NEW YORK STATE
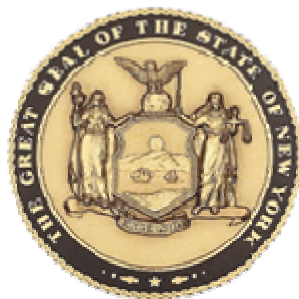# MANAGED LONG-TERM CARE

FINAL REPORT

Report to the Governor and Legislature

March 28, 2006

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EXECUTIVE SUMMARY

This report has been prepared in fulfillment of the statutory requirement under the Managed Long-term Care Integration and Financing Act (Chapter 659 of the Laws of 1997) to provide a Final Report to the Governor, Temporary President of the Senate and the Speaker of the Assembly on the status of the managed long-term care plan development, implementation and operation.

Managed Long-term Care in New York State

New York State continues to experience an increase in interest and growth in managed long-term care (MLTC). Enrollment in MLTC has grown at a rate of about 20% per year during the period January 2003 through January 2006. As of March 2006, there were 15,000 enrollees in 16 plans in the State. Of the 16 plans, 12 are partially-capitated managed long-term care plans and 4 are PACE organizations. The vast majority (85%) of enrollees are members of the 8 plans that serve all or part of New York City. (One plan has sites in both the City and Westchester County.) Nine plans serve enrollees in counties outside of New York City. Three additional plans were designated as a result of legislation enacted in 2005 and are in various stages of development. Some existing plans are developing a second model type (PACE or other MLTC plan) and some MLTC plans have or plan to expand into new counties. A summary of enrollment since January 2003 is shown in the table below.
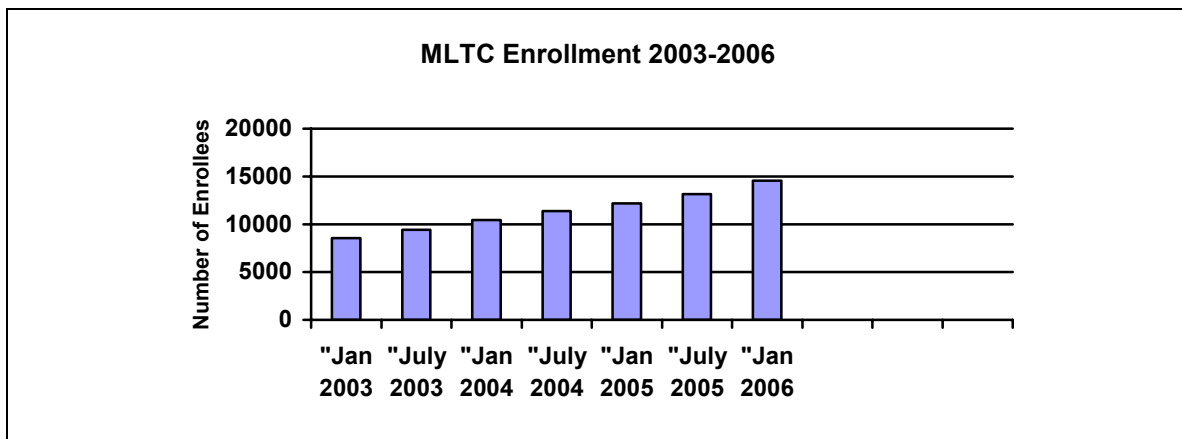
Since the 2003 Interim Report was submitted to the Legislature, a number of activities at the federal and state level have helped shape the development and future of New York's MLTC program. MTLC plans have made significant strides in complying with federal and state requirements and improving operational and financial performance. We believe that these efforts will help improve the long-term viability of the managed long-term care program. Highlights include:

- *Expansion of MLTC Plans*

  A number of operating MLTC plans have expanded or are in the process of expanding their geographic service areas to include additional counties. A number of existing plans are also in the process of diversifying their product offerings to include additional models of long-term care. One large PACE organization is in the process of developing a partial capitation plan while a number of partial capitation plans have applied or expressed interest in becoming PACE organizations. Either way, the thinking is clear – plans are interested in having a variety of product offerings to appeal to prospective members.

- *Medicare Special Needs Plans*

  Nearly 90 percent of MLTC enrollees are dually eligible for Medicare and Medicaid. The Medicare Modernization Act of 1997 created the authority for Medicare Special Needs Plans (SNPs) to serve subsets of the Medicare population including individuals who reside in an institution or who meet the criteria but reside in the community; persons dually-eligible for Medicare and Medicaid; and persons with specified diseases as approved by the Secretary of Health and Human Services. Medicare SNPs offer partially-capitated MLTC plans a new opportunity to expand their business to provide Medicare covered acute care services to their existing enrollees and new enrollees. Medicare SNPs also create a new vehicle for the State Medicaid programs to integrate Medicare and Medicaid service delivery and financing as was envisioned by authorizing state statute without the need for the State to seek additional federal waivers. Five existing MLTC plans and two of the MLTC plans designated in calendar year 2005 are now in the process of applying with the Centers for Medicare and Medicaid Services to be Medicare SNPs starting January 1, 2007.

- *Compliance with the Federal Balanced Budget Act*

  Rules promulgated pursuant to the Balanced Budget Act of 1997 imposed new requirements on partially-capitated MLTC plans. The regulations required plans to make significant modifications to policies and procedures, particularly in the areas of marketing, member materials, service authorizations and appeals and grievances. Plans, with the technical assistance of Department staff and representatives of the health plan associations, worked diligently to implement these new requirements.

- *Promulgation of New York State Regulations*

  In June 2005, the Department of Health promulgated regulations at 10 NYCRR Part 98-1 that explicitly include MLTC plans in the definition of

managed care organization. Promulgation of these regulations began the process for issuing Certificates of Authority to MLTC plans under Article 44 of Public Health Law. Applications from operating demonstrations were due from MLTC plans in November 2005 and are currently under review within the Department with the goal of issuing Certificates of Authority to operating MLTC plans by June 2006.

- *Improvements in Data Collection and Reporting*

  The Department's 2003 Interim Report found that MLTC plans generally faced challenges in collecting and reporting data about enrollees and their service utilization. Data systems were manual and plans had difficulty collecting, reporting and analyzing data. Since that time, the Department and plans have successfully implemented two electronic data capture systems to address these concerns. The Medicaid Encounter Data System (MEDS) was implemented in spring 2005. The data produced by MEDS provides patient level information for monitoring service utilization, plan quality and fiscal performance. In summer 2005, the Department established the Semi-Annual Assessment of Members (SAAM) for plans to report electronically on the health care status, primary diagnoses, and Assistance with Daily Living (ADLs) of their members.

- *Improved Financial Performance*

  Overall, the managed long-term care industry has operated profitably and financial performance has improved. In 2004, eleven of the plans operated profitably with four plans reporting losses. Of the four plans operating at a loss, two of the plans reported very small losses of less than 1% of their revenue. Based on the latest data available for 2005 (through September), overall, plans have continued to operate profitably, with twelve of the fifteen plans reporting surpluses. The three plans operating at losses have enrollments ranging from 77 to 316 people.

  Also indicative of improvement in financial viability, the net worth of the four plans with 75% of total MLTC enrollment increased dramatically over the last four years. The largest plan has more than doubled its net worth, while the second largest plan increased net worth from $2.5 million to $24 million. The third and fourth largest plans also saw significant growth in their net worth during the same period. These increases are largely attributable to the successes that these plans have had in increasing enrollment and the administrative efficiencies they have achieved. As we have gained more experience with the MLTC program it is clear that enrollment growth is critical to the plan's financial viability and cost-effectiveness.

Findings

In 2003, the Department submitted an Interim Report to the Governor and the Legislature on the managed long-term care program. In that report, we indicated that the program was growing slowly but steadily and that plans were providing high quality service with high levels of client satisfaction. This remains true today. The Department's 2003 Interim Report also indicated some concern about the cost effectiveness and financial vulnerability of managed long-term care plans, largely due to their small size. Since that time, plans have made important strides in implementing effective marketing and growth strategies and reducing administrative costs.

MLTC plans continue to serve some of the most complex and medically needy individuals in the Medicaid program. The majority of MLTC plan enrollees have multiple chronic conditions. A large percentage of enrollees display some level of confusion or impairment of cognitive functioning. Most require assistance with one or more Activities of Daily Living (ADLs) such as grooming, dressing, bathing, toileting, transferring, walking or eating. On average, 7.3% of enrollees reside in a nursing home; the remainder resides in the community. MLTC enrollees have diverse ethnic and cultural backgrounds and MLTC plans have developed creative approaches to meeting the members' needs.

The Department conducts a comprehensive program of quality review and monitoring including readiness reviews before the plan begins operations, reviews of periodic reports submitted by plans, on-site reviews and complaint monitoring. While these reviews have identified some findings, most are relatively minor and the plans have acted quickly to correct the deficiencies.

Consumer satisfaction with MLTC plans remains high. Based on the most recent surveys conducted by the plans, ninety percent (90%) of enrollees rate their plans' overall performance from good to excellent, 80% said that they would recommend their MLTC to others and 85% responded that they have benefited from plan membership or that their health has improved since joining the plan.

As MLTC enrollment has grown, financial performance has improved. Most plans operate at a surplus and as described above, the largest plans have seen significant growth in their net worth helping to ensure that they have the ability to meet financial solvency requirements and sustain operations and future expansion.

We believe that the past three years have been positive for the MLTC program. MLTC provides a coordinated system with the potential for allocating resources effectively and efficiently. It permits plans and providers to place a greater focus on prevention and offers consumers another long-term care choice. To fully realize this potential, the Department believes the following elements to be important as the program moves forward:

- continued enrollment growth;

- better integration of Medicare and Medicaid financing;

- improvement in enrollee assessment tools;

- continued refinement of data reporting and analysis, and

- development of quality measures specific to the MLTC enrolled population.

To allow the Department and MLTC plans to continue to develop these models, the 2006-07 Executive Budget has proposed a three-year extension of the legislation that authorizes the Managed Long-Term Care Program. We believe that the next three years will be pivotal in terms of shaping the managed long-term care program as a key part of the State's long-term care reform initiative.

1. INTRODUCTION

The New York State Department of Health respectfully submits this Final Report to the Governor of the State of New York and to the Honorable Members of the New York State Legislature. The Report fulfills the provisions of The Long-Term Care Integration and Finance Act (Chapter 659 of the Laws of 1997) regarding submission of a Final Report on the development and operation of managed long-term plans (MLTCPs) in New York State.

The Final Report follows-up on the findings of the Interim Report prepared by the Department in 2003 and provides more recent information about the development and operation of the plans.

The intervening years since the Interim Report have been positive for MLTCP plans in terms of their ability to successfully identify and meet the needs of members and their families. They have been challenging as well. While daily operations are the primary focus of the plans, they have also concentrated their efforts on refinement of their overall long term care service delivery and financing models, increasing enrollment levels, and in some instances, expanding their geographic service areas and product offerings.

Most of the MLTCPs (with the exception of the PACE organizations which are established pursuant to separate federal statute) have been required to meet additional federal requirements for managed care organizations promulgated at 42 CFR 438 under Section 1932 of Title XIX of the Social Security Act. The regulations required significant changes in a number of plan policies and procedures, especially as they relate to grievance and appeals systems, service authorization processes and performance improvement and quality assurance methods. Additional changes were required in marketing materials and activities, including member handbooks.

The enactment of final New York State regulations under Part 98 of the Public Health Law in June 2005 also required the MLTCPs (again, with the exception of the PACE organizations) to move from their demonstration status to obtain Certificates of Authority (COA) from the Department in order to continue to operate as managed care organizations under Public Health Law. The partially-capitated MLTC plans have until June 2006 to receive a COA from the Department.

The Department also developed new methods of monitoring the MLTCPs, including electronic submission of encounter data on a regular basis and collection and reporting of patient assessment data.

New federal legislation authorizing Medicare Advantage Special Needs Plans provides MLTC plans with a new opportunity to expand into the Medicare market focusing on the population with which they have the most experience. Under the SNP legislation, partial capitation plans can apply to the Centers for Medicare

and Medicaid Services to serve the subset of the Medicare population who are dual-eligible or who reside in an institution or meet the criteria to reside in an institution but receive services in the community.

Scope of Report

The Long-Term Care Integration and Financing Act (Chapter 659 of the Laws of 1997) established a regulatory framework under Article 44 of New York Public Health Law (Section 4403-f) for the integration of long-term care service delivery and alternative financing through the development of managed long-term care (MLTC) plans. This statute expires December 31, 2006.

Chapter 659 consolidated, under one legislative authority, all operational managed long-term care plans in New York State at the time the legislation was enacted and authorized the development of additional plans. The objectives of the legislation are to create the necessary building blocks for enhanced coordination of long-term care and other health care delivery and financing, and to test a variety of service delivery, target population and financing models. Additionally, Chapter 659 permits plans to attempt more effective alignment of Medicare and Medicaid reimbursement within managed long-term care, and provides a framework for the full integration of financing and service delivery for beneficiaries who are dually-eligible for Medicare and Medicaid.

A requirement of the statute is the submission by the New York State Department of Health of a Final Report to the Governor and the Legislature on the results of implementing the managed long-term care plans authorized under the Act. This report is submitted in accordance with that requirement, and addresses the following issues, consistent with legislative provisions:

- Enrollment levels and enrollee characteristics
- Distribution of impairment levels of enrollees
- Quality, accessibility and appropriateness of services
- Level of consumer satisfaction
- Levels of disenrollment
- Utilization of services
- Rate-setting methodology
- Report prepared by the Superintendent of Insurance
- Feasibility of increasing the number of plans that may be approved

2. **MANAGED LONG-TERM CARE IN NEW YORK STATE**

Although other states such as Minnesota and Arizona have developed a single model for managed long-term care, New York State's legislation has enabled the development of a variety of service delivery and financing models to meet the varied needs of the State's diverse elderly and disabled populations. However, all MLTC plans in New York share the same goal: to assist people who are chronically-ill or have disabilities and who need health and long-term care services to remain in their homes and communities as long as possible. MLTC plans, regardless of the model, arrange and pay for an array of health and social services. All plans offer their members choice and flexibility in obtaining needed services through a coordinated central point of contact.

Managed long-term care is designed to reduce the costs of long-term care by making clinical and non-medical services available to frail elderly and disabled populations in a home or community setting. The availability of a range of services minimizes the use of high-cost institutional resources. When services are available in these settings they are generally more satisfactory to consumers and their families. MLTC differs from other models of non-institutional long-term service delivery insofar as it places a greater emphasis on care coordination, as well as reimbursement methods designed to contain cost growth.

Managed Long-Term Care Plan Enrollment

New York State continues to experience an increase in interest and growth in managed long-term care. As of March 2006, there were 15,000 enrollees in 16 plans in the State. Overall MLTC plan enrollment continues to grow steadily, at the rate of about 20% per year over the past three years. While several plans have remained at relatively constant enrollment levels and have had difficulties recruiting new members, one plan in New York City saw its enrollment increase by almost 50% in 2005. The most recently established partial capitation plan began operation in December 2005 and, consequently, data for this plan is not included in this Report.

Of the 16 plans, 12 are partially-capitated managed long-term care plans and 4 plans are PACE organizations. The vast majority (85%) of enrollees are members of the 8 plans which serve all or part of New York City. Nine plans serve enrollees in counties outside of New York City – Erie, Monroe, Onondaga, Oneida, Herkimer, Schenectady, Albany, Orange, Rockland, Westchester, Nassau and Suffolk. One plan has sites in both New York City and Westchester.

Three additional plans are under development as a result of legislation enacted last spring authorizing 6 new plans. Some existing plans are developing a second model type (PACE or other MLTC plan) and some MLTCPs expect to expand into new counties. In addition, five plans are in the process of seeking approval from the federal Centers for Medicare and Medicaid Services to operate Medicare Special Needs Plans (SNPs) in order to serve beneficiaries who are

dually-eligible for Medicare and Medicaid or to serve individuals who are institutionalized.

Managed Long-Term Care Program Model

MLTC provides a framework for a coherent system of long-term care services, care coordination and social supports. Plan services and operations are developed around patient requirements and preferences whenever possible. All services required by enrollees are coordinated through the plans' care managers/teams who serve as a central point of contact for all service providers.

MLTC is intended to:

- provide a better, coordinated system that allocates resources effectively and efficiently by providing the right service to the right consumer at the right cost;
- encompass a flexible system that decreases reliance on institutional care and makes long-term care more responsive to individual needs and preferences;
- allow for better coordination between Medicaid and Medicare;
- permit plans to place a greater focus on prevention;
- offer consumers another long-term care choice, and
- provide consumers opportunity for increased participation in their care delivery and management.

Currently, there are two basic models of managed long-term care in New York State: Programs of All-Inclusive Care for the Elderly (PACE) and partially–capitated Managed Long-Term Care Plans.

PACE Organizations

PACE organizations are individually approved by the U.S. Centers for Medicare and Medicaid Services (CMS) and serve members age 55 years and older who are medically eligible for nursing home admission. The PACE model is a permanent health care provider type within the Medicare program. States may also opt into the PACE program for Medicaid beneficiaries, subject to CMS approval.

PACE organizations fully integrate Medicare and Medicaid health care delivery systems and financing.   Enrollment is voluntary.   PACE participants are expected to need long-term care services for at least 120 days and be able to live safely in the community at the time of enrollment. Most PACE enrollees are dually eligible for Medicare and Medicaid, although a small percentage of enrollees are Medicare and private pay or are only eligible for Medicaid.

A PACE organization receives monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing apply. The PACE assumes full financial risk for participants' care, without limits on amount, duration or scope of medically necessary services. The PACE is the sole source of medical and health care and services for its enrollees.

In the PACE model, an interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers directly and/or arranges all services required by PACE participants (including acute care services and when necessary, nursing home services). The ability to completely integrate services ensures seamless provision of all necessary care. PACE organizations provide social and medical services, often in an adult day center, supplemented by in-home and referral services as needed. In most instances, PACE participants are required to use PACE staff physicians as their primary care physicians.

Services covered under PACE organizations' Medicare and Medicaid capitation payments 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; occupational, podiatry; physical, speech and occupational therapies; respiratory therapy; medical equipment and supplies; orthotics/prosthetics; personal emergency response systems (PERS); nursing home services (some Medicaid eligibility restrictions apply), and other social and environmental supports.

As of March 2006, there were four PACE plans operating in New York with a total enrollment of less than 2,500. Though enrollment is low, New York has the largest PACE enrollment in the country, followed by California with 1,644 enrollees and Massachusetts with 1,343 enrollees.

Partially-Capitated Managed Long-term Care Plans

The partially-capitated MLTC model is unique to New York State. Partially capitated MLTCPs receive only a Medicaid capitation payment and do not provide comprehensive coverage. Enrollees must be age 21 and over, although target populations vary; most plans have opted to enroll only those individuals age 65 and over, while in others that concentrate on a younger, disabled population, 21 is the age criteria. Enrollees also must be nursing home certifiable, be able to live safely in the community at the time of enrollment and need long-term care services covered by the plan's benefit package for at least 120 days. Enrollment is voluntary. Most enrollees are

dually eligible for Medicaid and Medicare, although a small number of members are eligible for only Medicaid.

The Medicaid capitation rate covers an array of long-term care services including care management and coordination; home health and personal care; nursing home care (Medicaid eligibility restrictions apply); physical, speech and occupational therapies; respiratory therapy; medical and social day care; meals; nutrition services; podiatry; dentistry; optometry; audiology; non-emergency transportation; medical equipment; orthotics/prosthetics; PERS, and other social and environmental supports. In addition, care managers are responsible for arranging and/or coordinating non-covered services with the services covered by the plan. Enrollees access services not provided by their plan, such as physician services, pharmacy and hospital, through fee-for-service Medicare and/or Medicaid. The MLTCPs also are responsible for coordinating and/or arranging services not covered by the plan. Since physician services are reimbursed on a fee-for-service basis, enrollees of partially-capitated MLTCPs do not need to change their existing primary care providers when they join a plan, although the physicians must agree to collaborate and coordinate services with the MLTCP

The key differences between the PACE and partially capitated models are the funding streams and the scope of services provided by the plan. However, the basic elements of both program models are quite similar.

1. A single point of access to help members navigate the health care system.
2. A care plan, whether developed by an individual care manager or an interdisciplinary team, which relies heavily on community services that results in good clinical outcomes and supports the member and the care giver. The focus of the care plan is to keep the member in a setting that meets his/her medical necessity, without over or under utilizing service.
3. The ability to be creative and flexible in developing the care plan. Plans are not limited to providing only those services covered under Medicaid or Medicare. The plan can use a cost-effective service that supports the care plan and allows the member to stay home. For example, Medicaid does not pay for a "wander guard" system (perimeter monitoring at home), but one plan has found the system quite useful in preventing "elopements" by members with dementia.

Enrollee Case Illustrations

The following enrollee case studies illustrate how MLTCPs arrange, deliver and coordinate services, as well as the diversity of the individuals they serve.

- Mr. E is 82. His Parkinson's disease caused advanced tremors and swallowing difficulties that resulted in significant weight loss. Working with the PACE team, Mr. E opted for a feeding tube; his nurse assists

him with his feeding 3 times each day. He enjoys regular visits to the PACE Day Center and walks to activities by himself with a walker. He has gained 25 lbs. since the insertion of the feeding tube and had a special party at the PACE Day Center to celebrate.

- Mrs. D is 52 with a diagnosis of Multiple Sclerosis. As a result of severe pressure ulcers, she was placed in a nursing home, away from her supportive family, husband and children. After several months, Mrs. D enrolled in a MLTC plan, which allowed her to return to her family. The plan provides and/or coordinates all of the services Mrs. D requires, including skilled nursing, a physical therapy home exercise program, and a custom wheel chair. There has been a concomitant improvement in her quality of life as well as her physical health.

- Mrs. S. is 81, alert and reasonably well oriented. However, she is socially isolated with no close family. She is blind and was unable to walk around her apartment without "holding on to things" - there were a number of safety issues including a history of falls, non-working smoke detector, no safety equipment in the bathroom, and inability to access 911. When she enrolled, plan staff found multiple brown bags with unused medications in her apartment and a week's worth of uneaten, un-refrigerated sandwiches in her kitchen. The plan arranged for installation of a personal emergency response system (PERS); Con Edison and Adult Protective Services were notified of her status. Personal care assistance is provided 7 days a week and an RN visits for medication pre-pouring and health status monitoring. Mrs. S. was taught how to use adaptive equipment to increase her safety and sense of well being.

- Mr. R is 85, illiterate and mentally challenged. He lives alone and has had no involved family in his life. His inability to read correspondence sent by physician offices reminding him of appointments caused several providers to discharge him from their practices. Upon enrollment with a MLTCP, staff arranged for a primary care physician to accept him as a patient. Now, plan staff call to remind him of his appointments and provide him with transportation to and from the visits. He is unable to cook; the plan provides him with an aide who prepares hot meals during visits and leaves cold prepared meals in the refrigerator. He also receives assistance with housekeeping, laundry and shopping. A visiting nurse pre-fills his medications each week and reads any communications from his physician. In addition, the plan coordinated with a representative from the Salvation Army to help him manage his money and to purchase necessities such as clothing and supplies for his apartment.

3.   **ENROLLEE CHARACTERISTICS**

Thirty-eight (38%) of the enrolled population in MLTC plans is White not of Hispanic origin; 28% is White of Hispanic origin, and 23% of the enrollment is Black. The remaining 11% of the plan enrollees identify themselves as Asian American, Native American, or Hawaiian.

By way of comparison, the age 65 and over population in New York State is 82% White not of Hispanic origin; 6% is White of Hispanic origin, 10% is Black; 2% is Asian-American and less than 1% are identified as Hawaiian/Pacific Islanders or Native Americans/Alaskan Natives based on the 2000 U.S. Census.

The table below provides a breakdown of the MLTCP enrolled population as of January 1, 2006 by gender and age group.

MLTCP Enrollee Population by Gender and Age

	NYC	Rest of State	All
Gender:	%	%	%
Male	25	17	24
Female	75	83	76
Age Groups			
21 – 54	7	4	6
55 – 64	5	5	5
65 – 74	22	17	22
75 – 84	40	36	39
85+	22	39	28

The majority (76%) of enrollees is female, which is to be expected in an elderly population given the relative longevity of the female population. However, in New York City where some of the larger plans serve younger populations, there is a relatively larger percentage of male to female members than in the rest of the State.

4. LANGUAGE AND CULTURAL COMPETENCY

Language and cultural issues are key factors affecting the ability of the MLTCPs to appropriately serve their members.

The primary language of most MLTC plan enrollees is English, although there is a great degree of diversity in the other languages spoken. In only one plan is English the primary language of all members. Spanish is the primary language of over 25% of enrollees, with Russian and Chinese accounting for another 15% of spoken languages. The remaining 2%-3% of enrollees speak at least 20 other languages, including Yiddish, Hebrew, Greek, Italian, German, Korean, Ukrainian, Bengali, Farsi, French, Polish, Hindi, Urdu, various Slavic languages, Serbian, Croatian, Haitian-Creole, Vietnamese, Italian, Hungarian, American Sign language and Rumanian.

Plans are required to translate key written materials including member handbooks, marketing brochures and enrollment agreements into a language other than English if 5% or more than 50 members, whichever is the lower number, speak a primary language other than English. Additionally, plans rely on U.S. Census data to identify language proficiencies in their service area. All but one plan (i.e., the plan with only English speakers) translate their written materials into Spanish. In New York City, some plans translate materials into as many as three other languages, including Russian, Chinese and Korean. Additionally, all provider listings made available to members and prospective enrollees must identify languages of participating network providers.

Plans are continually developing new methods of maintaining effective communication with their members and prospective enrollees. All plans provide oral translation service and actively recruit bilingual and multi-lingual staff. One plan that serves all New York City boroughs employs "escort/translators" who accompany nurses and aides into certain areas of the City and who are fluent in the language of the member. Alternatively, and when acceptable to the member, relatives or friends will translate.

All plans have the ability to access a telephonic translation service (e.g., AT&T Language Line) that provides simultaneous translation and interpretation over the telephone for those circumstances in which a bi-lingual staff person is not available. Several plans use portable electronic/telephonic language translation devices for use in a home-based setting (e.g., a Cyraphone). These options permit the simultaneous translation of almost 150 languages.

In addition to addressing the language issues of members, the plans continue to develop new approaches to meet unique cultural needs of their members. Assessing ethnic, religious and cultural needs of new enrollees is now routine. Assessments then result in care plans designed to meet those needs wherever possible. Care plans may incorporate special dietary requirements or

assignment of plan and provider staff from similar cultural and/or linguistic backgrounds. Plans make a point of linking members with primary care physicians with culturally similar backgrounds whenever possible and desired by the enrollee.

Plans have adopted a variety of methods to enhance members' quality of life through the recognition of their culture and significant cultural events. Many plans celebrate holidays, i.e., Cinco de Mayo or Chinese New Year, with parties for members. On a more routine basis, the MLTCPs devise creative strategies to meet the needs of linguistically or culturally isolated members, such as bringing these individuals together in small groups to chat in their native language and eat native foods. Religious observance is likewise very important for many MLTC plan members. Many MLTCPs incorporate religious services and observances into the development of the care plan.

While the MLTCPs have gained much experience in dealing with unique cultural or religious preferences of their enrollees on a daily basis, issues remain that plans continue to try to address. One particular concern is the relationship between cultural and religious beliefs and end of life issues. Consequently, some plans are working to improve how their staff can assist enrollees with their preferred approaches to advance directives, living wills and health care proxies, and dealing with such concerns as nondisclosure of medical information and family-centered decision-making.

5. ENROLLEE IMPAIRMENT LEVELS

Medical Diagnoses/Conditions

The majority of MLTC plan enrollees have multiple chronic medical conditions. The most prevalent diagnosis (82%) among enrollees continues to be hypertension. Cardiac problems/heart disease account for the second most frequent diagnosis (52%). Visual impairments (cataracts, glaucoma, blindness, other visual impairment, etc.) affect 44% of enrollees. Osteoarthritis ranks fourth at 42%, and 40% of enrollees have been diagnosed with diabetes.   Twenty-three percent (23%) of enrollees have suffered a stroke or other cerebrovascular accident (CVA).

Functional Status/Behavioral Assessments

The MLTC plans collect information on enrollee behaviors, levels of functional impairment and clinical diagnosis on a semi-annual basis and whenever there has been a significant event (e.g., hospitalization, a fall, etc.). Data are collected using the Semi-Annual Assessment of Members (SAAM), a modified version of the federal (Medicare) Outcome and Assessment Information Set (OASIS) which is designed to assist health providers in care planning and outcome monitoring, as well as clinical assessment. The functional status data are critical, since these data are the basis for the MLTC plans' care planning processes, and it facilitates the plan's identification of areas where the patient's status differs from optimal health or functional status.

Behavioral Assessment Results

Based on the SAAM data submitted for 2005, MLTC plan enrollees experience relatively significant levels of behavioral impairment:

53% display some level of confusion;
49% display some impairment of cognitive functioning;
43% demonstrate some level of anxiety;
26% exhibit depressive feelings;
19% exhibit memory deficits to the extent that some level of supervision is
     required, and
17% demonstrate impaired decision-making abilities.

Activities of Daily Living (ADL) Assessment Results

The SAAM dataset captures information about "Activities of Daily Living" (ADLs), a term commonly used to describe a person's ability to care for him or herself. ADLs include everyday activities such as eating, dressing, and bathing. When people are unable to perform these activities, they need help either from other human beings and/or from mechanical devices. Plans use an assessment of the member's ADL needs to develop an individual care plan. Most MLTC plan enrollees have multiple ADL impairments.

The following section describes the level of ADL impairment among MLTC plan enrollees.

Grooming

- Only about 25% of MLTCP enrollees are able to groom themselves unaided. The remainder require assistance or depend entirely on someone else to perform their grooming tasks.

Dressing

- 89% of enrollees require assistance with dressing; of these over 20% depend entirely upon someone else to dress them.

Bathing

- Less than 8% of enrollees are able to bathe or shower independently or with the aid of an assistive device. 50% can bathe themselves with assistance. However, 43% cannot bathe themselves even with assistance.

Toileting

- 54% of enrollees are able to toilet independently. Another 26% are able to toilet when reminded, assisted or supervised. The remaining 20% of enrollees do not use bathroom facilities, but they can either use a bedside commode or a bedpan/urinal or may be totally dependent on assistance from another person.

Transferring

- 72% of enrollees require some level of assistance with transferring. The majority of these enrollees can transfer with limited human assistance or

an assistive device. However, 12% of enrollees are unable to transfer without extensive assistance or are completely bedfast.

Walking

- Less than 5% of enrollees are able to walk independently. The remaining 95% require assistance walking, including the use of a device such as a cane or a walker or some supervision or assistance, or are able to wheel themselves independently or with assistance. Less than 1% of enrollees are bedfast.

Eating/Feeding

- Only 22% of enrollees are able to feed themselves independently. The majority of enrollees require assistance in meal preparation or set-up. Slightly less than 1% of enrollees require the use of a nasogastric or gastromic tube.

The level of functional impairment among MLTC plan members in New York State is quite marked. The table below compares ADL dependency of members of both partially-capitated and PACE MLTC plans in New York to ADL dependency among all PACE participants nationwide in 2005.

Prevalence of ADL Dependency
MLTCP Enrollees and PACE Participants Nationwide

ADL	MLTCP Enrollees	PACE Participants
Bathing	92%	69%
Dressing	89%	56%
Grooming	74%	54%
Toileting	46%	43%
Transferring	72%	38%
Walking	95%	48%
Eating/Feeding	78%	29%

Source: National Pace Association 2005

6. QUALITY, ACCESSIBILITY AND AVAILABILITY

The Department of Health is responsible for on-going assessment, monitoring and evaluation of managed long-term care plan service quality, availability and accessibility. The first level of this oversight is the plan's internal Quality Assurance and Performance Improvement (QA/PI) Program. The Department's external monitoring is conducted through readiness, operational and targeted reviews, analysis of information/data submitted by the plans, and investigation of complaints made directly to the Department by enrollees, their family members or other interested parties.

MLTCP Quality Assurance and Performance Improvement Program Requirements

The plan's Quality Assurance and Performance Improvement Program is designed to promote healthy outcomes, identify and correct problems, and ensure care is consistent with generally accepted medical standards and clinical guidelines. The Program must identify specific and measurable activities to be undertaken by the plan. Required elements of the QA/PI Program must include:

- Board level accountability for overall oversight of program activities and review of the QA/PI program.

- Goals and objectives that provide a framework for quality assurance and improvement activities, evaluation and corrective action.

- Standards for access, availability and continuity of services.

- Quality indicators that are objective, measurable and related to the entire range of services provided by the plan.

- A process to review the MLTCP's ability to assess enrollee care needs, treatment goals, effectiveness of interventions, adequacy and appropriateness of service utilization and sustain enrollee informal supports.

- Enrollee and caregiver involvement in QA/PI activities and evaluation of satisfaction with services.

- A quality review committee to make recommendations to the board regarding the process and outcomes of the QA/PI and provide input related to processes to evaluate ethical decision-making including end-of-life issues.

State Monitoring of MLTCPs

MLTCP Readiness Reviews

Certain aspects of a plan's ability and readiness to provide necessary care and services can be evaluated from review of plan materials, policies and procedures. For example, marketing and enrollment/disenrollment materials are reviewed to ensure they convey all necessary information, including the voluntary nature of the program, in plain and simple language which is easily readable and meet federal and state regulations.

An on-site readiness review is performed prior to the start of enrollment to ensure the plan has appropriately implemented necessary operational components. During the on-site review, the plan's infrastructure is examined, including adequacy of quality and information systems; staffing patterns; qualifications and training; and the roles of the Board of Directors and the Medical Director. It also includes an assessment of plan policies and procedures, including: provider recruitment and credentialing; adequacy of the provider network; practice guidelines; care management processes, and the operation of the marketing plan and member services. During the readiness review, the MLTCP must demonstrate that it is prepared to operate according to departmental standards before the plan is authorized to begin marketing.

Ongoing MLTCP Monitoring

The Department routinely monitors reports submitted by the plans. Quarterly reports include information on grievances and appeals, as well as potential fraud and abuse. Disenrollment data are reported every six months. Information on changes to the plans' provider networks is also submitted quarterly. The data in these submissions are reviewed for trends or patterns that may warrant further examination of such issues as marketing practices, satisfaction with services, capacity to deliver covered services and appropriateness of providers within the network.

Additionally, all MLTCPs are required to collect and submit electronic data on encounters for all contracted services. The final version of the Medicaid Encounter Data System (MEDS) was implemented in spring 2005 replacing the manual system that plans had used to report patient specific service utilization. The data produced by MEDS will be a source of information for monitoring individual and aggregate MLTCP performance.

In summer 2005, the Department established a new system for plans to electronically report data on the health care status, primary diagnoses, etc. of their members. This new system, the Semi-Annual Assessment of Members (SAAM), requires the collection of information at those times when the plan conducts an assessment of the member's condition (no less than twice a year or every time there is a significant change in the member's health status, e.g.,

hospitalization, nursing home admission). SAAM is the source for much of the data contained in this Report.

Performance Reviews

Annual on-site performance reviews are conducted by the Department to assess the extent to which plans are in compliance with applicable laws, regulations and guidelines, as well as their contract, and how well the plans have operationalized these requirements. They also enable the Department to identify potential problem areas or areas in which plans can make improvements. Reviews focus on aspects of plan performance that can't be readily monitored from plan reports. They provide an opportunity to evaluate marketing, provider credentialing, enrollment and disenrollment practices, grievance and appeal processes and the plans' QA programs. Additionally, a random sample of care management records is reviewed for completeness, timeliness of service delivery, consistency with the plan's practice guidelines and service authorization criteria and processes.

Recent Performance Review Findings

The most recent series of performance reviews found that, overall, plans were performing satisfactorily and, with few exceptions, services continue to be well managed and delivered appropriately. Plan staff at all levels exhibit high levels of commitment and dedication to the provision of quality services to their members. In instances where problems were identified, the plan was required to propose and implement solutions to the problems through either the development and submission of corrective action plans (CAPs) or other mechanisms. Below is a summary of the findings noted.

- **Governance and Management Services**

A few plans have yet to completely work through issues surrounding governance and relationships with parent organizations and management contractors, as well as formal consumer participation. These issues must be completely addressed for plans to receive a certificate of authority (COA).

- **Enrollment and Disenrollment**

A few plans have been directed to develop and implement CAPs to address problems associated with patterns of enrolling members who have relatively low-level care needs. Others were directed to change their enrollment policies regarding application of eligibility criteria for plan enrollment, as well as processes and procedures for handling applications from individuals who do not meet eligibility criteria as defined in the MLTCP/State contract.

Disenrollment issues centered largely on plan practices that sometimes resulted in delays in the processing of disenrollments requested by members.

Perhaps the most serious finding, one plan was required to develop a CAP to address the disenrollment of higher cost/higher utilizing members.

- **Care Management**

Care management activities are at the very heart of managed long-term care and processes have continued to improve as plans have matured. Most of the issues found during operational reviews relate not to actual care management, but to its documentation, and how the care management is reflected in the written care plan and/or service authorization provided to members.

- **Quality Assurance**

Plans continue to make excellent progress with their quality assurance and performance improvement programs. However, the next step for many is to further develop the ability of their quality assurance/review committees to move from a largely case-specific approach to a system-wide plan focus, using plan-wide information to evaluate overall plan activities and operations. The QA committees, based on their findings from this larger review, will be expected to develop recommendations that will result in general improvements, applicable to all members.

- **Compliance with Federal Regulations**

As previously discussed, new federal regulations at 42 CFR 438 resulted in significant changes in MLTC plan operations. To further complicate matters, in certain cases, federal regulations had to be "cross-walked" against New York regulations, with federal regulations precedent in some instances and state regulations in others. It has taken the plans some time to develop their own policies and procedures consistent with the new regulations and to adapt their existing systems. Initially, some plans were slow to operationalize new requirements. However, in recent months plans have accelerated their activities in this area and the Department expects nearly full compliance during the next review cycle.

State Complaint Investigation Process

The Department encourages plans and members to resolve problems through the plans' internal grievance systems. However, members are advised, in the member handbook, the New York State Managed Long-Term Care Consumer Guide and the Department's website that they also have a right to complain directly to the Department though a direct toll free telephone number.

Depending on the severity of the complaint, it will be investigated by the Department or forwarded to the MLTC plan for self-investigation with follow-up by the Department. If the complaint is substantiated, corrective action is required and implementation of the corrective action(s) monitored by the Department.

During the years 2003, 2004 and 2005, the Department received an average of 31 complaints about MLTC plans each year. Complaints from a variety of sources (members, family members/care givers, local departments of social services, plan staff, etc.) were received for 12 of the 16 MLTC plans.

Approximately 40% of the complaints were judged to be of such potential seriousness that they were investigated directly by Department staff.   Of these complaints slightly more than 1/3 were substantiated and the MLTC plan was required to develop and implement a corrective action plan (CAP) approved by the Department. In only one instance has the Department found a condition, based on a complaint, sufficiently serious to warrant the Department's issuance of a statement of deficiencies to the plan.

The remaining 60% of complaints received were referred to the plans for self-investigation, with their findings to be reported to the Department. The plans themselves substantiated the complaints in approximately 1/3 of the cases – the same percentage substantiated by the Department when it investigated directly. In most instances in which a complaint was substantiated, the plan was required to submit a written CAP.

Other State Monitoring

● **Performance Improvement Projects**

   Annually, since 2003, each MLTC plan has been required to conduct at least one focused study/project designed to result in a major improvement in Plan operations. Island Peer Review Organization (IPRO) staff has assisted plans in this process by providing on-going technical assistance. Studies have included the following:

   - improving medication compliance;
   - identifying and reducing sudden unexpected weight loss;
   - improving management of shortness of breath;
   - improving diabetes testing and control;
   - reducing the number of ER and hospital visits due to congestive heart failure;
   - increasing the number of annual eye exams among enrollees;
   - reducing the number of pressure ulcer among members;
   - improving diagnosis and treatment of osteoporosis;
   - increasing screening for and treatment of depression;
   - improving pain management, and
   - increasing the number of enrollees with health care proxies.

7. CONSUMER SATISFACTION

Consumer satisfaction can be a key indicator of the quality of care provided by the managed long-term care plans.   Plans and the Department can assess satisfaction through the review of:

- plan-administered consumer survey data;
- grievance and appeal data collected by the plans and submitted to the Department quarterly, and:
- data on disenrollments initiated by members (collected by the plans and submitted to the Department semi-annually).

Consumer Satisfaction Surveys

Every MLTC plan in New York State conducts at least one consumer satisfaction survey of its enrollees each year. Most plans perform an annual survey of all enrollees, while several conduct surveys more frequently (semi-annually and/or quarterly) on a sample of enrollees. In addition to surveying members, many plans survey family members as well, to get a sense of how they perceive the MLTCP. In the upcoming year, the Department will work with MLTC plans and the Department's external quality review organization to develop a standardized consumer survey instrument appropriate for the MLTC population.

A large MLTC plan in New York City with a large visually impaired enrollment conducts its survey via telephone; the other plans use written surveys. The majority of the written questionnaires are translated into Spanish, as well as English. However, some plans with large non-English speaking enrollments also translate surveys into other languages such as Korean, Chinese and Russian. The telephone survey was conducted in English, Spanish and Russian. Survey response rates vary widely. As would be expected, the response rate to the telephone survey, at 78%, is the highest. The average response rate is in the 35% to 45% range.

While most of the consumer survey data collected by the plans do not meet rigorous statistical requirements, they provide valuable insight about general levels of satisfaction and specific information about various elements of plan operations. While survey questions vary among plans, there is generally a small set of common questions relating to overall satisfaction with the MLTCP, willingness to recommend the plan to others, improvements in health since enrolling in the plan and benefits from joining a plan.

Based on the most recent surveys, enrollees' satisfaction with their plans continues to be relatively high. On average, the majority (90%) of enrollees rate their plans' overall performance from good to excellent – with satisfaction rates ranging from 75% to 98%. When plans ask members would they recommend the MLTCP to others, approximately 80% indicate that they would. And when plans ask members if they feel they have benefited from plan membership or whether

they feel their health has improved since they joined the plan the response is 85% positive.

The issues that MLTC plan members across the state continue to be less pleased with are generally consistent among plans. For many of the plans with Adult Day Centers, quality of meals/food ranks lowest. Survey questions about transportation arrangements also often elicit less positive responses from members. There are, however, two other areas that are worth noting. Members of several plans ranked their ability to gain telephone access to plan staff on nights and weekends less positively than other survey elements. And in some plans, communication/collaboration between the plan and members also surfaced as an area where there was room for increased member satisfaction.

Grievances and Appeals

Grievances and appeals are perhaps the best expressions of member dissatisfaction because they provide immediate and 'real time' information from enrollees about their perception of their care and services.

Both PACE organizations and partially-capitated MLTC plans identify all expressions of dissatisfaction about the plan as grievances. If an enrollee files a grievance with the plan, and the plan makes a decision about the grievance that is not in the participant's favor, the member may file an appeal of the grievance.

In the partially-capitated plans, grievances that can be resolved to the enrollee's satisfaction the same day they are lodged are called "same day grievances." This type of grievance is primarily the result of a telephone call by an enrollee or a family member. Grievances that can't be handled to the enrollee's satisfaction the same day become "standard grievances" that must be acknowledged in writing by the plan (Note: all PACE grievances, regardless of their source and disposition, require a written response from PACE staff.)

Both types of MLTC plans are required to maintain grievance logs and to use the data they collect as part of their quality improvement process. They are also required to report this information to the Department (and in the case of PACE organizations, to CMS as well).

Grievances

The majority of all grievances in both plan types relate to the delivery of in-home services by a home health or personal care aide. In the partially-capitated MLTC plans, 49% of same day grievances relate to in-home care, and in the PACE organizations, these reasons account for 48% of all grievances. Transportation issues are the next largest category of grievances for both groups - 26% of the same day grievances in the partially-capitated MLTCPs and 15% of the PACE grievances. Quality of services (i.e., not related to home care or transportation) ranked third in terms of overall grievances in both plan types – 9% in the partially-capitated plans and 16% in the PACE plans. (One might expect this

higher rate of dissatisfaction among the PACE participants since the PACE organization covers a much wider range of services). The remaining grievances in both plans are related to such issues as plan operations, staff attitudes, care management, communication with staff, etc.).

As previously indicated, in the partially-capitated MLTCP, if the grievance can't be resolved to the member's satisfaction, it becomes a standard or expedited grievance, which requires a written acknowledgement by the plan. A grievance will be expedited if there is a situation that may jeopardize the member's health or safety. There were far fewer of these grievances: there is a 6 to 1 ratio between same day grievances and standard/expedited grievances.

The majority (71%) of the standard grievances was decided in the member's favor.

There were 5 expedited grievances in the partially-capitated plans in 2005; all were resolved in the member's favor.

Appeals

In the PACE, if the member is not satisfied with the plan's decision about a grievance he or she may file an appeal. In most cases, PACE appeals were about the amount or frequency of services. In CY 2005, there were 24 appeals lodged by PACE participants.

A member may file an appeal when a partially-capitated MLTC plan either disapproves a member's request for a new service provided it is a covered benefit of the plan or the plan initiates a reduction, suspension or termination of service the member is already receiving. In 2005, there were 35 appeals initiated by enrollees – 27 appeals were decided in favor of the member and in the remaining 8 appeals, the plan found the services were not medically necessary. In these cases, the members were notified of their right to a Medicaid Fair Hearing and/or an External Appeal through the New York State Department of Insurance.

Disenrollments

Enrollment in managed long-term care is voluntary. Consequently, information on the number of and reasons for disenrollments requested by enrollees from the plans can be a potentially useful indicator of consumer satisfaction.

Disenrollment data are submitted by the plans to the Department at six (6) month intervals. These data fall into two general categories: individuals who voluntarily left the plan and individuals who were involuntarily disenrolled by the plan. Information on deaths among plan members is collected as well.

In CY 2005 there were 1,250 disenrollments reported by all MLTC plans. Voluntary disenrollments accounted for 78% of total disenrollments; 22% of

disenrollments were involuntary. There were 968 deaths among MLTC plan members during the same period.

Voluntary disenrollment reasons encompass a range of possibilities; for example, moving outside of the plan's service area, joining another Medicaid program, etc. However, four of the possible disenrollment categories are better indicators of possible dissatisfaction with a plan. Two are clear cut – "dissatisfaction with quality of services provided" and "dissatisfaction with the quantity of services provided" -, which accounted for 4.5% and 1.6% of voluntary disenrollments, respectively. The remaining two reasons, "did not like being locked in to the provider network: and "did not like the approval process" may be more indicative of a general dislike of managed care and accounted for 68.8% and 4.9% of voluntary disenrollments, respectively.

Over 90% of all involuntary disenrollments are initiated by MLTC plans because the member no longer meets the criteria for enrollment in the plan (i.e., they have moved out of the plan's service area, left the service area for over 60 days or are hospitalized for more than 45 days). Twenty- three members were disenrolled by plans because they failed to pay their Medicaid spend-down surplus or because they exhibited such abusive or disruptive behavior that it was no longer possible for the plans to continue providing the member with effective and quality services.

8. RATE SETTING METHODOLOGY AND FINANCIAL STATUS OF PLANS

Capitation Risk Model

One of the innovative aspects of the MLTC demonstrations is the use of an insurance or "risk" model where plans are paid a predetermined amount per member per month (PMPM), referred to as the monthly capitation rate, and in return must manage and pay for all services included in the benefit package. Different capitation rates are paid for an enrollee depending on age category (generally 21-64 and 65+ for the partial capitation plans and 55+ for the PACE plans). The monthly capitation rate is intended to cover the costs of all medical services in the benefit package, as well as the care management and administrative costs of the plan. Capitation rates are set on an annual basis. This has been the mechanism for establishing Medicaid capitation premiums for the State's managed long-term care program since its inception.

Federal and State Requirements

Since the start of the demonstration program, capitation rates for MLTC plans have been subject to both state and federal requirements regarding payment levels. Section 4403-f of the Public Health Law requires that Medicaid capitation rates reflect savings when compared to the cost of providing comparable services on a fee-for-service basis to an actuarially equivalent non-enrolled population. Until 2003, federal regulations for the partial capitation plans required that no plan be reimbursed more than what it would have cost the State to provide State Plan-approved services to an equivalent non-enrolled population group. This is referred to as the Upper Payment Limit (UPL). New federal regulations effective in 2003 changed the requirements for partial capitated plans, as will be described later in this section. These federal and state standards are intended to ensure that New York's MLTC program is cost-effective for the state and federal governments.

The Department has met federal regulatory requirements, as well as the state statutory standard, by determining annual UPLs based on historical Medicaid fee-for-service costs of an actuarially equivalent non-enrolled population group: all Medicaid long-term care recipients under fee-for-service who are nursing home certifiable. For actual enrollment into an MLTC plan, a person is determined as nursing home certifiable if he or she has a score of 60 or more on the DMS-1 assessment form completed for the individual as part of the enrollment application process. Since the DMS-1 is not used in many long-term care fee-for-service programs, the Department has had to use a proxy for determining nursing home certifiability to construct an appropriate fee-for-service population for the purposes of calculating the UPL. The proxy employed is any Medicaid recipient who incurred long-term care expenditures for at least four continuous months. This would include all residents in nursing homes, and individuals receiving a minimum dollar amount of long-term care services in the community for four or more consecutive months. The result of using this proxy is

that almost half of the individuals identified as nursing home certifiable in the UPL are nursing home residents and half are community-based long-term care recipients.

People who are in nursing homes are not eligible to enroll in MLTC plans, although an enrollee who comes to need nursing home care remains enrolled. As of September 30, 2005, the average percent of MLTC plan enrollees in nursing homes was 7.3%, with a range of 0% to 23.4%. Because the proportion is so much less than in Medicaid Fee-for-Service, the Department has had concerns about the appropriateness of the UPL for rate setting purposes.

Federal Regulatory Changes and Their Impact on Rate Setting

Effective August 2003, federal regulations issued by the Centers for Medicare and Medicaid Services at, 42 CFR 438.6, require that states use a prescribed method and process to determine the actuarial soundness of MLTC plan Medicaid reimbursement rates. The new regulations require that for partial capitation plans, the state must obtain an independent actuarial certification of the plans' capitation rates in lieu of a UPL test. PACE organizations are not subject to these new federal regulations, and must continue to meet the Upper Payment Limit test as described above.

The Department has contracted with an actuarial firm to meet the requirements of these new federal regulations. The new regulations allow the use of actual service utilization and cost data from the plans as well as fee-for-service data to evaluate the actuarial soundness of the rates. The Department's independent actuary has certified all partial MLTC plan rates as actuarially sound based upon this approach.

For PACE plans, which are not affected by these new regulations, the rates continue to be subject to the UPL test based on the fee-for-service population of nursing home certifiable individuals.

Plan-Specific Premium Development

Although all plans' capitation rates are subject to the federal and state requirements described above, individual rates are developed for each plan. Generally, each plan submits a premium rate proposal and operational budget based on its specific network of providers, target population, and benefits covered. The plan must project enrollment levels, and identify the type and amount of services that will be provided to its enrollees in the upcoming rate period. This plan specific budget reflects each plan's approach for managing care and providing services, and provides benchmarks for evaluating actual plan performance.

Plan proposals are reviewed and plans have the opportunity to discuss all assumptions with Department staff before the rates are established. All capitation rates are subject to approval of the State Division of the Budget.

The individual plan premium proposal review process provides the opportunity to address each plan's changing enrollee health status, care planning and coordination policies, and service delivery network. Unlike many other states, where rates are set as a prescribed discount off the UPL, New York has relied on a more interactive and plan-specific process for ensuring that the capitation rates are sensitive to the plans' financial needs and their unique programmatic features. While this is a labor-intensive process for the State and the MLTC plans, it results in a payment system that is, in fact, risk-adjusted based on the individual delivery systems and populations served by each plan. A few plans have advocated for a different rate methodology in which payment would be "risk-adjusted", although they have not suggested or demonstrated which variables or enrollee characteristics correlate to or better predict the cost of providing care. In fact, most risk-adjustment methods currently in use are based on the enrollee's diagnosis and are used to predict the cost of providing acute care medical services not included in the benefit package for partially capitated MLTC plans. There are many open questions about how or whether to risk-adjust the long-term care portion of Medicaid services and reliable equitable data is a key challenge.

For rates effective in 2006, the premium proposal process is not being used. Instead, the Department has developed trends that will be applied to the 2005 rates.

Financial Performance of Plans and Cost Effectiveness for New York State

Overall Plan Financial Performance

Overall, the MLTC plans are operating profitably and financial performance has improved over the years. In 2004, for example, twelve plans had an operating surplus and three plans reported losses, two with losses of less than 1% of their revenue. Based on the latest data available for 2005 (through September), this pattern has continued. Twelve of the fifteen plans have reported a surplus for this period, with an overall statewide average surplus, of $36 million, or 7% of premium. The three plans reporting losses were all very small, with 77, 302 and 316 enrollees, respectively, as of September, 2005.

The financial performance of managed long-term care plans has improved considerably since the early days of the program. By contrast, in 2001 only nine of the fourteen plans operated profitably and in 2002 only six of fourteen plans reported a surplus. This improvement has occurred for several reasons:

- Increases in capitation premium paid;
- Increased efficiency controlling and allocating administrative and care management costs, and
- Increases in enrollment.

With Medicaid premium revenues increasing modestly by 9% from 2001 to 2005, the primary reasons for the improved financial performance are enrollment growth and increased plan efficiency, as evidenced by administrative and care management costs that have declined on a combined basis by over $325 per member per month (pmpm).

Effect of Enrollment Growth on Administrative Cost and Plan Net Worth

Total enrollment growth across both models has been slow but steady overall. Enrollment was 8,500 at the start of 2003. As of February 2006, enrollment is 14,822, a growth of roughly 20% per year. Growth has varied by plan; over 75% of total enrollment is in four plans, and for a few plans enrollment has remained relatively flat or even declined.

Small MLTC plans still have prohibitively large overhead costs. Plans with extremely low enrollment are simply not financially viable in the long term, not only because the fixed overhead cannot be supported by such low enrollment, but also because with low numbers of enrollees, a single enrollee can affect the plans overall average medical cost significantly.

Currently, administrative cost averages $350 pmpm, a 30% reduction from the $500 average pmpm in 2001. PACE organizations are significantly more expensive, with an average administrative cost of $538 pmpm, versus partial plans at $312 pmpm. There is evidence from new plans and applicants that even the $312 pmpm amount can be reduced significantly, by as much as two-thirds, for larger plans.

The overall net worth of the four plans with 75% of total MLTC plan enrollment has increased dramatically over the last four years. The largest plan has more than doubled its net worth from $25 million in 2001 to $64 million as of September 2005. The second largest plan increased net worth from $2.5 million to $24 million. The third and fourth largest plans also have dramatic increases in net worth. The remaining smaller plans show much less dramatic changes in net worth over this time period. This again demonstrates the importance of plan size.

PACE versus Partial Capitation Plan Results

Financial results have varied between the partial MLTC plans and the PACE organizations. Medicaid premium revenue pmpm has increased modestly for all plans; 9.5% for partial plans and 8.5% for PACE plans, from 2001 to 3rd quarter 2005. However, PACE plans have also received a 61% increase in Medicare pmpm revenue during this same period, whereas partial plans do not receive Medicare capitation.

Partial plans and PACE plans had similar changes in medical costs; a 15% increase for partial and 17% for PACE. Interestingly, even without Medicare

revenue, the partial plans increased their average pmpm surplus from $12 in 2001 to almost $300 in 3rd quarter 2005. This is due to a 38% reduction in pmpm administrative costs, and a 25% reduction in care management costs. PACE plans on the other hand, <u>increased</u> their administrative cost by 12%. As a result, even with a $720 pmpm increase in Medicare premium, their average surplus only went from $47 to $219 pmpm. Even for the largest PACE organization, enrollment growth has not resulted in expected economy of scale. Administrative cost pmpm for the largest plan is comparable to all but the smallest PACE.

Enrollment in partial MLTCPs increased much more than for PACE organizations. Partial plan enrollment increased by 150% from 2001 (4,551 to 11,346) versus a PACE increase of only 42% (1,629 to 2,309). The PACE model by definition is limited to the capacity at the PACE day centers and results suggest that growth is more difficult and efficiencies not as attainable for this model.

Cost Effectiveness of the Managed Long Term Care Program for New York State

From the State's perspective, the cost-effectiveness of the MLTC program can be evaluated by comparing the MLTC plan capitation cost to the Medicaid fee-for-service costs for an actuarially equivalent population. Since the program's inception, the State has annually made this comparison by comparing rates to the fee-for-service Upper Payment Limits (UPL). Using this data, the Medicaid program is not paying more for its MLTC program than it would have paid for these individuals under fee-for-service had there been no such program. However, this determination has relied on a proxy for defining an actuarially equivalent fee-for-service population - nursing home certifiability criterion based on receiving four consecutive months of a minimum amount of long-term care services, of which half are in nursing facilities. To the extent that this proxy population is not reflective of the population actually enrolled in MLTC plans, which only has 7.5% of enrollees in nursing homes, the cost-effectiveness test may not be fully appropriate.

The revised Part 438 regulations allow states more flexibility in developing partial capitation plan premiums that are not exclusively based on fee-for-service costs, but can reflect actual plan costs. The Department's actuarial consultant has attested that the partial and PACE rates are actuarially sound. However, the Department remains concerned that continued enrollment growth is needed to defray the sizable overhead reported by these programs ($650 per member per month for partial MLTC and $812 per member per month for PACE) and to help ensure the cost-effectiveness of these models.

9. RECOMMENDATIONS AND FUTURE ACTIVITIES

In 2003, the Department submitted an Interim Report to the Governor and the Legislature on the MLTC program. In that report, we indicated that the program was growing slowly but steadily and that plans were providing high quality service with high levels of client satisfaction. This remains true today. Both MLTC models provide coherent systems of long-term care services, care coordination and social supports. Plan services and operations are developed around patient requirements and preferences. Plans arrange for a wide range of clinical services, backed by support services. All services are coordinated through the plans' care managers who serve as a central point of contact for providers.

The Department's Interim Report also indicated some concern about the cost effectiveness and financial vulnerability of managed long-term care plans, largely due their small size. Since that time, plans have made important strides in implementing effective marketing and growth strategies and reducing administrative costs. Further efficiencies are necessary to ensure plan viability on an ongoing basis and cost-effectiveness for the State.

Overall, the MLTC industry has operated profitably and financial performance has improved. In 2004, eleven of the plans operated profitably with four plans reporting losses. Of the four plans operating at a loss, two of the plans reported very small losses of less than 1% of their revenue. Based on the latest data available for 2005, plans have continued to operate profitably, with twelve of the fifteen plans reporting surpluses

We believe that MLTC provides a coordinated system with the potential for allocating resources effectively and efficiently. It permits plans and providers to place a greater focus on prevention and offers consumers another long-term care choice. To fully realize this potential, the Department believes the following elements to be important as the program moves forward:

- Continued Enrollment Growth

As pointed out throughout this Report, enrollment in MLTC plans has increased by about 20% per year since 2003. Most of this growth has occurred in large partially-capitated plans. Based on New York's experience and the experience of other States', we anticipate that enrollment in PACE plans will remain relatively small. While an attractive care model for some and of interest to MLTC applicants, PACE does not have the large-scale replicability needed to bring coordinated integrated care to large numbers of recipients. Likewise, we believe that a number of partially capitated MLTC plans will struggle to increase enrollment. Years of experience with the MLTC program have now shown that a plan's ability to grow enrollment is critical to its ability to establish sound operational systems, its long-term financial viability and its ability to be cost-effective. As the MLTC program moves forward, we believe that strategies to

grow individual plan enrollment need to be developed. One strategy currently being implemented is streamlining of the enrollment process. The Department has worked with the New York City Human Resources Adminstration to develop a new process that transitions HRA's application review process to a post enrollment audit activity. This change should significantly reduce enrollment processing time.

Also, as we look at the clear relationship between enrollment and financial viability, another strategy is to encourage the partnership of larger insurers with smaller MLTC plans to provide an integrated long term care benefit, which promotes more cost effective overhead, yet maintains the expertise developed by the MLTC plan in serving the nursing home certifiable population.

- Better Integration of Medicare and Medicaid Financing

The integration of Medicare and Medicaid services and financing was an integral element of the MLTC authorizing statute. At the time the legislation was enacted, the only vehicle for achieving integration other than PACE program was to seek a federal waiver, a process that often took years. The Medicare Modernization Act now provides another avenue to achieve integration through Medicare Special Needs Plans. Working with several of the larger MLTC plans, the Department is in the process of developing a model in which the MLTC plans would participate in both the Medicare and Medicaid programs and provide dually-eligible persons comprehensive care including acute and long-term care services. This important change at the federal level promises to positively impact the cost effectiveness of the MLTC program, improve care coordination and provide new opportunities for enrollment growth.

- Assessment Tools Must be Improved

The development of a tool to reliably assess the care needs of enrollees continues to challenge New York and other states as well. The Department is one of five states selected by the Centers for Health Care Strategies (CHCS) to receive a grant for its Integrated Care Program initiative. With the support of the grant and in cooperation with the MLTC plans, the Department will develop an improved assessment tool to assess enrollees' care needs and for potential use in identifying those factors that correlated with the cost of providing services to members.

- Continued Refinement of Data Collection and Analysis

Since the Interim Report, tremendous strides have been made in replacing manual data collection and reporting systems used by the MLTC plans with standardized electronic data systems similar to those used in the Medicaid Managed Care Program to monitor the quality, appropriateness of service delivery and to support capitation rate setting. As both the Department and the

MLTC plans gain experience with these new systems, the data that they produce will help direct and improve the program.

- Quality Outcome Measures Must Be Developed Specific to the MLTC Population

For over a decade, the Department has led the nation in measuring and reporting quality for the Medicaid Managed Care program. Most of these measures are based on HEDIS measures and focus on acute care and preventive services not currently provided by partially capitated MLTC plans. As the MLTC model develops, it will be critical to develop measures that allow for the measurement and comparison of quality provided by MLTC plans.

- DOH Monitoring Must Continue and Be Enhanced

The Department must continue its efforts to enhance its oversight and monitoring of MLTC plans. New federal and state regulations, as well as the addition of new plans and models, will place additional demands on these resources.

To allow the Department and MLTC plans to continue to develop these models, we look forward to extension of the legislation that authorizes the Managed Long-Term Care Program. With recent federal changes promising new flexibility in achieving the goal of truly integrated care models, we believe that the next three year period will be pivotal in terms of shaping the managed long-term care program as a key part of the State's long-term care reform initiative.

NEW YORK STATE INSURANCE DEPARTMENT'S REPORT ON MANAGED LONG-TERM CARE

Section 4403-f of the New York State Public Health Law (PHL) gives the Superintendent of Insurance (Superintendent) certain regulatory responsibilities for managed long term care plans. Those responsibilities include regulation of enrollee contracts, premium rates and fiscal solvency. As stated in Section 4403-f 4.(a) of the PHL, the Superintendent oversees fiscal solvency regulation in consultation with the Commissioner of Health (Commissioner). As stated in Section 4403-f 4.(c) of the PHL, the Superintendent determines premium rates for managed long term care plans except where the Commissioner establishes payment rates for services provided to enrollees eligible under Title XIX of the federal Social Security Act (Medicaid). In establishing Medicaid payment rates, Section 4403-f 8. Of the PHL states the Commissioner must consult with the Superintendent. Section 4403-f 4.(a) of the PHL indicates the Superintendent regulates enrollee contracts, and enrollee contract regulation is done in coordination with the Commissioner because managed long term care plans enroll Medicaid, Medicare and private pay populations. The Superintendent (along with the Commissioner and Director of the State Office for the Aging) also has a role in regulating managed long term care plan marketing materials pursuant to Section 4403-f 7.(c)(ii) of the PHL. Certain regulations of the Health Department (in Title 10 NYCRR, Subpart 98-1, which took effect on June 29, 2005) describe regulatory responsibilities of the Superintendent for managed long term care plans.

Solvency

The Insurance Department continues to recommend specific financial solvency requirements for managed long term care plans, developed within the confines of Section 4403-f 4. of the PHL, to the Commissioner. The Insurance Department's financial solvency requirements are based upon the coverage arrangements that will be offered to the specific disabled population served by the managed long term care plan, as well as revised requirements of Subpart 98-1.11(f) of Health Department regulations as follows:

1. A "partially-capitated" managed long term care plan that serves a population composed of individuals that are covered by the Medicaid program solely for the services mandated for a managed long term care plan (these do not include hospital and/or medical coverage); or
2. A "fully-capitated" managed long term care plan where the managed long term care plan covers hospital and medical services as well as the services statutorily mandated for the managed long term care plan.

The financial solvency requirements are based upon the managed long term care plan applicant's financial projections that are submitted to the Health Department for the determination of the capitation premium for the program. These same financial projections are used to determine the initial solvency requirement. This is calculated as follows:

- The accumulated operating deficit until the projected break-even month,
- To that amount, the Insurance Department adds the calculated escrow deposit

account per the requirements of Subpart 98-1.11(f) of Health Department regulations. This escrow account shall be equal to the greater of (i) 5 percent of the estimated expenditures for health care services for the calendar year of operations; or (ii) $100,000. This requirement is consistent with the June 29, 2005 amendment to Subpart 98-1 of Health Department regulations.

A majority of the approved managed long term care demonstrations will continue to meet the revised financial solvency requirements and maintain their respective unimpaired financial condition. However, the Insurance Department will consider, in accordance with the requirements of Subpart 98-1.11(f)(3), a managed long term care plan's request to reduce its escrow requirement up to 50 percent, based on the financial condition of the plan.

It does appear that the most successful approved managed long term care demonstrations are those that have sponsoring organizations that have a significant disabled population network that they can direct to the services of their affiliated managed long term care plan. Those managed long term care plans that do not have a readily available network of potential membership must expend, at times, significant marketing expenses to obtain new members.

Finally, educating managed long term care plan management in the concept of maintaining adequate capitalization to cover underwriting risk has shown positive results since the last report. Some applicants were initially reluctant to accept such a concept, inasmuch as they were accustomed to receiving Medicaid fee-for-service reimbursements for serving the disabled population as a service provider, not as a managed care organization that had to assume certain underwriting risks. However, we can credit the managed long term care plans for their efforts at understanding, and continued acceptance of, the financial solvency criteria the Insurance Department has established.

Enrollee Contracts

All managed long term care plan members receive enrollee contracts. The enrollee contract document sets forth the rights and obligations of the plan and its members.

The Insurance Department reviews the proposed enrollee contract, and comments are provided to the Health Department when the enrollee population consists solely of persons eligible for Medicaid. In certain instances where a plan allows a small population not eligible for Medicaid to pay full premium for coverage, the Insurance Department has approved necessary modifications to the enrollee contract making it appropriate to use with a private pay population.

With the effectiveness of the federal Medicare prescription drug benefit on January 1, 2006 (Medicare Part D), certain changes were made to the benefit package offered by managed long term care plans. Certain benefits became covered under Medicare Part D and/or fee-for service Medicaid. Due to these benefit package changes, the Insurance Department has been involved in the review of revisions to the enrollee contract language of managed long term care plans.

The Insurance Department reviews enrollee contracts to ensure they contain accurate, factual, clear and consistent language. Insurance Department review of enrollee contracts focuses on issues related to compliance with Section 4403-f of the PHL, 42 Code of Federal Regulations Part 438, 42 Code of Federal Regulations Part 460 and other pertinent federal and New York State statutes and regulations.

Rates

Pursuant to Section 4403-f 8. of the PHL, the Insurance Department has consulted with the Health Department in the formulation of the Medicaid rate capitation methodology (Medicaid rate methodology) applied to managed long term care plans. Input from the Departments of Health and Insurance and interested plans focused on issues concerning the components to be used in developing the Medicaid rate methodology, specifics of the rates for new plans and work plans under which existing managed long term care plans would transition to the Medicaid rate methodology. The Departments of Health and Insurance consult as necessary on an ongoing basis concerning any revisions to the Medicaid rate methodology.

As previously noted, some plans enroll a small number of participants not eligible for Medicaid who pay a full premium for coverage (a maximum of 10 private pay enrollees is permitted in a managed long term care plan). The premium to be paid by this private pay population requires approval by the Insurance Department. The Insurance Department had received private pay rate submissions for six plans as of December 31, 2005, and had approved rates for all six plans.

Marketing Materials

Pursuant to Section 4403-f 7.(c)(ii) of the PHL, the Insurance Department along with the Health Department and the State Office for the Aging reviews plan marketing materials. The Health Department receives the marketing materials from the managed long term care plans and coordinates the review of the marketing materials among the three state agencies.

During the review of plan marketing materials by the Insurance Department, issues often arise about the accuracy or appropriateness (in relation to enrollee contract language) of marketing material language. The Insurance Department prepares written comments about those issues indicating that the enrollee contract is the legally binding document between the managed long term care plan and the enrollee. As the legally binding document, the enrollee contract serves as the template for marketing material accuracy. Insurance Department review
of marketing materials also evaluates their accuracy and appropriateness in relation to the requirements of federal regulations for partially capitated or PACE managed long term care plans as pertinent.

Marketing material review often includes the examination of managed long term care plan annual marketing goals. These annual marketing goals often include targets for numbers of enrollees and/or plans for expansion to other geographic service areas in New York State. Receiving this information in the review of marketing plans aids the Insurance Department in ascertaining when updates to enrollee contracts or updates to rate and fiscal solvency matters are necessary.

<u>Other Activities</u>

Pursuant to Section 4403-f 6.(e)(f) of the PHL, the Insurance Department has entered into twelve written agreements with approved managed long term care demonstrations about matters to be regulated by the Superintendent. These written agreements identify certain Insurance Law statutory sections to which the plans must adhere. An example of such a statutory section is Section 308 that requires provision of special reports to the Superintendent when necessary. Another example is Section 3224-a that requires cooperation by the plan with the Superintendent to resolve consumer complaints according to a Section 3224-a timeframe (where applicable). Further examples of Insurance Law statutory sections include the possibility of a Section 1307 loan for a plan, either for initial capitalization purposes or upon a determination of impairment, and the applicability of Insurance Law Article 74 concerning rehabilitation or liquidation when necessary.

Since the enactment in 1997 of the Long-Term Care Integration and Finance Act, the Insurance Department has participated in many meetings and conference calls. Initially these meetings and calls (including calls with federal staff, individual plans and organizations seeking to become managed long term care plans) required Insurance Department presence to explain the requirements of Section 4403-f of the PHL with respect to matters regulated by the Superintendent. More recently these meetings and calls have included exchanges with the Health Department and certain managed long term care plans about contract and financial issues and interactions with the Health Department on the day to day issues involving managed long term care plan regulation. With the enactment of Health Department regulations affecting approved managed long term care demonstrations under Section 4403-f 6.(c) of the PHL, the Insurance Department has engaged in exchanges with the Health Department to be certain that the provisions of the Insurance Department written agreements with approved managed long term care demonstrations continue in force and effect when the approved managed long term care demonstrations are issued a certificate of authority as a managed long term care plan.

A considerable amount of Insurance Department staff time is expended on the exchanges noted above and on document review.

<u>Conclusion</u>

Since Chapter 659 of the Laws of 1997 was enacted, the Insurance Department has effectively implemented its role under Section 4403-f of the PHL in the regulation of managed long-term care plans.

For an almost nine year period of time, the Insurance Department has advanced the operations of managed long term care plans in New York State through the regulation of fiscal solvency, enrollee contracts, premium rates and marketing materials. The managed long term care plans over this nearly nine year time period have refined their business processes to comply with the standards set by Insurance Department review and regulation.

The Departments of Health and Insurance have also developed an excellent ongoing relationship to further the goals of having managed long term care plans in New York State which are financially stable and advantageous to consumers who participate in those plans. This relationship between the two Departments builds upon other areas of health insurance where both Departments share regulatory responsibilities based upon their respective areas of expertise.

Appendix 2

Managed Long Term Care Plans in New York State
Information Current as of January, 2006

New York City

Name/ Sponsor	Mailing Address/ Phone Number	Service Area by County	Age Requirements	Payment Accepted
CarePlus Connections (AMERIGROUP Corp.)	21 Penn Plaza 360 West 31st Street New York, New York 10001 (877) 692-8669	New York City (All boroughs)	21 and older	Medicaid
Comprehensive Care Management (Beth Abraham Family of Health Services)	612 Allerton Avenue Bronx, New York 10467 (718) 515-8600 (877) 226-8500	Bronx, New York (Manhattan), Queens Westchester and Kings (Brooklyn)	55 and older	Medicaid Medicare Private Pay
CO-OP Care Plan (Hebrew Hospital Home)	801 CO-OP City Blvd. Bronx, NY 10475 (888) 830-5620 (718) 678-1600	Bronx	21 and older	Medicaid
GuildNet (The Jewish Guild for the Blind)	15 West 65th Street 4th Floor New York, New York 10023-6694 (800) 932-4703 (212) 769-7855	Bronx, Kings (Brooklyn), New York (Manhattan) and Queens	21 and older	Medicaid
HomeFirst, Inc. (Metropolitan Jewish Health System)	6323 Seventh Avenue Brooklyn, New York 11220 (877) 771-1119	Kings (Brooklyn), New York (Manhattan) and Queens	65 and older	Medicaid

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Managed Long Term Care Plans in New York State
Information Current as of January, 2006

New York City

Name/ Sponsor	Mailing Address/ Phone Number	Service Area by County	Age Requirements	Payment Accepted
Independence Care System (Cooperative Home Care Associates)	257 Park Avenue South, 2nd Floor New York, New York 10010-7304 (212) 584-2500	Bronx, New York (Manhattan) Brooklyn	21 and older	Medicaid
Senior Health Partners (Mt. Sinai Hospital, Jewish Home and Hospital, Metropolitan Council on Jewish Poverty)	4 East 107th Street New York, New York 10029 (800) 633-9717 (212) 427-2600	New York (Manhattan)	55 and older	Medicaid Private Pay
VNS CHOICE (Visiting Nurse Service of New York)	5 Penn Plaza 11th Floor New York, New York 10001 (888) 867-6555 (212) 609-5600	New York City (All Boroughs)	65 and older	Medicaid

Name/ Sponsor	Mailing Address/ Phone Number	Service Area by County	Age Requirements	Payment Accepted
Comprehensive Care Management (Beth Abraham Family of Health Services)	612 Allerton Avenue Bronx, New York 10467 (718) 515-8600 (877) 226-8500	Bronx, New York (Manhattan), Queens, Westchester, Kings (Brooklyn)	55 and older	Medicaid Medicare Private Pay
Eddy Senior Care (Northeast Health)	504 State Street Schenectady, New York 12305 (518) 382-3290	Albany (Not all of county) Schenectady (Not all of county)	55 and older	Medicaid Medicare Private Pay
Elant Choice (Elant Inc.)	46 Harriman Drive Goshen, New York 10924 (877) 255-3678 (845) 569- 0500	Orange	21 and older	Medicaid Private Pay
Health Partners of New York (Long Island Home)	400 Sunrise Highway Amityville, New York 11701 (516) 336-2000	Nassau Suffolk	21 and older	Medicaid
Independent Living for Seniors (Via Health)	2066 Hudson Avenue Rochester, NY 14617 (585) 922-2800	Monroe (Not all of county)	55 and older	Medicaid Medicare Private Pay

Managed Long Term Care Plans in New York State
Information Current as of January, 2006

Rest of New York State

Name/ Sponsor	Mailing Address/ Phone Number	Service Area by County	Age Requirements	Payment Accepted
PACE CNY (Loretto Rest Nursing Home, Inc.)	Sally Coyne Center for Independence 100 Malta Lane North Syracuse, New York 13212 (877) 208-5284 (315) 452-5800	Onondaga	55 and older	Medicaid Medicare Private Pay
Partners in Community Care (Fidelis Care)	400 Rella Boulevard Suite 211 Suffern, New York 10901 (800) 688-7422	Orange Rockland	21 and older	Medicaid
Senior Network Health, LLC (Mohawk Valley Network, Inc.)	2521 Sunset Avenue, Utica, New York 13502 (888) 355-4764 (315) 624-4545	Oneida Herkimer	65 and older	Medicaid Private Pay
Total Aging in Place Program (Weinberg Campus, Inc.)	461 John James Audubon Parkway Amherst, New York 14228 (716) 250-3100 (866) 888-8185	Erie (Not all of county)	55 And older	Medicaid Private Pay