MANAGED LONG-TERM CARE AND NURSING HOMES

Frequently Asked Questions

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healthcare education project

MANAGED LONG-TERM CARE AND NURSING HOMES

This FAQ is divided into 4 sections:

(1) The overview of Managed Long-Term Care in NY State
(2) How it works
(3) How it affects resident/patient care
(4) How it affects workers and collective bargaining

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SECTION 1: Overview

1. What is Managed Long-Term Care?

Managed Long-Term Care (MLTC) refers to an arrangement where the state contracts with managed care plans to provide a set of long-term services and supports to Medicaid beneficiaries. It helps people who are chronically ill or have a disability who need long-term care services and supports. One goal of MLTC is to help people remain in their homes and communities as long as possible and prevent or delay use of hospital and nursing home care.

Introducing MLTC was a major recommendation of New York State's Medicaid Redesign Team (MRT), which Governor Cuomo created in 2010. Members of the MRT include George Gresham, (President, 1199SEIU UHE), Dennis Rivera (Senior Advisor to the President of SEIU), Ken Raske (President – GNYHA), and Eli Feldman (President/CEO – MJHS).

The MRT's **Triple Aim** is to: (1) improve quality of care, (2) address the root causes of poor health, and (3) reduce costs.

The first step for mandatory MLTC is for the state to enroll individuals eligible for both Medicaid and Medicare who currently live in the community and receive more than 120 days of long-term care services. Mandatory MLTC will not affect nursing home residents immediately, but it is expected to in the coming year.

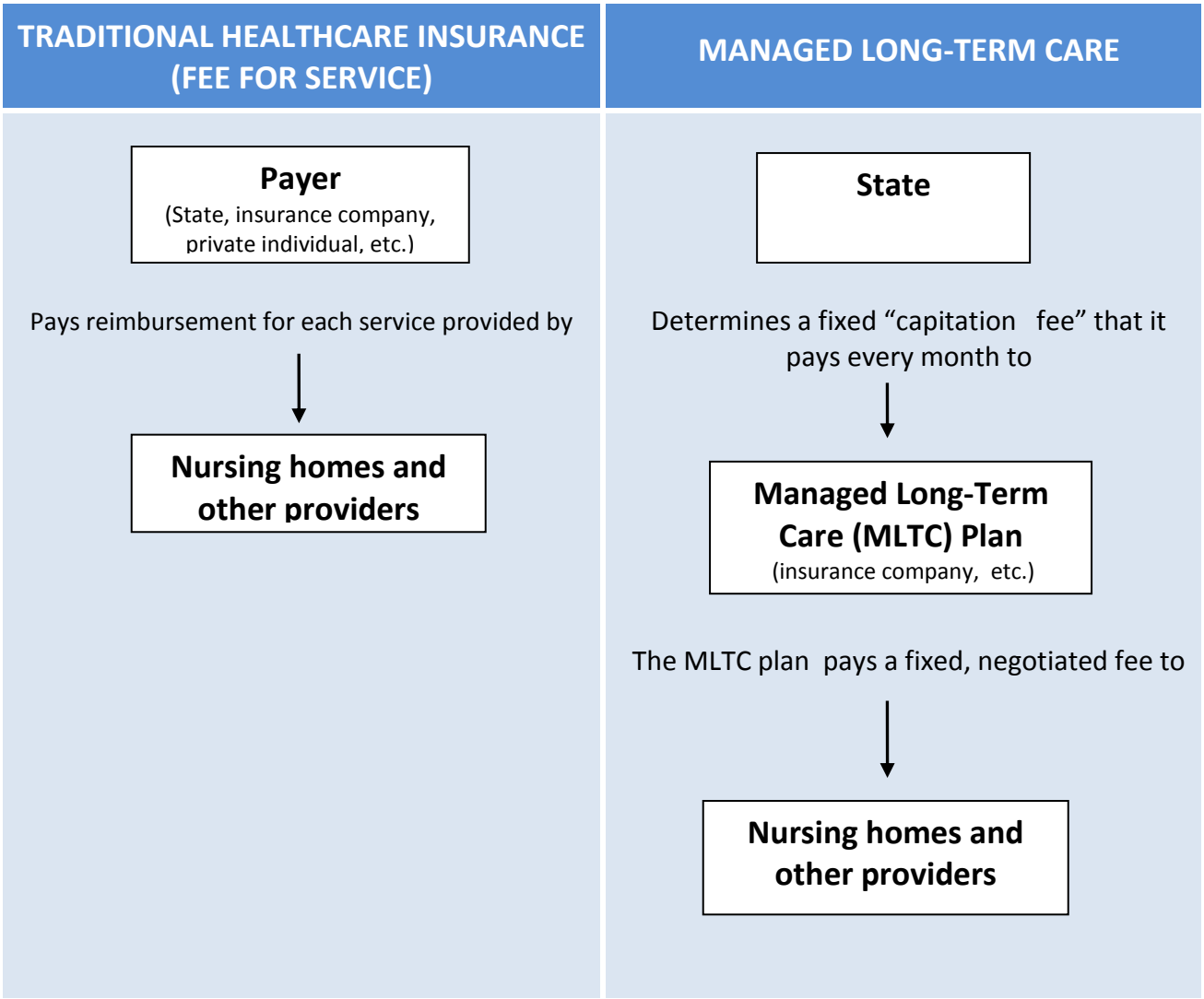
2. How is MLTC different from the earlier form of managed care?

Traditional healthcare insurance follows a fee-for-service payment system. The payer (insurance companies and, in the case of Medicaid, the state) directly reimburses nursing homes for specified services they provide to an insured individual. This reimbursement system is being replaced by a capitation fee system, where Managed Care Organizations (MCO) are paid a fixed fee each month by the state, called the capitation fee, and the MCO provides all health care services, including nursing home care. Under managed care, nursing homes are paid a negotiated rate for each resident enrolled in that MCO. This payment system is discussed separately below.

Another important difference is that the MCO (also known as a contractor) coordinates a wide range of services in different settings (for example in a nursing home, adult day health center, or at home with support services). This is in contrast to the current fee-for-service system where a provider such as a nursing home is responsible for only what happens in that particular setting.

3. What is the capitation fee?

In MLTC, the state pays the MCO a flat fee on a monthly basis for the services it provides to its plan members. This fee is based on an actuarial assessment of all the services needed for the plan members. The MCO has to meet the medical needs of the population it serves within this amount of money. The MCO negotiates a flat rate with each provider in its network.



4. Why the change to MLTC?

The aim of Medicaid redesign, as stated above, is threefold: improving care, addressing the causes of poor health, and reducing costs. MLTC plans seek to meet this triple aim by **coordinating services** and increasing reliance on **primary care and preventive care**.

To address the goal of reducing costs, an MLTC plan assumes a financial risk when providing services under a fixed fee: If the cost of care averaged across all enrollees is more than the fixed fee that it receives from the state (the capitation fee), the MLTC plan loses money. If it costs less, the MLTC plan makes money. Managed care is therefore described as risk-bearing contracting. MLTC plans have an incentive to closely control the use of services. They may do so, for instance, by reducing inappropriate use of specialist care, or the use of institutional services (nursing homes and hospitals), and by increasing care management services and making more appropriate use of home and community-based services.

5. What is the state envisioning for MLTC in the future?

There are two basic models of Managed Long-Term Care in NY State: (I) Fully Capitated Plans (with 3 variations) and (II) Partially Capitated Plans (Managed Long-Term Care Plans). It is the second type, partially capitated plans, which will become mandatory. People will be receiving information about enrolling in all of these plans, so it's important to know the differences.

(I) Fully Capitated Plans: All Medicare & Medicaid services

1. PACE (Programs of All-Inclusive Care for the Elderly) &
2. MAP (Medicaid Advantage Plus)

   Both PACE and MAP provide **both** primary medical care **and** long-term care services, including all services paid for by Medicare and Medicaid. The PACE and MAP plans receive a capitated (fixed) monthly payment to cover all Medicare and Medicaid services, regardless of setting. PACE or MAP members are required to use PACE network physicians, home care providers, hospitals and other providers. The PACE or MAP plan is responsible for directly providing or arranging for all primary, hospital, and long-term care services that a member needs and provides ongoing care management.

3. Medicaid Advantage Plans are a variation on the MAP (Medicaid Advantage Plus) plan described above. These provide and control access to all primary medical care paid for by Medicare and Medicaid; however they **do not cover most** long-term care services paid for by Medicare or Medicaid.

(II) Managed Long-Term Care Plans: Partial Capitation Plans – Limited Medicaid services only

Managed long-term care plans provide long-term care services (home health care, adult day care, nursing home care) as well as ancillary and ambulatory services (dentistry, optometry, eyeglasses, medical equipment). These plans receive Medicaid payment only. Members continue to use their regular Medicaid and Medicare coverage for primary care physicians and inpatient hospital services. Members must meet criteria for nursing home admission. While several plans in NY State enroll younger members, most of these MLTC plan enrollees must be at least age 65.

New York State is applying for a waiver to combine Medicaid and Medicare funds, in order to save costs across both government programs. This can be accomplished in various ways, such as by reducing potentially avoidable hospitalizations. As of the date this FAQ we have not learned if this waiver request has been accepted.

SECTION 2: HOW MLTC WORKS

6. How do MLTC plans operate?

MLTC services are provided by a number of plans across the state. The MLTC plans differ in their organizational structures, types of practitioners and services, access strategies, payment for practitioners, etc. Some of them may be stand-alone for-profit insurance companies; others are anchored in long-term care institutions, which are known as provider-based MLTC plans.

As discussed earlier, the MLTC plans negotiate payment rates and sign contracts with various long-term care providers, and work with only those providers in their network. MLTC plans determine the level and intensity of services for each individual in each care setting. All MCOs must get their model of care approved by the state.

7. How is the capitated fee to MLTC plans calculated?

The state assesses the historical level of acuity of the entire population of residents in a plan and determines the capitated rate for the MLTC plan based on this calculation.

8. If the quality of care improves, will the nursing home be paid more by the MCO?

Under most MLTC contracts, there is no incentive paid to the nursing home for improving care. However, if the nursing home enters into a risk-bearing agreement, there could be incentives for improving care. For example, nursing homes may enter cost-saving agreements such as the Medicare Institutional Special Needs Plan, where the nursing home gets an incentive payment if it safely and appropriately keeps patients out of hospitals.

9. What determines the rates paid by MCOs to nursing homes?

There is currently no official policy that determines the rates. We anticipate a transition period of about two years where nursing home payments are based on existing rates. In the future, MCOs and nursing homes will need to negotiate a payment rate that satisfies the contracting standards that the NYDOH will create. All industry stakeholders, including the union, will be involved in the development of these standards.

10. What are the criteria for accepting a nursing home into a managed care network?

When licenses are given to MCOs they are required to have a certain number of nursing homes, physician groups, etc. in their network, spread over a certain geographical area. Location, capacity, costs, reputation, quality, and staffing are some factors that decide whether a nursing home is accepted into a network.

11. How does an individual transition to MLTC?

Currently, mandatory enrollment is required for dually eligible individuals (people covered by both Medicaid and Medicare) who receive more 120 days of community-based long-term care. Any individual in need of long-term care services can voluntarily enroll in a MLTC plan, and some individuals in LTC plans might need nursing home care.

Mandatory enrollment of nursing home residents covered by Medicaid only will begin in October 2013; residents who are dually eligible for Medicaid and Medicare will be enrolled in 2015. Anyone in the community enrolled currently in a managed care plan who enters a nursing home will remain enrolled in their current plan, and the MCO will pay the nursing home for their care.

The state will use *enrollment brokers* to assist individuals to enroll in a MLTC plan. An individual's current provider might also be helpful in the transition to MLTC.

SECTION 3: QUALITY AND CHOICE

12. How does MLTC affect consumer choice of nursing homes and services?

MCOs use various methods to manage services and costs. For example, they typically limit the specific providers that enrollees can see. Providers may need to meet certain qualifications and may accept a rate that could be less than their fee-for-service rates. Providers will select the MCOs that they want to contract with.

Some consumers are concerned that they will have fewer choices and will not be able to get the care they need. They worry that MLTC will limit their ability to direct their own services or that they will be denied access to specialists. In Medicare, a person can go to any provider that accepts Medicare. But in MLTC, not every provider will be in every MCO's network. Some feel that MCOs can violate their privacy by collecting information about the services they use.

On the other hand, consumers who use many different kinds of services (as long-term care beneficiaries often do) may find the care coordination helpful. Also, in Medicaid MLTC programs there is no cost sharing except perhaps for prescription medications. Some MLTC programs offer enhanced benefits, such as a more coordinated set of all health care services, as an incentive to enrollment.

13. What consumer protections are in place?

Consumers will have a choice of plans: there will be at least two MLTC plans available in each county. And MLTC plans will be required to have networks that can meet the needs of plan members by offering them a choice of providers. There will be an appeals process for instances when a plan enrollee feels he or she has been denied certain services.

14. What will the patient to nurse ratio be?

The ratio will continue to follow existing federal and state staffing regulations and will depend on the level of care required and the need to provide quality care. The MCOs do not issue guidelines about this.

15. How does MLTC affect patient care?

Everything that a patient's plan of care requires will have to be provided. Nursing homes will still have to meet all federal and state regulations and standards. CMS (Centers for Medicare and Medicaid Services) and the DOH will continue to survey nursing homes. MLTC plans must adhere to the state's quality measures for managed care plans, including satisfaction with the plan.

SECTION 4: MLTC, HEALTHCARE WORKERS, AND UNIONS

16. How will managed care affect my job?

For the immediate future, things will stay the same. However, there are discussions of new job titles, blending skill sets and responsibilities, and new models of care. Staff education and training, for direct care and well as managers & supervisors, will play a bigger role in the months to come. All staff will need to work more effectively as members of interdisciplinary teams. Learning and using new tools to document and communicate information about residents will be essential.

17. Will there be a role for the union in lobbying for increases in the Medicaid budget that could positively impact wages?

This will be part of the Medicaid budget process every year, and the union will maintain an active voice in Albany. The union will focus its lobbying in supporting management efforts to ensure adequate funding. The union will also work with consumer groups, providers, and the state to require MCOs to offer comprehensive and high quality services to patients.

18. How does managed care affect collective bargaining?

Collective bargaining will continue to be between the union and employers. The New York State DOH will set contracting standards for MCOs. Labor and management will have to work with NYSDOH to insure that these standards provide adequate funding for providers so that they can cover the costs of labor, including wages and benefits. Legislators will allocate money for MLTC from the Medicaid budget. The union will focus its lobbying on supporting management efforts to insure adequate funding. The union will also work with consumer groups to require MLTC to offer comprehensive and high quality services to patients.

There will be a formula devised for allocating the money MCOs pay to nursing homes. The union is working to achieve contracting standards that will be included in the calculations of what MCOs should pay the nursing homes. Unions will have to seek ways to influence the standards that MLTC programs must meet. These standards should focus on outcomes regarding quality, patient satisfaction, and fair wages. Unions will also have to fight for contracting standards to ensure that MCOs cover these costs. Our objective is to have a requirement to protect wage and labor standards.

Unions will also need to lobby around the process by which nursing homes are included in an MCO's network.

19. What can nursing home staff do NOW to prepare for these changes?

- Be open to change. Do not waste valuable time and energy resisting this new methodology.
- Continue to learn about MLTC by attending chapter meetings.
- Find out what your facility is planning – form a labor-management committee if your nursing home does not already have one.
- Upgrade your skills – see what the Training Fund offers with regard to computer skills, GED, foreign language training, etc.
- Continue to learn new approaches/techniques to provide high quality care (INTERACT, Palliative Care, Dementia Care, etc.).

20. Where do I direct any questions I may have?

You can begin by talking with your Union Organizer or Vice President. The Healthcare Education Project (HEP) will continue to collect questions, meet with industry and legislative leaders, and provide additional information on a timely basis in the months to come.

You can contact HEP directly by calling 646-473-8481.

GLOSSARY

Adult Day Health Care: Medically supervised services for individuals with physical or mental impairment (e.g., children, people with dementia, AIDS patients). All patients are required to be eligible for nursing home placement. Most services are operated by nursing homes, but are not necessarily located at the nursing homes. Generally, services are offered from one to five days per week, with some services available on weekends and evenings.

Capitation fee : A fixed fee paid by the state to managed care organizations (MCOs) for the services they provide to the entire population of their plan members.

Community Based Long-Term Care: Long-term care services, both medical and non-medical, offered in patients' homes or in community-based settings such as assisted living facilities.

Care Coordination Model: An option besides MLTC for dual eligible individuals age 21 and older who require community-based long-term care services for more than 120 days. It provides or contracts for all Medicaid long-term care services.

Consumer Directed Personal Assistance Program (CDPAP): A Medicaid program that provides services – help with activities of daily living (ADLs) or skilled nursing services – to chronically ill or physically disabled individuals. The consumer or the person acting on the consumer's behalf assumes full responsibility for hiring, training, supervising and, if need be, terminating the employment of persons providing the services.

Certified Home Health Agency: CHHAs provide part-time, intermittent health care as well as long-term nursing and home health aide services. There are many CHHAs in New York State, with at least one in each county. NYS Department of Health regulations ensure that staff are appropriately qualified, trained, and supervised.

Dual Eligibles: People who qualify for both Medicare (usually over age 65) and Medicaid (low income levels and assets).

Enrollment Broker: An entity that contracts with the state and identifies dual eligible cases to enroll in MLTC, and helps them with the plan options and other assistance.

Licensed Home Care Service Agencies: LHCSAs provide hourly nursing care and social services to clients who have private insurance and those who pay privately. In some cases licensed agencies contract with local social services departments, or certified home health agencies, to provide services to persons with Medicaid coverage.

Managed Care Organization: Entity that offers care management and coordination by signing contracts with various providers, including nursing homes, in its network. Nursing home patients/residents receive long-term care services through this network of providers. MCOs have to get their model of care approved by the state.

Medicaid Advantage and Medicaid Advantage Plus: The two integrated care plans in New York State designed to allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits. Both plans have a state contract with Medicare Advantage Plans. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare. The Medicaid Advantage Plus Plan also covers Medicaid long-term care benefits, and recipients must be eligible for nursing home level of care.

Medicare Advantage Plan: A health plan option for Medicare beneficiaries. The plans may or may not include prescription drug coverage. In most of these plans, there are additional services and lower co-payments than in the traditional fee-for-service Medicare Program. It is sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs.

MRT Waiver: A submission by the New York State Department of Health to the federal government seeking $10 billion in federal funds over five years to invest in the state's health care system. It is based on a projected savings expected from the reforms proposed by the Medicaid Redesign Team that are being implemented in New York State.

Partial Capitation Plans: One of two basic models of managed long-term care in New York State (the other being fully capitated plans). Partial capitation plans are Medicaid only, and will become mandatory.

PACE – Program of All-Inclusive Care for the Elderly: A fully capitated program which is both Medicare and Medicaid, that helps people meet primary and long-term care in the home, the community, and PACE centers. PACE Members must be age 55 and older, and eligible for nursing home admission.

Triple Aim: The three aims of Medicaid redesign in New York State are: improving the quality of care, addressing the root causes of poor health, and reducing per capita costs.

MLTC TRANSITION TIMELINE

	COMMUNITY BASED CARE	NURSING HOME
	2012	
January		New nursing home methodology establishes a price for operating which will assist homes in preparing for market-driven managed care
April	**Phase I: New York City** • Any new dual eligible case fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action • Begin personal care cases in New York County *Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in November, 2012*	
May	Continue personal care cases in New York County	
June	• Begin personal care in Bronx County • Continue personal care cases in New York County	
July	• Begin consumer directed personal assistance program cases in New York and Bronx counties • Continue personal care in New York and Bronx counties	
August	• Begin Kings County • Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties	
September	Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings counties	
October	• Begin Queens and Richmond counties • Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties	
November	Initiate enrollments citywide of long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases not enrolled under personal care case activity and	

	COMMUNITY BASED CARE	NURSING HOME
	individuals in Medicaid Advantage in receipt of personal care	
December	Continue personal care, consumer directed personal assistance program, long term home health care program, home health over 120 days, adult day health care program and private duty nursing cases and individuals in Medicaid Advantage in receipt of personal care in New York, Bronx, Kings, Queens and Richmond Counties	
	2013	
January	**Phase II: Nassau and Suffolk Counties** Enroll dually eligible community based long-term care service recipients in these additional counties as capacity is established	TBD – Whether dual eligible individuals in nursing homes will be required to enroll in managed care
June	**Phase III: Rockland, Orange, and Westchester Counties** Enroll dually eligible community based long-term care service recipients in these additional counties as capacity is established	
November		Non-dual Medicaid nursing home residents will be required to select a managed care plan and all mainstream plans will begin covering nursing home placement
December	**Phase IV: Albany, Erie, Onondaga and Monroe Counties** Enroll dually eligible community based long-term care service recipients in these additional counties as capacity is established.	
	2014	
June	**Phase V: Other Counties with capacity** Enroll dually eligible community based long term care service recipients in these additional counties as capacity is established.	

	COMMUNITY BASED CARE	NURSING HOME
June	**Phase VI:** Previously excluded dual eligible groups contingent upon development of appropriate programs: • Nursing Home Transition and Diversion waiver • Traumatic Brain Injury waiver • Nursing home residents • Assisted Living Program • Dual eligible that do not require community based long term care services	
Nursing home residents are among the last cohorts scheduled to enroll in managed care. Residents will enroll "in place" to avoid disruptions in care. Homes will likely continue to receive fee-for-service rates for "in place" enrollments. Plans are required to demonstrate to the state that they have adequate network participation.		

Managed Long-Term Care Covered Services

- Care management
- Home care, including nursing, home health aides, occupational, physical and speech therapies
- Optometry/eyeglasses
- Dental services
- Rehabilitation therapies
- Audiology/hearing aids
- Respiratory therapy
- Nutrition
- Medical social services
- Personal care (such as assistance with bathing, eating, dressing, etc.)
- Podiatry (foot care)
- Non-emergency transportation to receive medically necessary services
- Home delivered and/or meals in a group setting (such as a day center)
- Medical equipment
- Social day care
- Prostheses and orthotics
- Social/environmental supports (such as chore services or home modifications)
- Personal emergency response system
- Adult day care
- Nursing home care

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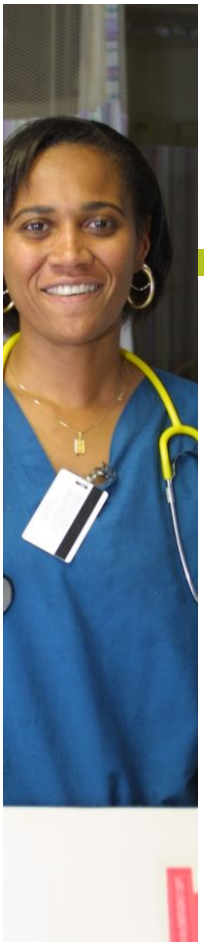

Managed Long-Term Care Covered Services

- Additional Services/PACE
  - Inpatient hospital services
  - Primary care and specialty doctor services
  - Outpatient hospital/clinic services
  - Laboratory services
  - X-Ray and other radiology services
  - Prescription and non-prescription drugs
  - Chronic renal dialysis
  - Emergency transportation
  - Mental health and substance abuse services

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