, Rockland	433	2,710.28	88.3%	8.5%	11.5%	108.3%	0.1%	-8.4%
GuildNet	NYC, Nassau, Suffolk	7281	3,732.47	73.8%	8.5%	8.7%	91.0%	1.1%	7.9%
HHH Choices	NYC	1248	3,598.16	79.8%	9.2%	12.7%	101.7%	0.0%	-1.7%
Independence Care System	NYC	1943	4,888.76	80.4%	7.3%	8.6%	96.3%	0.8%	2.9%
Senior Health Partners (Healthfirst)	NYC	3340	3,619.92	66.1%	8.0%	13.0%	87.1%	1.5%	11.4%
Senior Network Health	Herkimer, Oneida	386	1,721.65	69.0%	15.6%	15.7%	100.3%	0.0%	-0.3%
Total Aging in Place	Erie	131	2,759.77	70.3%	15.3%	14.0%	99.6%	0.7%	-0.3%
VNS Choice	NYC	9768	4,092.98	77.5%	7.0%	7.1%	91.6%	0.7%	7.7%
Wellcare Advocate	NYC	1887	3,496.34	58.0%	6.5%	17.0%	81.5%	0.2%	18.3%

Based on 2011 MMCOR Data – NYS DOH .

NOTES: Total premium revenue includes collected spend-down payments
A – Medical Expenses – Broken down in Chart Below based on type of service

C -- Allowed admin. expenses include management/admin. salaries/fringe, rent, legal fees, utilization mgt. (appeals & external review costs), travel, marketing, advertising, & enrollment activities, cost to develop initial care plan, finance/audit, provider relations, recruitment & contracting, member services (including translation, phone staff), phone, postage, MIS, printing, occupancy & depreciation, equipment rental, association fees, workers comp and other insurance, medical records, cost of assisting enrollees with Medicaid renewal

D – Non-allowable expenses include political contributions, donations, lobbying expenses, entertainment costs, fines and penalties.

Appendix D:

Percentage of 2011 PMPM Premium Spent on Medical Services – MLTC Plans NYS - based on 2011 MMCOR DATA – listed in order of percentage spent on Nursing Home care

% of 2011 PMPM Premium Spent on Medical Services – MLTC Plans NYS - based on 2011 MMCOR DATA – in order of Nursing Home costs

Plan	Location	Nursing Facility	Home Health Care	Person-al Care	Transportation Non-Emer-gency	Dental	Vision Care	Podiatry	Durable Medical Equipment & Supplies	Personal Emergency Response Svcs	Home Delivered and Congregate Meals	Adult Day Health Care	Social Day Care	Out-patient Physical Therapy, Other Medical
Elant Choice	Orange, Rockland	19.1%	6.8%	19.5%	6.1%	0.6%	0.0%	0.1%	3.3%	0.4%	0.3%	1.9%	6.0%	0.2%
Senior Network Health	Herkimer, Oneida	17.1%	13.2%	13.4%	8.3%	1.1%	0.2%	0.2%	4.2%	1.4%	3.7%	3.0%	1.6%	1.5%
Total Aging in Place	Erie	11.2%	0.0%	30.9%	2.7%	0.2%	0.1%	0.2%	1.7%	0.6%	3.2%	0.0%	16.6%	2.9%
VNS Choice	NYC	9.0%	8.8%	55.7%	1.8%	0.1%	0.0%	0.0%	1.0%	0.4%	0.1%	0.0%	0.5%	0.1%
Fidelis Care at Home	Orange, Rockland	8.5%	11.5%	47.0%	7.1%	0.5%	0.1%	0.1%	1.5%	0.7%	1.3%	2.3%	7.7%	0.1%
Senior Health Partners (Healthfirst)	NYC	5.1%	4.3%	47.5%	2.9%	0.4%	0.0%	0.1%	1.4%	0.3%	0.3%	2.5%	0.6%	0.7%
HHH Choices	NYC	4.8%	17.2%	51.4%	3.6%	0.5%	0.1%	0.0%	0.8%	0.5%	0.2%	0.5%	0.0%	0.4%
CenterLight Select	NYC, Westchestr	4.4%	11.6%	64.2%	3.6%	0.3%	0.0%	0.0%	1.5%	0.2%	0.0%	0.0%	3.1%	0.1%
HomeFirst (Elderplan)	NYC	2.5%	3.6%	69.4%	3.0%	0.4%	0.1%	0.0%	1.1%	0.2%	0.0%	0.4%	0.0%	0.0%
GuildNet	NYC, Nassau, Suffolk	2.0%	40.8%	22.4%	3.2%	0.3%	0.1%	0.0%	1.2%	0.3%	0.0%	3.2%	0.1%	0.3%
Amerigroup MLTC	NYC	1.9%	0.8%	82.3%	3.1%	0.3%	0.0%	0.0%	0.9%	0.3%	0.0%	1.1%	0.0%	0.6%
Independence Care System	NYC	1.7%	2.4%	62.7%	3.5%	0.4%	0.1%	0.1%	5.6%	0.2%	0.4%	1.3%	0.2%	1.6%
Wellcare Advocate	NYC	1.0%	2.8%	52.1%	0.4%	0.3%	0.0%	0.0%	0.6%	0.3%	0.0%	0.4%	0.0%	0.1%
ElderServe Health, Inc.	NYC, Nassau, Suffolk, Westchestr	0.2%	8.4%	55.1%	4.7%	0.3%	0.0%	0.0%	0.9%	0.1%	0.0%	0.0%	4.3%	0.0%