Medicaid Redesign Team (MRT) #90 Risk and Opportunity by Service Line

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The Medicaid Redesign Team (MRT) Proposal #90, mandates enrollment of Medicaid recipients who need more than 120 days of community-based long term care services into an managed long term care plans (MLTCP) or a similar care coordination model (CCM), starting April 1, 2012.

SERVICE	RISKS/THREATS	OPPORTUNITIES	ACTION PLAN
Adult Day Health Care (ADHC) BEGINS JANUARY 2013 FOR NEW YORK CITY COUNTIES NOT ENROLLED UNDER PERSONAL CARE CASE ACTIVITY. SEE APPENDIX FOR STATEWIDE IMPLEMENTATION PHASE-IN	• Potential loss of patients to alternative levels or sites of care, and/or if ADHC is not in network of Managed Long Term Care Plan(MLTCP)/Coordinated Care Model (CCM) • Program at risk	• Become downstream provider – multiple MLTCP/CCM programs • Could increase volumes if ADHC demonstrates cost effective "solution" for high need Medicaid patients • Contract with Medicaid Managed Care plan; may be source of increased referrals • Consider becoming a hybrid model as means of becoming an effective downstream provider • Become part of a health home or care coordination model • Evolve into/become part of a MLTCP/CCM	• Contract/partner with multiple MLTCP/CCM • Seek ways to demonstrate cost effectiveness and value for ADHC • Determine true cost of care and develop insurer rate negotiation strategy • Explore opportunities to become an approved provider with MLTC/CCM plans. • Develop MLTCP/CCM • Follow /support progress of the Adult Day Health Care Council's hybrid model proposal
Assistive Technology (AT) - home based	• Patients served as waivered service under contract with Long Term Home Health Care Program (LTHHCP) (ex – Personal Emergency Response System [PERS]) will be moved to MLTCP/CCM	• Significant opportunity to increase business if able to demonstrate cost effective "solution" for high cost patients • Support managed care members living at home	• Contract/partner with multiple MLTCP/CCM • Seek ways to demonstrate cost effectiveness and value for AT solutions. • Telehealth
Certified Home Health Agency (CHHA) BEGINS JANUARY 2013 FOR NEW YORK CITY COUNTIES NOT ENROLLED UNDER PERSONAL CARE CASE ACTIVITY. SEE APPENDIX FOR STATEWIDE IMPLEMENTATION PHASE-IN	• Loss of chronic care patients to MLTC/ CCM • Loss of patient volume if not participating with MLTC plan • Financial risk of capitation and/or negative financial impact of MLTCP reimbursement • Increase competition with lifting of the CHHA moratorium • Special Needs CHHAs required to rebalance their census to meet mandated % population mix – potential loss of non- specialized	See "new opportunity" on page 5 related to expansion of CHHA services* • Become downstream provider as acute/ Medicare home care agency for MLTCP/CCM • Participate in a health home coordination model • Provide Short term care transition services • Become MLTCP • Increased volume thru MLTCP • Increased revenue if contracts	• Contract/partner with MLTCP/CCM to provide Medicare episodic care. • Develop expertise in difficult to manage acute care dx. ↑ value to MLTCP/CCM • Increased contracts with MC Plans to develop relationships with potential MLTC sponsors • Analyze expenses to determine revenue rates and ID opportunities to control costs

SERVICE	RISKS/THREATS	OPPORTUNITIES	ACTION PLAN
	needs clients.	negotiated well and costs managed	
Community Services for the Elderly (CSE)	• Depends on service line of CSE funding • Social Adult Day Services (SADS) contractors – see SADS • Preventive/exercise programs typically not covered by insurers	• Potential for coverage by MLTC plans	• Develop package to promote preventive/wellness services
Consumer Directed Personal Assistance Program (CDPAP) BEGINS SEPTEMBER 2012 FOR NEW YORK AND BRONX COUNTIES SEE APPENDIX FOR STATEWIDE IMPLEMENTATION PHASE-IN	• Autonomy of the consumer being eroded • Individuals with the most serious disability might have hours reduced or be placed on waiting list as a result of a capitated payment model		• Develop contracting procedures with MLTC/CCM • Draft regulatory changes, if necessary, for CDPAP in MLTC/CCM
Expanded In-home Services for the Elderly Program (EISEP)	• Funding will be reduced so clients will receive fewer homecare hours	• Changes referral recommendations for chronic clients • If provider, then provide HHA's to managed care provider as downstream provider	• Familiarize with MLTC/CCM in area for referrals and patient advocacy purposes
Health Insurance Information Counseling and Assistance Program (HIICAP) State Funds	• Not impacted at this time. Funding is stable for the time being	• HICAP could assist potential members with providing education about Medicare, MA, managed care, EPIC and others to help members understand the differences	• Familiarize the MLTC/CCM in area about the role of HIICAP
Home Delivered Meals (HDMs)	• Clients served as waivered service under contract with LTHHCP will be moved to MLTC/CCMs. Could lose client if Meal Service is "out of network" for MLTC/CCM	• Potential for increased volumes as a cost effective alternative to Aide Service • Insure that care managers are aware of services and continue to provide based on existing contracts	• Contract/partner with multiple MLTC/CCM
Hospice			• Dedicated unit development
Legal Assistance Program	• Not impacted at this time. Funding is stable for the time		• Familiarize the MLTC/CCM in area about the role of the Legal Assistance

SERVICE	RISKS/THREATS	OPPORTUNITIES	ACTION PLAN
	being		Program
Licensed Home Care Services Agency (LHCSA) For enrollment schedule see Personal Care	• Potential loss of chronic care patients in Personal Care programs. PCA clients moved to MLTC/CCM • MLTC may drive hours down - loss of hours of service • Potential negative financial impact of MLTC reimbursement	• Provide home health aides to managed care companies as downstream provider • Increased volume thru partner with MLTC/CCM plan • Increased revenue if reimbursement contracts negotiated well and costs managed	• Contract/partner with multiples MLTC/CCM • Develop expertise in difficult to manage chronic care dx. ↑ value to MLTC/CCM • Analyze expenses to determine revenue rates and identify opportunities to control cost
Long Term Home Health Care Program (LTHHCP) BEGINS JANUARY 2013 FOR NEW YORK CITY COUNTIES NOT ENROLLED UNDER PERSONAL CARE ACTIVITY. SEE APPENDIX FOR STATEWIDE IMPLEMENTATION PHASE-IN	• LTHHCP will not exist in their current operational structure and/or payment methodology once MRT #90 is fully implemented	• Apply to become a CCM or MLTC • Contract with MLTCP/CCM as a LTHHCP downstream provider • Apply to become a CHHA and contract with a MLTC/CCM as a downstream provider • Develop payment and delivery models for contracting with MLTCP/CCM, such as sub-capitation or shared risk collaborations	• Analyze feasibility to become a CCM or MLTC; alone or in partnership with other home care providers • Follow changing regulatory environment that offer contracting methods as a downstream provider • Seek MLTC/CCM contract partners. Create innovative partnership models and shared risk proposals that offer value to MLTCP/CCM
Managed Long Term Care Plans (MLTC)	• Aggressive timeframe of 7/1/2012 • Rapid expansion into other areas of the State • Tenfold increase of MA recipients • Transitioning of recipients • Soundness with rate setting – 2 yr. lag in rate adjustment • Wage Parity – Living Wage Requirement • Significant capital costs associated with start-up • Financial risk capitation/risk assumption • Adequate volume of members • Recruitment of qualified staff	• Growth and expansion of MLTCs • New markets • Migration of medical services away from other models	• Prepare to expand into other areas and other parts of the state • Providers need to explore collaborative relationships with established LTC providers. Likewise, established downstate providers should explore opportunities to collaborate with upstate organizations. Upstate, organizations that already have a significant presence (a large home care organization) may have the network, volume and resources needed to start a MLTC program. • Providers may want to consider collaborating with other similar providers to join together to become a MLTC
Naturally Occurring Retirement Communities (NORC)/NNORC/NORC-	• Not impacted at this time. Funding is stable for the time being	• To the extent there are Medicaid eligible residents, provide information about managed care	

SERVICE	RISKS/THREATS	OPPORTUNITIES	ACTION PLAN
SSP		options before auto assignments	
Nursing Home Transition and Diversion (NHTD) Medicaid Waiver FINAL PHASE-IN TIMEFRAME TO BE DETERMINED	• Loss of patients to MLTC/CCM (phase II of MRT #90) • Excluded from initial mandatory enrollment • Program oversight and staff training needs to comply with expectations of MLTC/CCM	• NHTD Service Coordinators become contracted care management service to MLTC/CCM • Other NHTD waiver service lines (AT, meals, home mod, etc) become downstream providers to MTLC/CCM	• Service coordinators seek contract/partnership with MLTC/CCM. Seek ways to demonstrate expertise and value • Other NHTD service lines seek contracts as downstream providers • Explore becoming a provider
Personal Care Assistant (PCA) program BEGINS JULY 2012 FOR NEW YORK COUNTY SEE APPENDIX FOR STATEWIDE IMPLEMENTATION PHASE-IN	• Loss of long term patients to MLTC/CCM	• Become downstream provider for contracted PCA services under MLTC/CCM	• Contract with multiple MLTCs/CCMs • Develop expertise in difficult to manage chronic care dx. to demonstrate ↑ value to MLTC/CCM
Respite	• Depends on type of respite. Refer to individual service lines for types of respite providers (PCA, SADS, LTHHCP, etc.)		
Senior Centers – Support Services, Nutrition Services for Aging, Congregate Meals	• Not impacted at this time. Funding is stable for the time being	• Senior Centers could provide socialization services to MLTC/CCM	• Initiate contracts with MLTC/CCM for socialization services
Subsidized Senior Housing	• Definition of independent senior housing needs to be better defined to allow for housing with supportive services	• To the extent there are Medicaid eligible residents, provide information about managed care options before auto assignments • Opportunities for senior housing and MLTC partnerships • Develop housing with services models and funding as a result of managed care	• Initiate contacts with MLTC/CCM to provide information about subsidized senior housing
Social Adult Day Services (SADS)	• Patients served as waivered service under contract with LTHHCP will be moved to MLTC/CCM; could lose client if SADS is "out of network" for MLTC/CCM. • SADS patients served through other Medicaid or state funding source (State Office For Aging [SOFA], Title III E, NHTD) currently not impacted • Partner with an ADHC to become	• Potential for increased volumes as a cost effective "solution" to non-medical chronic care population • Social adult day program could provide socialization services to a MLTC/CCM	• Contract/partner with multiple MLTC/CCM • Seek ways to demonstrate cost effectiveness and value of SADS • Initiate contracts with managed care companies for socialization services. • Initiate private pay program (clients/families pay out-of-pocket for services) • Follow/support progress of ADHCs hybrid model proposal.

SERVICE	RISKS/THREATS	OPPORTUNITIES	ACTION PLAN
	a hybrid model		
Title III E, National Family Caregiver Support Program	• Currently not impacted – may depend on individual service type being funded		
Title XX	• Currently not impacted – may depend on individual service type being funded		
Transportation Operation Expenses (AAA Transportation Program)	• Impact on program resulting from impact on Day Health Program	• Opportunity to expand services to covered non-emergent transportation in MLTC benefit	• Estimate potential impact of MLTC services • Use own ambulance service
Traumatic Brain Injury (TBI) Medicaid Waiver FINAL PHASE-IN TIMEFRAME TO BE DETERMINED	• Loss of patients to MLTC/CCM • Excluded from initial mandatory enrollment • Level of ongoing oversight needed to manage program & training time needed to accomplish competency of direct service provider for MA Long Term Care (LTC) insurers vs. Regional Resource Development Centers	• TBI Service coordinators become contracted care management service to MLTC for TBI clients • Other TBI waiver service lines (AT, meals, home mod, etc) become downstream providers to MTLC. • Continued demand; possible need for added services, e.g. assistive technology and home modifications	• Service coordinators seek contract/partnership with MLTC/CCM as expert care managers for TBI population • Other TBI service lines seek contracts as downstream providers • Explore opportunities to add services

NEW OPPORTUNITY:

The Public Health and Health Planning Council adopted an amendment to 760.5 of Title 10, NYCRR which then provided the Department of Health the ability to issue a Request for Application (RFA) to establish new certified home health agencies (CHHAs), or expand the approved geographic service area and/or approved population of existing CHHAs.
This is a time sensitive event, the responses to the CHHA RFA are due by March 9, 2012.*

Enrollment Plan Mandatory Managed Long Term Care and Care Coordination Model

- **Mandatory Population:** Dual eligible, aged 21 and over, receiving community based long term care services for over 120 days, excluding the following for now:
  - *Nursing Home Transition and Diversion waiver participants;*
  - *Traumatic Brain Injury waiver participants;*
  - *Nursing home residents;*
  - *Assisted Living Program participants;*
  - *Dual eligible that do not require community based long term care services.*

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Voluntary Population

- In addition to those who must enroll in a Managed Long Term Care Plan or Care Coordination Model, the following people may voluntarily enroll:
  - *Dual eligible, 18-21, in need of community based long term care services for over 120 days.*
  - *Dual eligible age 18-21 and non-dual eligible age 18 and older assessed as nursing home eligible.*

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Phase I: New York City

People New to Service

- Beginning July 1, 2012 - Any dual eligible case new to service, fitting the mandatory definition in any New York City county will be identified for enrollment and referred to the Enrollment Broker for action.
  - *Enrollment Broker will provide with educational material, list of plans/CCMs, answer questions and provide assistance contacting a plan if requested.*
  - *Plan/CCM will conduct assessment to determine if eligible for community based long term care.*
  - *Plan/CCM transmits enrollment to Enrollment Broker*

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People in Service

- **Enrollment will be phased-in by service type by borough by zip code in batches. People will be given 60 days to choose a plan according to the following schedule:**
  - ***July 1, 2012:*** *Begin personal care* cases in New York County.*
  - ***August 1, 2012:*** *Continue personal care cases in New York County.*
  - ***September, 2012:*** *Continue personal care cases in New York County and begin personal care in Bronx County; and begin consumer directed personal assistance program cases in New York and Bronx counties.*
  - ***October, 2012:*** *Continue personal care and consumer directed personal assistance program cases in New York and Bronx counties and begin Kings County.*

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(continued)

Phase 1

- ***November 2012:*** Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings counties
- ***December 2012:*** Continue personal care and consumer directed personal assistance program cases in New York, Bronx and Kings Counties and begin Queens and Richmond counties
- ***January 2013:*** 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.

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(continued)

Phase 1

- ***February 2013 and until all people in service are enrolled:*** 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 in New York, Bronx, Kings, Queens and Richmond Counties
  - *Individuals receiving personal care while enrolled in Medicaid Advantage will begin MLTC/CCM enrollment in January, 2013.

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Next Phase(s)

- **As plan capacity is established, dually eligible community based long term care service recipients will be enrolled as follows:**
  - ***Phase II:*** *Nassau, Suffolk and Westchester Counties – Anticipated January 2013.*
  - ***Phase III:*** *Rockland and Orange Counties – Anticipated June 2013.*
  - ***Phase IV:*** *Albany, Erie, Onondaga and Monroe Counties – Anticipated December 2013.*
  - ***Phase V:*** *Other counties with capacity – Anticipated June 2014.*

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Final Phase

Phase VI: Previously excluded dual eligible groups contingent upon development of appropriate programs:

- *Nursing Home Transition and Diversion waiver participants;*
- *Traumatic Brain Injury waiver participants;*
- *Nursing home residents;*
- *Assisted Living Program participants;*
- *Dual eligibles that do not require community based long term care services.*

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