

The New Frontier: Social Programs for Older Adults and Managed Long Term Care Plans

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Several months ago, a well-established not-for-profit agency providing services to seniors in Manhattan received a phone call from one of the City's proprietary managed long term care plans; the plan wanted to contract for services. Not having had this relationship or experience before, the director was intrigued and asked the plan for more details.

The Managed Long Term Care (MLTC) plan representative focused his attention on the agency's senior center noting that the plan could contract with the center for day care services. The representative also inquired about the possibility of setting up an information table at the center to educate participants about the plan's offerings.

After years of budget cuts, the center director was excited about potential new revenue but cautious as to how it would fit in with existing City and State contracts. The senior center director had dozens of questions: Will the NYC Department for the Aging approve of contracting with MLTCs? How do I cost allocate between contracts? How frail are the seniors in managed long term care plans and what types of services will they need? Do we have the capacity and ability to serve this population? Do we want to serve this population? Soon, the center director realized that the answers to these questions required additional information and guidance.

Increasingly, community-based nonprofit providers of services to older adults are being approached by managed long term care companies to explore potential contracting relationships. In response to this new trend, United Neighborhood Houses (UNH) has created this primer: *The New Frontier: Social Programs for Older Adults and Managed Long Term Care Plans*. Its goal is to help nonprofit community-based organizations understand the origins of this trend and implications for the future.

The Director's story mentioned above is not unique. In fact, conversations between MLTC plans and senior service providers are occurring regularly across the City. MLTC plans are seeking to contract with social adult day care centers, home delivered meal programs and in some instances, Naturally Occurring Retirement Communities (NORC) as well as senior centers. Most providers knew that New York State's Medicaid program had recently been overhauled, but few were able to see that the calls from MLTC plans were indeed a direct result of the State's Medicaid Redesign effort.

Medicaid Before and After Redesign

For decades, providers that operate services like senior centers and home delivered meals programs, have seen themselves as part of the long term care continuum, playing an essential role in helping seniors stay active and engaged in the community. Although these providers recognize the role they play in preventing social isolation and avoidable physical and mental decline, they have not been a traditional recipient of Medicaid dollars through Medicaid's Home and Community Based Service system in New York, *until now*.

As a result of the recent Medicaid Redesign process in New York, upwards of 40,000 Medicaid personal care recipients receiving 120 days or more of long term care services¹ will be required to join a Medicaid managed long term care plan. With the prospect of enormous growth, plans are strengthening their

¹ Presentation: Managed Long Term Care: The Next Steps, from July 8, 2011 Managed Long Term Care Workgroup of the MRT

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provider networks in order to best meet the needs of this population. Socially-oriented aging services providers are now being considered as potential partners in this network.

In New York, managed long term care is not new; plans that address and coordinate the long term care needs of older adults and people with disabilities in the community have been operational since 1994². The history of this coordination, however, dates back even further, with the development of the On Lok program in 1983; On Lok was the basis for the nationally recognized and utilized PACE program (Program for All Inclusive Care). PACE and On Lok plans center service provision around an adult day care model and offer wraparound services like multidisciplinary care management, personal care and home delivered meals.

Medicaid Redesign, as it relates to NYC's personal care program, will have an impact on 1) who is getting reimbursed by the State for the delivery of Medicaid long term care services; 2) the model of reimbursement for those services and 3) the scope of services that are reimbursed.

First, New York City's Personal Care Program, administered by the Human Resources Administration (HRA), will no longer have a coordinating role in the delivery of long-term care services for Medicaid beneficiaries receiving over 120 days of personal care a year. HRA had been playing an instrumental role in managing these services for decades. Mainstream managed care plans (also known as Medicaid HMOs) and managed long term care plans are assuming this responsibility.

Second, not only will the responsibility of coordinating services shift from HRA to MLTCs, the model of reimbursement for those services will also change. HRA had been serving this population for decades using a Fee-for-Service (FFS) model of Medicaid reimbursement. The shift from a FFS model of reimbursement to a partially capitated model is significant. In a FFS model, there is no 'cap' on how many hours of personal care the individual can receive; the level and amount of services is solely determined by the assessment of need and plan of care for meeting that need. In a partially capitated model, the MLTC is reimbursed at a per member per month (PMPM) rate by the State. It is up to MLTC plan to determine how to spend this fixed amount of funding in order to meet the individual's needs. The partially capitated model incentivizes the plan to meet the client's needs in a cost effective manner, utilizing care management.

And finally, prior to the shift, HRA was only able to assess, care plan and authorize 'personal care' for the individual. In managed long term care, while an assessment and care planning is required, the care manager in the MLTC plan has more options than just personal care to offer the client in order to meet his/her needs. The care manager can arrange for and provide an array of services³; some of those services are less costly than delivering one-to-one personal care.

MLTC Plans in NYC

By the end of 2012, most dually eligible (Medicaid and Medicare) beneficiaries who receive over 120 days of long term care a year, will be required to choose a **managed long term care plan** for his/her long term care services. As of July 2012, in New York City, there are:

- 13 Managed Long Term Care Plans (MLTC)- partial cap
- 9 Medicaid Advantage Plans
- 2 Programs for All-Inclusive Care (PACE) Programs

² US Dept. of Health and Human Services, April 2005. *The Past, Present and Future of Managed Long-Term Care*. Found online at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

³ The MLTC Model contract allows for the provision of: Nursing Home Care, Home Care (Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Pathology, Medical Social Services), Adult Day Health Care, Personal Care, DME (including Medical/Surgical

The Appeal of the Aging Services Network

The existing network of thirteen MLTC plans, nine Advantage Plans, and two PACE programs in New York City will experience exponential growth over the next two-to-three years as a result of Medicaid Redesign. These plans will contract for an array of services, including some already offered through the community based aging services network. Clearly, contracting with an existing, well-established community based provider will become more attractive.

Just like in a mainstream health insurance plan, a managed long term care plan's ability to attract members, meet the needs and preferences of those members, and keep the members satisfied, is partially contingent upon the services and care delivered by its network of community based providers. For this reason, the aging services network supported financially and programmatically by the NYC Department for the Aging (DFTA) and NY State Office for the Aging⁴ (SOFA), is an ideal resource to tap. With the appropriate safeguards, existing socially oriented aging services like social adult day care centers, home delivered meals, and even senior centers, could be viable alternatives to or enhancements in providing one-on-one personal care.

While providing one-to-one personal care to support an individual in the community is a reliable way to ensure consumer satisfaction and safety, from a financial perspective it is not necessarily the most efficient approach to supporting a Medicaid beneficiary. Generally speaking, the upfront costs associated with individual one-to-one care exceed the costs of providing similar care in a group setting. Moreover, the Medicaid personal care program, as has been administered by HRA in NYC, was flagged as too expensive by the State during the Medicaid Redesign process.⁵ For these reasons, it is to a MLTC plan's advantage to seek out and contract for additional, potentially more cost effective options for meeting the long term care needs of its plan members.

Appeal of the Network

In addition to the tangible and measurable services it provides, the nonprofit aging services network of providers has other very valuable, less quantifiable resources that may be attractive to managed long term care plans:

- Existing infrastructure and facilities;
- Community capital;
- Expertise in serving the older adult population, and
- An existing client base of seniors.

Making the community based network of providers even more appealing to MLTCs is the recent emphasis on healthier food options in the senior centers and home delivered meals program, implementation of the Chronic Disease Self-Management Program, the Health Indicators program in the NORCs, and the increased emphasis on health and wellness programming in the Innovative and Neighborhood Centers.

Contracting with Managed Long Term Care Plans

Now at a crossroads, with a direction determined but a path only loosely defined, the opportunities, the risks, and ways in which this community based network builds partnerships with managed long term

Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear), Personal Emergency Response System, Non-emergent transportation, Podiatry, Dentistry, Optometry/Eyeglasses, Audiology/Hearing Aids, Respiratory Therapy, Nutrition, Private duty nursing, services provided through care management (home delivered or congregate meals, social day care, social and environmental supports).

⁴ http://www.nyc.gov/html/dfta/downloads/pdf/publications/annual_plan_2011_12.pdf

⁵ Page 75 of the presentation, Managed Long Term Care: The Next Steps, from July 8, 2011 Managed Long Term Care Workgroup of the MRT

care plans are only now emerging.⁶ New York State's *Managed Long Term Care Model Contract* defines the covered services, including home-delivered and congregate meals, social day care, social and environmental supports.⁷ UNH believes the services that can be most easily contracted out in this inventory are social adult day care slots and home delivered meals. Both have established per diem and per meal rates and relatively straightforward ways to cost allocate between funding streams; moreover MLTC plans have experience in subcontracting with these two programs. But DFTA and SOFA funded providers must consider some important factors before doing so:

Factors for Consideration for Home Delivered Meals

- Cost allocation for infrastructure
- DFTA contracted meal count
- Dietary guidelines for Medicaid recipients
- Health Insurance Portability and Accountability Act rules

Factors for Consideration for Social Adult Day Care

- Cost allocation for infrastructure
- Future Licensing of Social Adult Day Care (not currently licensed or certified)
- Guaranteed attendance to ensure overhead costs are met
- Staffing pattern (skill level, training, supervision, overhead)
- Level of care and supervision required to support population
- Transportation arrangements and payment
- HIPAA and ADA regulations

The NYC Department for the Aging has been actively exploring how its contractors can best interface with MLTC plans. In fact, DFTA has expressed an interest in convening a Best Practice forum with the goal of sharing lessons learned and developing guidelines for all providers. DFTA is in no way prohibiting providers from contracting independently with MLTC plans.

Spotlight on DFTA

Aging services providers and MLTCs traditionally have not worked closely together, but the pending changes present new opportunities. In this environment, DFTA is exploring ways it can help home delivered meals providers, senior centers and social adult day care providers partner with MLTCs and other similar programs. During the coming months, DFTA expects to make available resources that can guide providers who may want to learn more about developing partnerships with MLTCs. DFTA's efforts will in no way prevent providers from forging their own relationships directly with MLTCs, should providers prefer to work independently.

A range of community based aging services are not necessarily 'shovel-ready' for this new era of collaboration with MLTCs. Senior Centers are at the center of the debate. Can or should centers be contracting with MLTC plans? And if so, how and for what? For some service providers, contracting with managed long term care plans will require some additional thought, information, resources, strategic planning and possibly guidance from oversight agencies like DFTA and NY SOFA.

There is no documented precedence for the payment to publically funded Senior Centers (outside of hybrid social adult day/senior centers) by Medicaid MLTC plans. While On Lok and PACE

⁶ The Lawyer's Alliance of New York has developed an expertise in helping aging service providers contract with managed long term care plans; and has offered to assist organizations who have concerns or problems with the process. A hotline has been established for this purpose: (212) 219-1800 ext. 224

⁷ 2007 MLTC Model Contract Miscellaneous/Consultant Services (updated January 1, 2011), Appendix G. Found online at: http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_contract.pdf

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programs use Centers (social adult day and medical day) as a hub for wellness programming and care delivery, the plans own and sponsor these centers; it is not a subcontracting relationship with a publically funded provider.

In New York City, there is a network of over 250 senior centers- including Innovative and Neighborhood centers. The centers range in size, specialty, and cultural composition of the populations served. As noted earlier, there has been increased attention paid to wellness both in the programs and meals offered, making them attractive resources. Before signing a contract, providers are encouraged to consider the following questions:

- Are you equipped and capable of providing what it is being contracted to provide?
- Will the managed care plan guarantee attendance and subsequently payment? Do you need guaranteed attendance to survive?
- How is transportation being arranged and paid for?
- How will the frailty of the population served affect staffing patterns and existing culture of the center?
- How will cost allocation be determined for staffing and other fixed costs?
- Will your Center need to comply with additional ADA or HIPAA regulations?
- Will your Center be subject to additional audits or program evaluations by different government entities or by the plan; how much time and energy will evaluation/audit consume?
- How will attendance by an MLTC client (and payment for this client's participation) affect the DFTA contracted meal and unduplicated senior count in the new DFTA performance based system?
- Does contracting with the managed care plan obligate the center to allow the plan to advertise in the Center?

Whether, and for what, senior centers are able to contract with MLTC plans for services and support they currently offer is still being discussed.

Other programs like case management, caregiver resource centers and Naturally Occurring Retirement Communities are also feeling the ripple effect on this trend in service provision. The Best Practices forum sponsored by the Department for the Aging will lead to more knowledge and a wealth of lessons learned that will shape future guidelines and potential policies.

While there are challenges, there are also opportunities. This is a time for experimentation and growth in the home and nonprofit community based system of supports in New York City.

For more information on Medicaid Redesign, please contact Carin Tinney, UNH Policy Analyst for Aging Services at CTinney@unhny.org or (212) 967-0322, ext. 331.

Glossary

Medicaid

Medicaid is a means-tested federal health program, operationalized by individual States, for certain individuals and families with low income and financial resources. The Medicaid program is paid for by federal and State funds; in New York, a small portion of funding is paid for by municipalities. An amendment to the Social Security Act in 1965 established the Medicaid program.

Medicaid Managed Care

Managed care is a health insurance plan that coordinates the provision, cost and quality of care for the enrolled population. As opposed to traditional Medicaid, the plan receives a capitated payment from the State to provide services/care to the enrollee. It is not reimbursed by the State on a fee-for-service basis. This creates an incentive to control the costs of care while focusing on prevention of decline in health.

Medicaid Managed Long Term Care

Medicaid Managed Long Term Care is managed care for individuals with long term care needs. That is, if a Medicaid recipient receives 120 days or over of long term care services a year, she/he could be deemed eligible for enrollment in a Managed Long Term Care Plan. Up until recently the eligibility requirement to be in a managed long term care plan was that the individual must be determined to need a nursing home level of care. There are fourteen, with the possibility of more, plans in New York City. Right now, MLTCs only coordinate and contract with providers for long term care services and are not responsible for the provision of acute and primary care. Managed long term care plans receive a per member per month capitated or partially capitated rate from the State.

Medicaid Capitation versus Fee for Service

Capitation and Fee-for-Services (FFS) are methodologies for paying health care costs. In a FFS model, the provider of the service, e.g. a doctor giving a check-up, is reimbursed by the State for the service through Medicaid. In a capitated system, the plan (who contracts with State for provision of Medicaid services) is paid a per member, per month rate (no matter how many times the individual visits a doctor). In a FFS model, there is little or no incentive to coordinate care to control costs; with plans receiving a capitated rate, there is financial incentive to provide care and services in a cost effective manner.

Dually Eligible Beneficiary

A dual eligible is an individual who qualifies for both Medicare and Medicaid; and receives care and/or services from both plans.

APPENDIX A: Covered and Non-Covered MLTC services⁸

**Managed Long-Term Care Covered/Non-Covered Services, When Provided,
 Would Be Covered by the Capitation**

Services Provided as Medically Necessary:
1. Adult Day Health Care
2. Audiology/Hearing Aids
3. Care Management
4. Dentistry
5. DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics and Orthopedic Footwear
6. Home Care <ul style="list-style-type: none"> a. Nursing b. Home Health Aide c. Physical Therapy (PT) d. Occupational Therapy (OT) e. Speech Pathology (SP) f. Medical Social Services
7. Non-emergent Transportation
8. Nursing Home Care
9. Nutrition
10. Optometry/Eyeglasses
11. Personal Emergency Response System
12. Personal Care
13. Podiatry
14. Private Duty Nursing
15. PT, OT, SP or other therapist provided in a setting other than a home
16. Respiratory Therapy
Services Provided Through Care Management:
1. Home Delivered or Congregate Meals
2. Social Day Care
3. Social and Environmental Supports

⁸CMS approved Model Contract for a Managed Long Term Care (MLTC) Partial Capitation plan:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_model.pdf

Non-Covered Services, Excluded From The Capitation, and Can Be Billed Fee-For-Service

Non-Covered Services
1. Alcohol and Substance Abuse Services
2. Assisted Living Program
3. Chronic Renal Dialysis
4. Emergency Transportation
5. Family Planning Services
6. Inpatient Hospital Services
7. Laboratory Services
8. Mental Health Services
9. OMRDD Services
10. Outpatient Hospital Services
11. Physician Services including services provided in an office setting, clinic, facility, or in the home.
12. Prescription and Non-Prescription Drugs, Compounded Prescriptions
13. Radiology and Radioisotope Services
14. Rural Health Clinic Services
All other services listed in the Title XIX State Plan