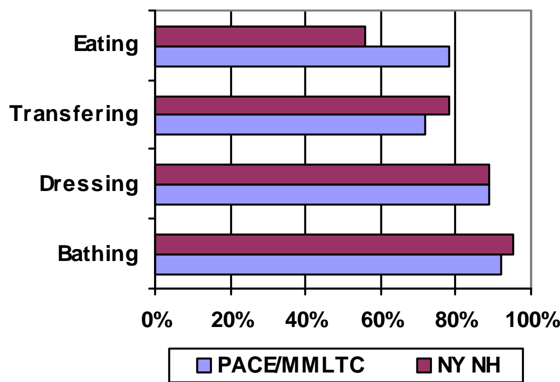
A Statistical Profile of the Efficacy of Managed Long Term Care in New York State (PACE & MMLTC)

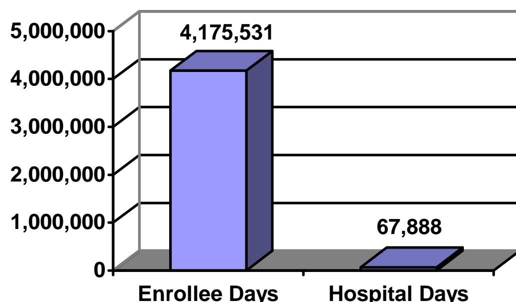
In New York State, managed long term care (MLTC) includes two models—the dually (i.e., Medicare and Medicaid) capitated Programs of All-inclusive Care for the Elderly (PACE) and Medicaid-only Managed Long Term Care (MMLTC) programs. These programs offer many benefits, including comprehensive coordination of services; integration of payment sources; multidisciplinary care; customized service packages dictated by need rather than programmatic restrictions; financial incentives that reward good outcomes; and increased access to community-based services for the state's most vulnerable population. While comparative data on outcomes and cost effectiveness is limited, available data shows that it is a model of care that meets consumer preferences, results in good clinical outcomes and is cost efficient.[1]

Managed Long Term Care Enrollees are Very Frail



PACE/MMLTC enrollees have similar functional assistance needs as nursing home residents. Most enrollees in these plans are dually eligible for Medicare and Medicaid, a population that is disproportionately expensive to serve and is associated with multiple chronic conditions. Many are approaching end of life, a time when health care expenditures are especially high.[2]

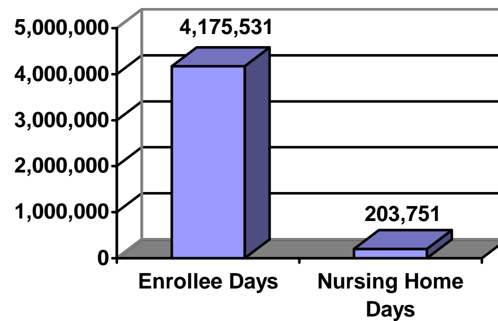
Hospitalization Rates Are Low



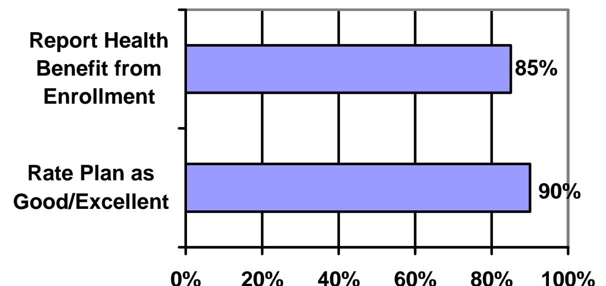
Although a frail population, PACE/MMLTC enrollees have a low hospital utilization rate, an indicator of successful care management. In 2004, hospital days represented just 1.6 percent of total enrollee days.[3]

Reliance on Nursing Home Care is Low

All MLTC enrollees are frail enough to qualify for nursing home care based on standardized assessments. However, the vast majority live in the community with non-respite nursing home days representing just 4.9 percent of total enrollee days.[4]

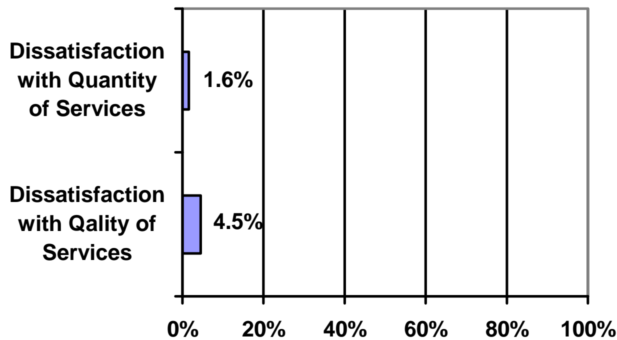


Enrollee Satisfaction is High



Satisfaction surveys show high levels of enrollee contentment with the plans. In 2005, 2,218 individuals left the plans, primarily due to relocation or death. During the same period, 4,426 enrollees joined, for a net gain of 2,208 enrollees.

Percent of Voluntary Disenrollments Due to Dissatisfaction with Plan Services

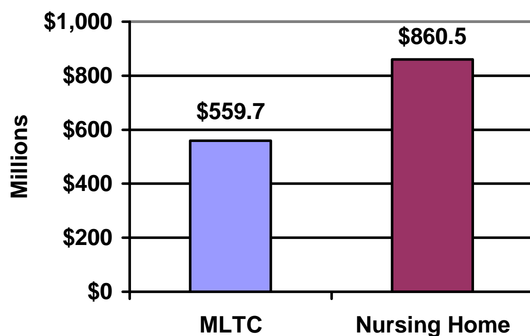


Plans have been stable, and most involuntary disenrollments occur because the individual no longer qualifies for enrollment. No program has reduced its service area or withdrew from the program, such as occurred with Medicare managed care in the late 1990s.[5]

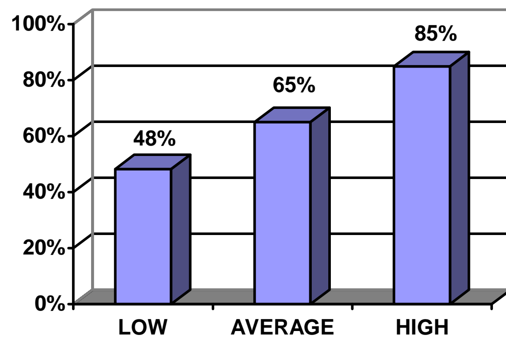
Cost to Medicaid is Lower than Nursing Home Cost

MLTC plans serve nursing home eligible individuals at a lower cost to Medicaid than if the care were provided in a nursing home. In 2004, it would have cost Medicaid an additional $300 million to provide the care in nursing homes based on a comparison of plan per-enrollee Medicaid revenue and county-specific average nursing home Medicaid rates.

Medicaid Cost: MLTC vs. Nursing Home (In Millions)



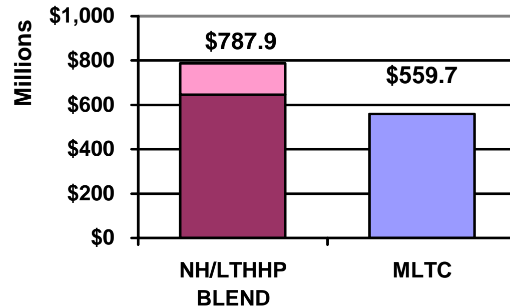
MLTC Medicaid Cost as a Percent of Nursing Home Care Cost



Medicaid payments to plans range from 48 to 85 percent of the average nursing home rate for the county or counties that the plan serves. The weighted average for all the plans is 65%, an average Medicaid savings of $23,500 per enrollee.

Even if 75 percent of the frail individuals enrolled in MLTC were instead served in nursing homes and the other 25 percent remained in the community and were served by the Long Term Home Health Care Program (LTHHCP), the cost to Medicaid would still exceed the cost of MLTC by $228 million per year. [6]

Medicaid Cost: MLTC vs. Nursing Home & LTHHCP Blend



Apart from the benefit of cost effective care at the time of enrollment, a large benefit of managed long term care may be that it effectively delays permanent institutional placement of a participant for a longer time than if the individual had received less comprehensive care in the community. The increased focus on preventive care and coordination of needed health and supportive services suggests, as does the experience of the plans with individual enrollees, that this is the case. However, this impact is especially difficult to quantify without a careful longitudinal study.

Less difficult to quantify is the impact of residents who transition out of the nursing home due to the supports available through the managed long term care plan.

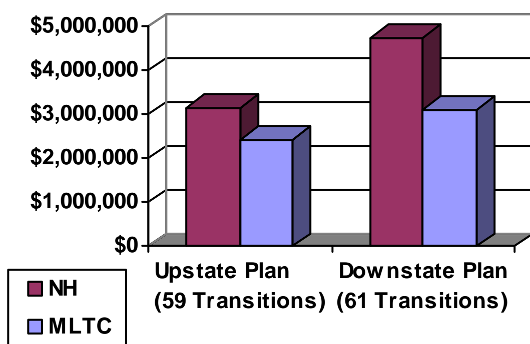
Plans Return Nursing Home Residents to the Community

Some plans work with nursing homes to identify individuals interested in returning to the community and provide all of the necessary services to make this happen. Although this statistic is not reported on cost or statistical reports, some plans track it.

For example, in the last three years an upstate plan has returned 59 individuals to the community, saving Medicaid over $700,000 each year that these enrollees remain in the community.

A smaller downstate plan transitioned 61 individuals during this same period, resulting in annual Medicaid savings that exceeded $1.6 million.

Two Examples of Medicaid Cost Differences for Individuals Transitioned out of Nursing Homes Who Remain in the Community



As these examples suggest, if the impact of nursing home transitions were aggregated for all of the plans, the figure would be significant. These savings are directly attributable to MLTC.[7]

[1] In an article summarizing available research on the cost effectiveness of community based long term care, David Grabowski notes that "somewhat surprisingly, there has not been a comprehensive review of recent evidence" regarding capitated models. (Grabowski, David. "The Cost-Effectiveness of Non-Institutional Long-Term Care Services: Review and Synthesis of Most Recent Evidence" Medical Care Research and Review, Volume 63, Number 1, (February 2006), pp 3-28, accessible on the National PACE Association Web site, www.npaonline.org/website/download.asp?id=1656). There are a number of studies on the benefits of integrated care, coordination and interdisciplinary teams. There is also a wealth of data indicating the high care needs and disproportionate costs of individuals dually eligible for Medicaid and Medicare, individuals with chronic conditions and for those at the end of life (e.g., Anderson, Gerard. Chronic Conditions, Making the Case for Ongoing Care(Chartbook), accessible at www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf; Liu, Korbin, et. al. "End of Life Medicaid and Medicare Expenditures for Dually Eligible Beneficiaries" , Health Care Financing Review, Volume 27, Number 4 (Summer 2006), pp 95-110.) The Medicaid High-Cost Care Initiative of the Medicaid Institute at United Hospital Fund has compiled information on high-need, high-cost individuals (www.medicaidinstitute.org/). Managed Long Term Care in New York is examined in the work of Michael Sparer and Susan Hughes. The Visiting Nurse Service sponsored Center for Home Care Policy has summarized some of their work and made it available on the organization's Web site www.vnsny.org/research/publications/index.html. The United Hospital Fund's (UHF) MLTC Quality Consortium project resulted in several articles. These, as well as several other MLTC reports with specific recommendations are accessible on the Fund's site, www.uhfnyc.org/pubs-stories3220/pubs-stories.htm. A list of PACE related articles is available on the NPA Web site at www.npaonline.org/website/article.asp?id=32, as is information on studies that several states have done showing cost savings (www.npaonline.org/website/article.asp?id=35). An in-depth evaluation of PACE should is currently underway by Mathematica Policy Research and should be available in the Spring of 2007.

[2] Source: PACE/MMLTC ADL rates are from New York State Department of Health report, New York State Managed Long Term Care: Final Report to the Governor and Legislature, March, 2006. Nursing Home ADL rates from 2001 Nursing Home Statistical Yearbook, Cowles Research Group. The average PACE enrollee nationwide has eight medical conditions. Based on NPA comparative assessment data for PACE sites nationwide, PACE participants in New York are more frail than in other states. Additionally, as published in the DOH MLTC Final Report, about half of those enrolled in PACE/MMLTC have cognitive impairments.

[3] Source: NYAHSA analysis of 2004 MLTC Medicaid Cost Reports obtained from DOH. Figures were compared with 2006 data obtained from several plans to validate that no large shifts had occurred.

[4] Source: NYAHSA analysis of 2004 MLTC Medicaid Cost Reports obtained from DOH. Figures were compared with 2006 data obtained from several plans to validate that no large shifts had occurred.

[5] Source: New York State Department of Health report, New York State Managed Long Term Care: Final Report to the Governor and Legislature, March, 2006; Medicaid Managed Care Monthly Enrollment Reports.

[6] Source: NYAHSA analysis of 2004 MLTC Medicaid Cost Reports and 2004 Nursing Home Master Medicaid Rate Setting File obtained from DOH. The LTHHCP, although not as comprehensive as MLTC, serves about 25% of nursing home eligible individuals. Individual expenditures are capped at 75% of the nursing home rate. Although the frailty of MLTC enrollees would suggest that they would likely be at the cap, for this comparison we used 65% of the county-specific nursing home rate as the standard for estimating LTHHCP costs. A complete comparison of Medicaid costs would need to include any other nursing home resident and LTHHCP participant expenses paid by Medicaid as well as cost sharing arrangements. A complete comparison of total state costs would need to include any housing subsidies provided by state dollars to MLTC and LTHHCP enrollees since nursing home rates include room and board.

[7] Source: Figures provided by MLTC plans to NYAHSA.