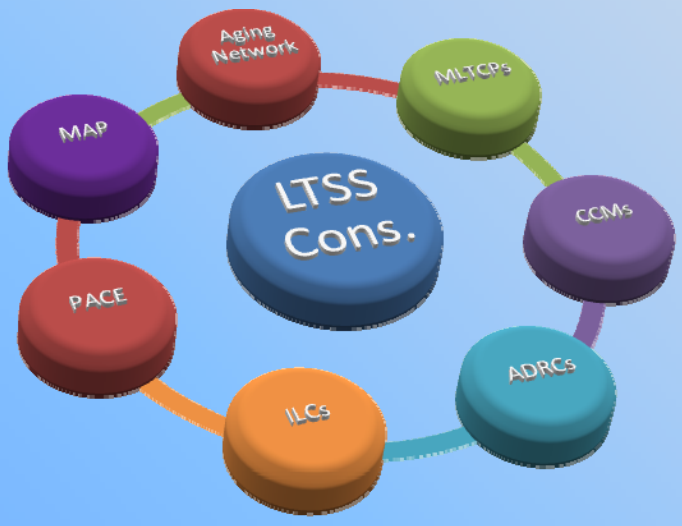
The Changing Landscape of New York's Long Term Services and Supports:

Implications for the Aging Services Network



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Supported by

Albany Guardian Society

New York State Coalition for Aging

New York State Association of Area Agencies on Aging

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The Sponsoring Organizations

Albany Guardian Society

Albany Guardian Society, located in Albany, New York, is one of the region's oldest charitable organizations. Founded in 1852 to provide housing for the aged and helpless, Albany Guardian Society now undertakes a variety of aging-related activities such as producing community forums, providing training opportunities for nursing assistants, producing a television series and developing a neighborhood-based faith initiative. Through the years, while Albany Guardian Society's projects have varied, their focus has remained the same—service to seniors.

As an operating foundation, Albany Guardian Society's mission is to reach out to seniors and those organizations that serve seniors. By collaborating with other well-respected not-for-profit organizations in the community, Albany Guardian Society is able to leverage its resources to impact a broad audience of seniors.

New York State Coalition for the Aging

For over thirty-five years NYSCA has provided strong advocacy, professional development and education for individuals and organizations serving older adults and their caregivers in New York State. NYSCA and its members believe that older adults have the right to live as independently as possible, with dignity, in their homes and communities with the appropriate support services. NYSCA is dedicated to strengthening and expanding the community based service network that serves older adults and their caregivers. NYSCA has continued to advocate for and promote improved state and federal policies for older adults. NYSCA has worked with other advocacy organizations both statewide and nationally to press for adequate funding for programs and services for the older adults in NYS.

NYSCA has provided training and educational sessions throughout the state and has developed a number of best practice workshops and webinars to support the professionals working with older adults and their caregivers.

New York State Association of Area Agencies on Aging

The New York State Association of Area Agencies on Aging supports the state's local offices for the aging and the broad network of 1,500 public and private organizations working in partnership to provide long term services and supports to an ever-expanding population of older New Yorkers. The Association is dedicated to strengthening and expanding community-based services to allow New Yorkers to age in place. We provide professional development for individuals in the field of aging with an education agenda that includes the annual Aging Concerns Unite Us (ACUU) conference, webinars on aging issues, regional caregiver forums and a fall Leadership Institute. A core philosophy is to work in collaboration with other agencies, which is accomplished through the Aging Alliance, a coalition of organizations representing older New Yorkers. Looking to the future, the Board of Directors has approved a new name, the Association on Aging in New York, to be more inclusive of the broad spectrum of aging programs and perspectives. www.nysaaaa.org will soon be replaced by www.agingny.org

Introduction

With the adoption of the Patient Protection and Affordable Care Act (ACA) coupled with the redesign of how Medicaid in New York State provides long term services and supports to its beneficiaries, enormous change is occurring in how health care and long term services and supports are delivered. The aging services network will be profoundly affected.

This paper is a truncated outline of the Patient Protection and Affordable Care Act and the redesign of how Medicaid in New York State provides long term services. Both are very complicated undertakings. It is not possible to reduce either to a simple presentation as too much important information would be sacrificed. Both of these change initiatives are still emerging and the reader will need to stay up-to-date on their cycles of implementation. The reader should see this paper as a beginning resource to grasp the magnitude of the changes that are now occurring, judge the implications for your organization, recognize the threats, and prepare your agency to take advantage of the opportunities. It is incumbent upon the reader to follow the implementation of both of these game-changing undertakings as new opportunities and threats will emerge.

The ACA and the redesign of Medicaid in New York State have the common goals of increasing the quality of care, increasing the coordination of care, improving consumer outcomes and containing costs. They offer the aging services network certain common opportunities and challenges. Examples of opportunities are:

- Both need to reach hard to serve populations and engage them
- Both increase a focus on prevention
- Both need service delivery mechanisms that are very cost effective
- Both are concerned about costly system shortcomings such as unnecessary readmissions to hospitals

They also have common challenges for the aging services network. The most important challenge is a lack of awareness of the aging services network, on the part of the implementing organizations, and its ability to contribute to the goals of these initiatives. Additionally, the aging services network has a very limited experience in contracting to provide its services (the notable exception would be contracting with the Long Term Home Health Care Programs) and establishing unit pricing for its services.

In order for the aging services network to seize the opportunities and surmount the challenges, it must be thoughtful and proactive. Waiting for the new system to discover the aging services network and all it has to offer, will likely result in a system change that sidelines the aging services network. The aging services network has a rich history in, and considerable capacity for, improving health and long term care consumer outcomes in a cost effective manner. Yet the principals in the emerging system do not understand the aging services network or how its relationships, services and outreach can play significant roles in achieving the goals of the coming change. Further complicating the field for the aging services network is the orientation of these principals. It is not in their history, training or their philosophical orientation to utilize non-medical oriented providers and services. There is nothing more important to the future of the aging services network than to alter this reality. If the aging services

network is to thrive, it will be necessary for it to partner with the lead service delivery organizations/plans to efficiently and effectively reach and serve their customers.

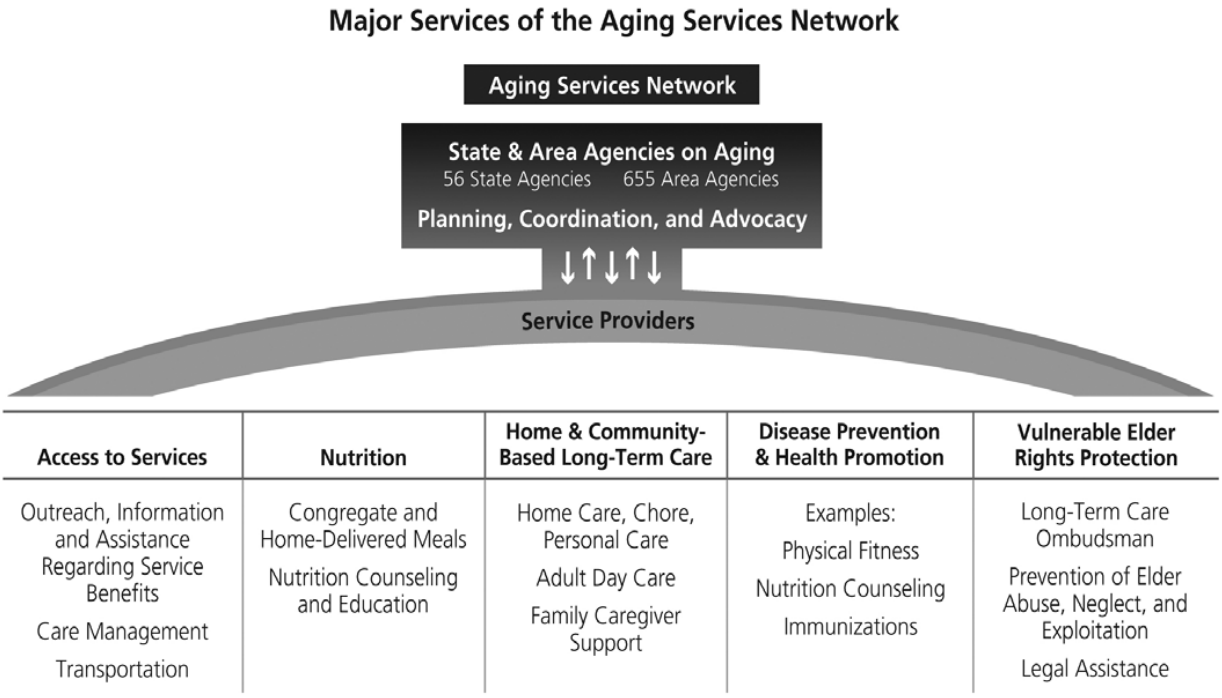
The redesign of Medicaid long term service and supports has implications far beyond the obvious. This "sea-change" will restructure how and what long term services and supports are available in any locality. Though the redesign applies only to the Medicaid program, it will change all long term services and supports regardless of payer. In New York State, Medicaid dwarfs any other payer of long term services and supports. It is an old, but accurate, truism that form follows financing. Providers of long term services and supports will change how, and what, they deliver to be part of the redesigned Medicaid system, they simply cannot afford not to. We have yet to understand what this change will look like, but change is now inevitable.

The Aging Services Network

The aging services network in New York State took shape with the establishment of the New York State Office for the Aging, predating the adoption of the Older Americans Act in 1965. With the subsequent funding of the Older Americans Act, New York State was able to create Area Agencies on Aging (AAAs) to provide planning, advocacy and services with, and for, older adults. Every New York county is served by an AAA.

While the creation of the State Office for the Aging and the AAAs were seminal events, the aging services network is much broader and deeper. It is comprised of numerous community-based organizations that provide direct services to the state's older population. The aging services network shares a philosophy of practice which emphasizes the individual's right to self-determination, independence and dignity; it is a social model of practice. For more than forty years, the aging services network has been supporting the independence of frail, at-risk older adults and the friends and families who care for them. It has promoted the health and well-being of older adults through a variety of prevention strategies. It has carried out its mission in a remarkably cost effective manner. This social model contrasts with the medical model of practice which values protecting the "patient" above all else. In the medical model the professional's view of the care needs of the "patient" determines the intervention; in the social model the "consumer's" view drives any intervention. The medical model focuses on treating the "patient" and spends very little effort on caring for the "patient's" caregiver(s) even though we know that 80% of the care provided to community dwelling frail older adults is provided by informal caregivers. The needs of persons with chronic conditions and disability are neither non-medical nor medical; rather each domain is vital to a positive outcome for the individual. If we are to realize the principal goals contained in the ACA and in the redesign of New York's Medicaid program, we must overcome the obstacles that separate the non-medical and the medical provider communities and form care partnerships that will result in the best possible supports for our at risk older adults.

The following graphic pictures the organization and major services of the aging services network. To read the full New York Area Agencies on Aging Association policy paper on long term care go to http://www.nysaaaa.org/PolicyPaper2011.pdf [1]



This paper is presented in two sections:

- Section 1. Describes the federal law known as the Patient Protection and Affordable Care Act or ACA.
- Section 2. Describes the work of the State's Medicaid Redesign Team as it relates to the delivery of Medicaid long term services and supports.

Section 1:
The Patient Protection and Affordable Care Act (ACA)

On March 23, 2010, President Obama signed the Affordable Care Act. The law puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014.

[1] (NYSAAAA, 2011 www.nysaaaa.org)

The impact of the Patient Protection and Affordable Care (ACA) on the well-being of older adults will lead to two significant outcomes as this landmark legislation is implemented. Within its primary goal of decreasing the number of people without health care coverage, older adults will benefit in a very substantial way. The 45 – 64 year olds represent nearly 30% of the adult uninsured population.[2] Secondly, major initiatives within the ACA will affect older adults to a far greater extent than other populations. These include: (1.) reducing hospital readmissions, (2.) moving people from nursing homes back to their communities, (3.) preventing unnecessary institutionalization, (4.) improving the coordination of care for the dual eligible population (consumers who have Medicare and Medicaid), (5.) creating healthy and livable communities, (6.) strengthening people's choice in how and where they receive long term services and supports, (7.) expanding the number of individuals with long term care insurance (though this component of the ACA is in doubt with the suspension of the Community Living Services and Supports Act), and (8.) increasing the availability of home and community based services.

A significant number of the requirements for the state's participation in improving the quality, accessibility and affordability of health care contained in the ACA can be efficiently and effectively met by utilizing the network of aging and disability services.

The New York State Office for the Aging (NYSOFA) and the Area Agencies on Aging (AAAs) have worked for the past seven years to implement NY Connects (NYS's Aging and Disability Resource Center or ADRC). NY Connects[3] is a locally based point of entry system that provides one stop access to free, objective and comprehensive information and assistance on long term services and supports. ADRCs, along with the broader aging services network, can provide a number of significant services that advance the goals of the ACA in an efficient and effective manner.

NY Connects is the federally designated ADRC (Aging and Disability Resource Center) initiative in NYS. ADRCs are person-centered access programs for long-term supports and services for older adults and people with disabilities. ADRCs are sometimes referred to as a "no wrong door" system. Through integration and/or coordination of existing aging and disability service systems, ADRC programs raise visibility about the full range of options that are available, provide objective information, advice, counseling and assistance, empower people to make informed decisions about their long term supports, and help people more easily access public and private long term supports and services programs.

www.nyconnects.ny.gov

Several states have demonstrated that community based organizations that are trusted members of their communities can be extremely important to engage difficult to reach populations and facilitate enrollment. Aging services network entities are in every community within the state and NY Connects is in many counties; both are valued and trusted.

Implications

While the aging services network's principal mission is to address the needs of older adults, they can, and do, serve all population age groups when it is efficient and effective for them to do so. Utilizing non-Older Americans Act monies, they are in position to provide the services described throughout this section.

[2] (Robert Wood Johnson Foundation, 2009)
[3] (Aging & Disability Resource Center; Technical Assistance Exchange)

Therefore, there are many ways that the New York State Office for the Aging (NYSOFA), the Area Agencies on Aging (AAAs), NY Connects and the aging services network can be supportive of the state's efforts to implement the ACA. Examples of the roles and activities are to:

- Reach out to, engage and support populations as they access the Health Benefit Exchange
- Provide services required for the state to participate in programs that increase the federal portion of funding the state's Medicaid program
- Be a significant part of the solution to reducing hospital readmissions
- Play an important role in reducing Medicaid and Medicare expenses for the dual eligibles
- Identify persons who could transition from the nursing home back to their communities
- Provide health insurance counseling to, and advocacy on behalf of, consumers
- Facilitate enrollment into approved insurance products, including Medicaid managed care, especially for diverse and hard to reach populations
- Assist in determining eligibility for health insurance subsidies and Medicaid
- Identify and report insurance provider malfeasance in marketing and outreach
- Become team members in community-based health teams and in Independence at Home demonstration initiatives
- Provide input into the design of the health exchange(s)
- Provide input into the design of the call center(s) that will be developed to support the activities of the Health Benefit Exchanges

Health Benefit Exchanges and Consumer Assistance

All states are mandated to have a Health Benefit Exchange (HBE). An HBE is the vehicle through which consumers and small businesses learn about, and enroll in, approved health insurance plans. All states must have fully functioning HBEs in 2014. If a state chooses not to create an HBE, the federal government will create and operate one within that state.

With the creation of the required Health Benefit Exchanges (HBEs) and facilitating greater access to health insurance, including Medicaid and other publicly supported options, there are a number of challenges that AAAs, NYSOFA and the broader aging services network can help the state to address. Historically, part of the aging services network role has been to reach out to vulnerable, high risk and difficult to engage population cohorts. That responsibility includes being both culturally and linguistically relevant to these populations. Over time the aging services network has become highly skilled in this type of outreach and, as importantly, are trusted by the ethnicities and other diverse populations residing in their communities. Outreach and engagement of difficult to reach populations is a core competency of the aging services network. Secondly, the aging services network has been providing health insurance counseling and navigation to adults, through its Health Insurance Information and Counseling Assistance Program (HIICAP) for many years. HIICAP and other programs of the aging services network have created a system of advocates working on behalf of adults to resolve a range of health insurance problems. Facilitating enrollment, engaging difficult to engage populations and being a health care and health insurance advocate for adults are also core competencies of AAAs as well as the

broader aging services network. NYSOFA, the AAAs and the aging services network represent a ready asset to New York to engage target populations, to facilitate enrollment, to be navigators for persons needing decision making support, and to be advocates for people experiencing problems with their health insurance provider.

Status

New York State has undertaken a planning effort to create its own HBE. NYSDoH is the lead agency for the development of the HBE. The Governor, by Executive Order, established New York State's HBE in April, 2012. NYSDoH is continuing to further develop the state's HBE plan.

Not part of the HBE, but a very important component of the ACA, will be the rating of health care providers and the development of incentives to choose those rated as "high value." Medicare beneficiaries will have financial incentive to encourage them to utilize "high value" providers. For many consumers the process of selecting the "high value" provider, which will be the best fit for them, will be a challenge. Currently this incentive program is pending further action by the Centers for Medicare and Medicaid Services (CMS).

Implications

The NYSDoH has been awarded federal funds to provide consumer assistance with navigating all health insurance options and other activities. (It is not clear what role, if any, the HBE will play for Medicare enrollment; it would be surprising if it played anything more than a very limited role of facilitation.) It appears that units of government and not-for-profits will qualify to be navigators for the HBE(s). However, a summary of the funded activities contained in NYS's application did not specifically mention units of local governments or aging services network organizations. It does mention enhancing community based organizations for outreach and support in enrolling[4]; a core skill of the aging services network.

States are required to establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and the small group markets.[5] AAAs are local (county-based) and have a well-developed health care advocacy structure (e.g. LTC Ombudsmen an HIICAP counselors). They, along with other aging services network organizations, are positioned to identify and report provider malfeasance in marketing and outreach. AAAs and other aging services network organizations are in a position to assist older adults, and other consumers, as advocates for persons in the individual and the small group markets. At the very least, aging services network organizations should assist older adults in receiving redress by facilitating their engagement with the office of health insurance advocate and provide outreach to this growing cohort on behalf of the office of health insurance advocate. Resources from the federal grants to establish the office of health insurance consumer assistance could potentially fund the aging services network for these activities.

[4] (HealthCare.gov, 2010)
[5] (Kaiser Family Foundation, 2010)

Each HBE is required to consult with various stakeholders, including enrollees in qualified health plans, individuals and entities experienced in facilitating enrollment, representatives of small business and the self-employed, Medicaid offices, and advocates for enrolling hard-to-reach populations.[6] Lessons learned in the implementation of health insurance reform in Massachusetts demonstrated that trusted community-based organizations (CBOs) played a critically important role educating hard-to-reach consumers about obtaining coverage and completed application forms on behalf of consumers. The state created an on-line application portal for use by trained CBOs and provider staff. As an automatic part of the application process, consumers were invited to appoint these application assisters as their authorized representatives throughout the eligibility determination process. As a result, the application assisters received copies of state correspondence asking for additional eligibility information. This let them work with consumers to respond satisfactorily to the state's requests. More than half of all successful applications were completed, not by consumers, but by CBOs or health care providers acting on the consumers' behalf. The CBOs were provided grants to perform these roles. In California, certified application assisters (CAA) have received payments of $60 (at initial enrollment) and $50 (at annual renewal) for each family whose children successfully enroll in Medicaid or CHIP.[7] It is likely that some grant program will evolve in New York State to provide the support in order to reach hard to reach population cohorts.

HBEs will provide refundable, and advanceable, premium credits to eligible individuals and families with incomes between 133-400% of the Federal Poverty Level (FPL) to purchase health insurance (through the HBE). Cost-sharing subsidies will be provided to eligible individuals and families. HBEs will be required to verify income and citizenship status in determining eligibility for the federal premium credits. With the complexities associated with eligibility for refundable and advanceable premium credits, as well as the cost sharing subsidies, many consumers will struggle to qualify for subsidies they are entitled to receive. The aging services network entities are very experienced in working with adults who are making complex health insurance choices. As was previously noted they have an experienced health insurance counseling infrastructure in place to assist older adults (and others) in navigating health insurance choices.

The HBE will determine eligibility for Medicaid and for other subsidies.[8] Yet the question of determining eligibility for Medicaid under the program's spend-down provisions is not yet clear. In order to determine eligibility for spend down a comprehensive assessment and care plan must be established in order to understand the amount of spend down the person qualifies for. There is a clear business case to utilize NY Connects for performing such comprehensive assessments. In counties that do not currently have NY Connects, it may be possible for existing mechanisms to be used to perform assessments for spend down consumers. However, these arrangements would need to meet the ACA criteria for independent, conflict free, assessment and care planning.

[6] (Urban Institute, 2010)
[7] (Urban Institute, 2010)
[8] (Urban Institute, 2010)

Aging services network associations should research other state's HBE planning to determine if there are any that envision using their aging services network as navigators and facilitators. The roles of community-based organizations, in California and in Massachusetts, are particularly instructive. Aging services network associations should engage with NYSDoH and promote the use of aging services network organizations as counselors, navigators/facilitators, advocates and play a significant role in assessment and care planning for those individuals who may be eligible for the Medicaid program because of the cost of their health and Long Term Services and Supports (LTSS).

As previously mentioned, a separate section of the ACA implements incentives for Medicare beneficiaries to select "high-value" providers.[9] There will be online tools to assist in choosing "high-value" health care providers. However, currently only about 60% of older adults are experienced users of the Internet.[10] The aging services network organizations are in the best position to provide older adults with the support they need to make an informed choice about the "high-value" provider that would be the best fit for them.

Hospital Readmission Rates and Community-Based Care Transitions Program

The HBE will approve all insurance plans. In order to be a "qualified plan" capable of being offered in the exchange, a plan must implement a "quality improvement strategy," which includes a payment structure that encourages:[11]

- Preventing hospital readmissions, whenever possible, through a comprehensive program for hospital discharge;
- Wellness and health promotion.

The ACA establishes community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities.[12] It is intended that these community-based health teams would improve patient health outcomes and reduce admissions/readmissions to hospitals.

Hospital readmission rates add enormous cost to the health care system. Current research indicates that as many as 20% - 30% of readmissions could be avoided. There have been a number of interventions developed and tested. The most promising interventions to date are those that are based on Dr. Eric Coleman's Care Transition Intervention (CTI).

Health homes are designed to be person-centered systems of care that facilitate access to, and coordination of, the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

[9] (Robert Wood Johnson Foundation, 2011)
[10] (AARP, 2009)
[11] (Urban Institute, 2010) (p.33)
[12] (Urban Institute, 2010) (P.10)

Status

Beginning with federal fiscal year 2013 (FFY 2013 begins October, 2012), hospitals with readmission rates that exceed their expected readmission rate will have their Medicare inpatient payments reduced by an amount approximately equal to the dollar value of the payments made for the excessive number of readmissions.[13]

Last year, 2011, CMS initiated a $500 million federally funded (funded through the ACA) Community-Based Care Transitions Program (CCTP) through which hospitals and community-based entities furnish evidence-based care transition services, including active post-discharge engagement, to Medicare beneficiaries at high risk for hospital readmission. The program is funded for the calendar years 2011 through 2015, but the program may be extended and expanded if HHS determines that such steps would lessen Medicare spending without reducing quality of care.[14] The goals of the CCTP are to:

- Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measurable savings to the Medicare program and expand the program beyond the initial five years

Implications

Hospitals will need to have an effective transition program in place in order to reduce readmission rates and avoid penalties established in the ACA. Older adults use a disproportionate amount of hospital care. Not only are there a greater number of older adults in hospitals than any other cohort, they are also at substantially greater risk of readmission than younger cohorts.[15]

Community-Based Care Transition Programs in NYS

Currently, there are four New York State funded Community-based Care Transition Programs (CCTP) that have been funded by CMS with monies made available through the ACA. Within one multi-county CCTP, an AAA (Tompkins County) is the lead community based organization. Tompkins County (along with Albany County) has experience in partnering with hospitals to reduce readmissions through the community supports navigator program and was well positioned to be a lead participant. The following are New York's four funded CCTPs:

1. **Brooklyn Care Transition Coalition** - Providing transition services and assistance to Medicare fee-for-service beneficiaries across 26 ZIP Codes throughout northern and central areas of Brooklyn. The Cobble Hill Health Center will serve as the lead CBO, partnering with The Brooklyn Hospital Center, the Interfaith Medical Center, and Independent Living Systems, Inc.
   Brooklyn Care Transition Coalition Detailed Summary (PDF)

[13] (The Hospital and Health Association of Pennsylvania, 2010)
[14] (Urban Institute, 2010)(P.33)
[15] (AHRQ, 2010)

2. **Lifespan of Greater Rochester Inc.** - Partnering with four acute care hospitals; Rochester General, Unity, Strong Memorial, and Highland Hospitals; two home health agencies; two additional CBOs; and the Finger Lakes Health Systems Agency to provide care transition services to high-risk Medicare beneficiaries across four counties in Western New York State.
   Lifespan of Greater Rochester Inc. Detailed Summary (PDF)
3. **P2 Collaborative of Western New York, Inc.** - Serving as the regional coordinating body for 10 community hospitals across seven rural counties in Western New York: Brooks Memorial Hospital (Chautauqua); Jones Memorial Hospital (Allegany); Olean General Hospital (Cattaraugus); Orleans Community Health (Orleans); TLC Health Network Lake Shore Health Care Center (Chautauqua); United Memorial Medical Center (Genesee); Westfield Memorial Hospital (Chautauqua); WCA Hospital (Chautauqua), and Wyoming Community Hospital (Wyoming County). Each participating hospital will collaborate with a local CBO to build upon and expand existing care transition services for Medicare beneficiaries.
   P2 Collaborative of Western New York Detailed Summary (PDF)
4. **Tompkins County, New York Office for the Aging** - Acting as the lead CBO for the Tomkins County Rural Community-based Care Transition Program (TCRCCTP). Serving the Finger Lakes region of rural Central New York, the TCRCCTP will work with Cayuga Medical Center, the County's sole hospital and multiple local host agencies to improve the quality of care and reduce avoidable hospitalizations among Medicare beneficiaries.
   Tompkins County Detailed Summary (PDF)

Community Supports Navigators

NYSOFA has partnered with Albany and Tompkins Counties' AAAs/NY Connects programs that are, in turn, partnering with hospitals within their communities to reduce readmission rates for the Medicare population. In these counties, Consumer Supports Navigators (CSNs) work directly with hospital personnel and follow-up with the consumer at the time of ~~their~~ discharge. CSNs coach the consumer on medication adherence, help to ensure that the consumer has a follow-up doctor visit and link the consumer with essential community supports, using NY Connects, to address other issues that would contribute to readmission to the hospital.

Given the many offerings of aging services network organizations that would contribute to reducing hospital readmissions and improving outcomes for persons with chronic disease, the aging services network has a very important role to play. With that noted, the philosophical and organizational culture barriers (i.e. medical model orientation), described in the following section on the work of the Medicaid Redesign Team, are very real and will not easily be overcome.

Recommended activities for aging services network state associations include:

1.) Surveying their membership to determine if any member organizations are partnering with a hospital to assist in reducing hospital readmissions. If there are members, the aging service network associations should disseminate the lessons learned by those organizations in establishing and maintaining these partnerships.
2.) Showcasing the CSN experience and encourage the development of CSN programs statewide.

3.) Demonstrating the experience and the successes of the aging service network in providing patient self-management chronic care management services (i.e. "Chronic Disease Self-Management Program" and "Diabetes Self-Management Program").
4.) Offering presentations and/or workshops on the CSN model and on aging service network patient self-management chronic care management services at conferences attended by hospital discharge planners and hospital management personnel as well as at conferences attended by community health organizations.
5.) Presenting and conducting workshops, which highlight aging service network best practices in wellness and health promotion services, at conferences attended by entities seeking to offer health insurance plans that are qualified by the HBE.

State Balancing Incentive Payments Program (BIPP) and the Community First Choice Option (CFC)

These two federal initiatives reward participating states with increased federal reimbursement (FMAP) to expand the availability of home and community-based services (HCBS) and reduce reliance on nursing home care in the Medicaid program. BIPP creates an opportunity for participating states to receive a temporary enhanced Federal Medical Assistance Percentage (FMAP) to help them rebalance Medicaid spending by increasing the percentage of home and community based expenditures for long-term services and supports under the state Medicaid program. A reasonable interpretation of the legislative language could mean over $190 million of federal funds to New York per year for each year of the four-year grant State Balancing Incentive Payments Program (BIPP).[16] Significant additional federal funding would result if the state makes changes to its Medicaid (MA) state plan in accordance with the ACA's Community First Choice Option (CFC). That change would provide the state with an additional 6% federal match for the care provided to qualifying consumers. Because CFC would be part of a state Medicaid plan, it is not a demonstration program and it is not time limited, promising an ever increasing federal share of the state's Medicaid program as more and more consumers receive support under this option.

In order for New York to participate in either BIPP or CFC it must meet certain requirements. Among those requirements to participate are that a state must have or establish a single point of entry for long term care services and supports (BIPP) as well as the provision of conflict-free case management services (BIPP & CFC). Currently, there is some question as to whether or not New York State will qualify for BIPP based on issues not related to single point of entry and conflict free case management.

Noted earlier in this paper; the New York State Office for the Aging (NYSOFA) and the Area Agencies on Aging (AAAs) have worked for the past seven years to implement NY Connects (NYS's Aging and Disabilities Resource Centers or ADRCs). NY Connects is in many of the state's counties, providing a point of entry for long term services and supports as well as conflict-free information, assistance and referral. A growing number of NY Connect entities have the ability, onsite, to establish consumers' eligibility for a number of publicly sponsored long term services and supports, including Medicaid.

[16] (AARP New York State, 2011)

Additionally, an increasing number provide conflict-free, person centered, comprehensive assessment, care planning and ongoing care management. This valuable resource will enable the state to meet many of the qualifying requirements to participate in BIPP and in CFC. NY Connects is recognized by CMS as New York's ADRC. CMS is the entity overseeing the BIPP and CFC provisions of the ACA. As previously stated, there is a solid case for utilizing NY Connects to continue as the CMS approved ADRC (single point of entry for long term care services and supports) and to provide conflict-free information, assistance, referral, person centered assessment, care planning and ongoing care management.

Status

NYSDoH has, as of this writing, not applied for either of these programs authorized under the ACA. Since BIPP alone would save $190 million a year for the four years that BIPP is available[17] and CFC would also save substantial state taxpayer dollars, it would appear likely that, at some point, NYSDoH will apply. NYSDoH is currently researching the possibility of applying for BIPP and CFC.

Implications

If NYSDoH does not apply for BIPP and it does not incorporate CFC into the state Medicaid plan, it will forego considerable federal assistance. That assistance would both reduce state tax dollars going into Medicaid and would continue to make the LTSS system more consumer friendly.

When/if the state moves forward on these two federal initiatives, the value of many services offered by the aging services network will grow significantly. The aging service network associations should continue to advocate with New York State's decision makers for the adoption of these two federal initiatives.

[17] (AARP New York State, 2011) (P.7)

Section 2:
Medicaid Redesign Team's (MRT) Work and Recommendations

A note to the reader: Many of the acronyms that appear in the following section may be new to you. In the Appendices to this paper is a taxonomy of terms to assist you. Secondly, MLTCPs (managed long term care plans/providers/programs) is used as an encompassing acronym that includes all of the various types of managed long term care plans allowed in the redesigned Medicaid system of long term services and supports, in a general category. MMLTC or MMLTCP are acronyms that apply to one specific type of managed long term care plan/provider. There are five different types of MLTCPs, MMLTC/MMLTCP is but one of those

The MRT is charged, by the Governor, to reformulate the delivery of Medicaid services in New York State. New York is spending an estimated $54.2 billion in SFY 2011-12; comprised of $21.1 billion in state funds, $24.5 billion in Federal funds and $8.6 billion in local funds. The intent is to limit growth in Medicaid expenditures to no more than 4% annually beginning with the SFY 2013-14.[18]

The stated goal of the redesign initiative is to achieve two principal outcomes; increased quality and improved efficiency. Its work encompasses the entire Medicaid program, including home and community based services (HCBSs) for recipients in need of long term services and supports (LTSS). It is anticipated that the redesign of Medicaid long term services and supports will be complete in all of the major urban areas of the state by the end of 2013 with the balance of the counties coming on line in 2014. The following link allows the reader to review the redesign changes contained in the adopted SFY 2012-13 Budget: http://www.health.ny.gov/health_care/medicaid/redesign/.

New York State has submitted amendments to the existing 1115 waiver (Medicaid) to CMS. Currently that waiver is under review. New York may not implement the major changes to the Medicaid program, including those affecting HCBSs, until CMS approves the State's proposed changes. This does not include voluntary enrollment in existing Medicaid Managed Long Term Care programs (MMLTCs) as they are already part of the Medicaid program. It is not clear when CMS will make its decision. Though, in early March, NYSDoH stated they are close to receiving approval.

In 2012, New York State plans to submit a new 1115 waiver to include, among other things, the costs (all or in part) of housing, especially supportive housing, in the State's Medicaid program for those persons eligible for Medicaid and who require LTSS. Associations and others wishing to express their views on housing with supports should initiate conversations with the NYSDoH's Office of the Medicaid Director.

The MRT formed ten work groups to tackle specific areas of concern. The work groups meet independently, formulate recommendations for the full MRT to consider, amend and/or adopt. This paper examines the work of the Managed Long Term Care Implementation and Waiver Redesign Work Group and the Affordable Housing Work Group. A list of all the work groups of the MRT can be found in the appendix. In the current Phase II, the MRT has established an implementation work group to assist

[18] (NYSDoH, 2012)

NYSDoH in rolling out the Medicaid long term services and supports. Their work is ongoing and can be monitored on the web by following the URL:
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm

Managed Long Term Care Implementation and Waiver Redesign Work Group (MLTC)

The Managed Long Term Care Work Group is one of 10 work groups constituted under the auspices of the MRT. The Managed Long Term Care Work Group's responsibility is to devise an approach to improve the quality and efficiency of LTSSs (those whose service and/or support needs will exceed 120 days).

The Managed Long Term Care Approach in NYS

The MLTC has recommended, and the full MRT has adopted, that all Medicaid recipients in need of community-based LTSS shall receive LTSS through a managed care entity. When, and if, CMS approves the 1115 waiver modifications that New York State has submitted, it will be mandatory that such individuals be enrolled in a managed care program that provides LTSS. Under the current recommendations, mandatory enrollment will only occur in areas when there are two or more managed long term care programs. In the current design, when there is one or none MLTCPs, mandatory enrollment is suspended. This is very much a work in progress. It is anticipated that changes will occur as lessons are learned during implementation.

Characteristics of Medicaid Long Term Care Plans (MLTCP)

New York's Medicaid redesign allows for several types of MLTCPs. It builds on existing managed care programs (Medicaid Managed Care Organizations and Medicaid Managed Long Term Care). Additionally, authorizing state legislation adds a new category (Care Coordination Model). A list of MLTPs in New York State is included in the appendix.

The two managed care approaches that are currently allowed in statute are:

1. Fully capitated programs (the managed care program pays for, and is financially at risk for, all LTSSs, including nursing home care, and all health care). These are:
    a. Programs of All-inclusive Care for the Elderly (PACE)
    b. Medicaid Advantage Plus (MAP)
2. Partially capitated models (the managed care program pays for, and is financially at risk for LTSSs, including nursing home care, but not for health care). These are:
    a. Medicaid Managed Long Term Care (MMLTCs)
    b. Medicaid Managed Care Organizations (MCOs)
    c. Care Coordination Model (CCMs). To see requirements to become a CCM go to the following link:
    http://www.health.ny.gov/health_care/medicaid/redesign/managed_ltc_workhroup.htm

Fully Capitated

"Both PACE and Medicaid Advantage Plus (MAP) provide primary medical care and long-term care services, including all services paid for by Medicare and Medicaid**.** PACE members must be age 55 or older, MAP members must be 18 years or older, all members must be otherwise eligible for nursing home admission. The PACE or MAP Plus plan receives a "capitated" monthly payment to cover

all Medicare and Medicaid services. PACE or MAP Plus members are required to use "in-network" physicians, home care providers, hospitals, and other providers (under contract with the program). The PACE or MAP Plus plan is responsible for directly providing, or arranging, all primary, inpatient hospital and long-term care services required by a member and provides on-going care management."[19]

Partially Capitated

Medicaid Managed Long Term Care programs (MMLTCs) provide long-term care services (like home health, adult day care, personal care and nursing home care) as well as ancillary and ambulatory services (including dentistry, optometry, eyeglasses, and medical equipment). MLTCs receive Medicaid payments only. Members continue to receive their regular Medicaid and Medicare from their primary care physicians and inpatient hospital services. The MMLTC plan does not control, or provide, any Medicare services. It does not control or provide most primary medical care. Members must be eligible for nursing home admission (must have functional impairments that meet the qualifications for nursing home admission). While several plans in New York State enroll younger members, most managed long-term care plan enrollees must be at least age 65.[20]

The newly developed Care Coordination Model is defined as "A CCM must provide or contract for all Medicaid long term care services in the benefit package (as described in NYS Medicaid Plan). A CCM will be at risk for the services in the benefit package and rates will be risk adjusted to reflect the population served. The CCM benefit package includes both community-based and institutional Medicaid covered long term care services and makes consumer directed personal assistance services available for eligible individuals. The CCM is responsible for assessing the need for, arranging and paying for all Medicaid long term care services."[21] "Five services (dentistry, audiology/hearing aids, vision/eyeglasses, outpatient therapies and podiatry) are not required to be in the benefit package until Year 2 of operation. Care management is a key function . . . A CCM also has two years to phase-in to the MLTCP reserve requirements."[22] Similar to MMLTCs and MCOs, CCMs would not be responsible for primary care paid for by either Medicare or Medicaid. The age of eligibility is 21 years or older. (See Appendix Table: SUMMARY OF LTSS MANAGED CARE PLANS IN MEDICARE AND MEDICAID[23].)

Long Term Home Health Care Program and Existing MMLTPs

As of this writing, it is not completely clear what role, if any, the Long Term Home Health Care Program (LTHHCP) will have in this new service delivery model. Effective July 1, 2012, LTHHCPs are prohibited from enrolling any new consumers (this is a delay from the original date of April 1, 2012). When the recommendations are fully implemented, unless they are changed, the LTHHCP will no longer exist in its current form.

LTHHCP can apply to be a MMLTC or CCM, but must meet the requirements governing those entities. Additionally, LTHHCP providers can contract with a MLTC or a Medicaid Managed Care Organization

[19] (NY Health access, 2012)
[20] (NY Health access, 2012)
[21] (New York State Department of Health; Medicaid Redesign Team, 2011)
[22] (NYS Department of Health, 2012)
[23] (NY Health access, 2012) as modified

(MCO) to provide service ordered by the MLTC/MCO.[24] Many aging services network entities currently provide a significant level of support services through contracts with LTHHCPs (home delivered meals, social adult day care, transportation are examples). If the LTHHCP no longer exists as a separate Medicaid supported program, and this is likely, then aging services network entities should be seeking relationships to provide their services through MLTCPs in their areas.

From the regulatory perspective PACE, existing MMLTCs and MAPs are fully or partially capitated managed long term care programs and should be largely unaffected in the realignment of New York's Medicaid program. PACE and MAPs qualify, but must make application to the New York State Department of Health to serve as a Managed Long Term Care Plan/Program. From an implementation perspective they may be challenged in managing a very large influx of consumers.

Other Issues Pending Outcome of the MRT's Work and Implementation

Demonstration for Dual Eligibles

On March 22, 2012, the New York State Department of Health (NYSDOH) published for public comment a proposal for a demonstration project that would provide all Medicare and Medicaid physical healthcare, behavioral healthcare, and long term supports and services through a fully-capitated managed care model. Public comment period ended April 20th.

The proposed plan can be found by following this link:
http://www.health.ny.gov/facilities/long_term_care/docs/demo_integrate_care_for_dual_elig.pdf

Uniform Assessment System for Long Term Care in New York State (UAS or UAS-NY)

The New York State Department of Health, Division of Long Term Care (DLTC) is in the midst of developing and implementing the Uniform Assessment System – New York (UAS-NY). The UAS-NY is planned to be a comprehensive, web-based system. Initially, the UAS-NY will focus on implementing the UAS-Community Health Assessment (UAS-CHA). The UAS-NY will possess the capability to expand in the future.

The development and implementation of the UAS-NY will occur in four phases:

- development and design of the system (currently in process)
- beta testing the UAS-NY and the UAS-CHA (projected March through May 2012)
- pilot testing the UAS-NY and the UAS-CHA (projected June through August 2012)
- statewide implementation (projected to begin September 2012)[25]

To track progress on implementing the UAS-NY follow this link:
http://www.health.ny.gov/facilities/long_term_care/uniform_assessment_system/phase_1-2_progress.htm

[24] (NYS Department of Health, 2012)
[25] (NYSDoH, 2012)

The UAS-NY is not required for aging services network programs. It will, however, be relevant to any aging services network entities that partner with a MLTCP.

State Balancing Incentive Payments Program (BIPP) and the Community First Choice Option (CFC)

As of this writing, the State has not applied for either the State Balancing Incentive Payments Program (BIPP) or the Community First Choice Option (CFC), described earlier in the discussion of the Affordable Care Act. Given the consumer-centered criteria required under these two federal initiatives, their implementation would likely alter aspects of the current effort. Specifically:

- BIPP would require greater protections for the consumer in selecting the types of, and providers of, LTSSs by having access to conflict-free information, assessment, care planning made available through an Aging and Disability Resource Center (ADRC). New York's federally recognized ADRC is New York Connects. Currently, New York Connects does not have a role in the implementation of MLTC recommendations. New York State has chosen not to invest sufficient resources in NY Connects. This lack of investment has prevented NY Connects from functioning in the manner that was envisioned by CMS. To provide perspective, in 2007, Wisconsin appropriated $14.38 million for its ADRCs, during that same year New York appropriated $6.1 million.[26] During 2007, the Wisconsin appropriation was estimated to provide access to ADRC services for 44% of its population. Wisconsin's population is 5.7 million with an estimated 600,000 living with a disability. New York's population is 19.4 million, with an estimated 2 million living with a disability.[27] Wisconsin's ADRC model is well regarded. It plays a central role in Wisconsin's managed long term care approach. It is a legitimate model to measure what funding is necessary to operate a fully functioning ADRC.
- CFC would require that the State include a far more robust and consumer-centric participant directed care program (one that includes both goods and services). Currently, the Consumer Directed Personal Assistant Program (CDPAP) is the only consumer directed option envisioned to be offered in the New York's managed long term care approach. CDPAP is limited to allowing the participating consumer to direct the personal assistant that they hire, train and can fire. There are no provisions for other goods and services. Currently, it is estimated that 9,000 individuals are enrolled in CDPAP, representing a very small percent of those receiving Medicaid supported LTSSs.

Timing of Implementation

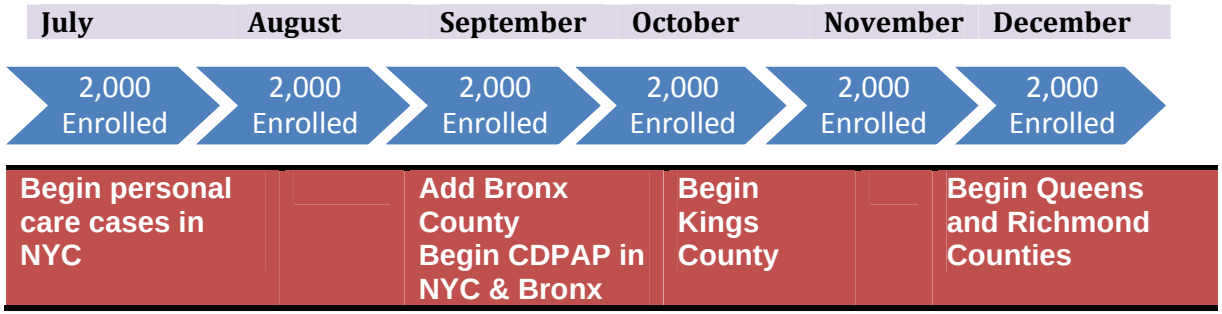
Voluntary enrollment of consumers in MLTCPs began as of January 1, 2012, in New York City. NYSDoH is providing incentives to NYC MLTCPs to encourage enrollment. The State intends to initiate mandatory enrollment, for 2,000 individuals, per month, beginning July 1, 2012, in NYC. Mandatory enrollment is subject to approval by CMS which is pending, as of this writing. The original target date for mandatory enrollment was April 1, 2012. However, New York's 1115 waiver modifications were not approved in time to implement the April start date. Despite the three month delay, NYSDoH still hopes to enroll 24,000 individuals in managed long term care by the end of the State's Fiscal Year (March 31, 2013).

[26] (Aging & Disability Resource Center; Technical Assistance Exchange)
[27] (U.S. Census Burea, 2011)

By 2013, mandatory enrollment will begin in Long Island for those individuals who are dually eligible for both Medicare and Medicaid (referred to as duals) according to the current state timeline. There are 700,000 such individuals in New York State. By mid-year of 2013, mandatory enrollment of duals will begin in Orange, Rockland and Westchester Counties. In December, mandatory enrollment of duals will begin in Albany, Erie, Onondaga and Monroe Counties.

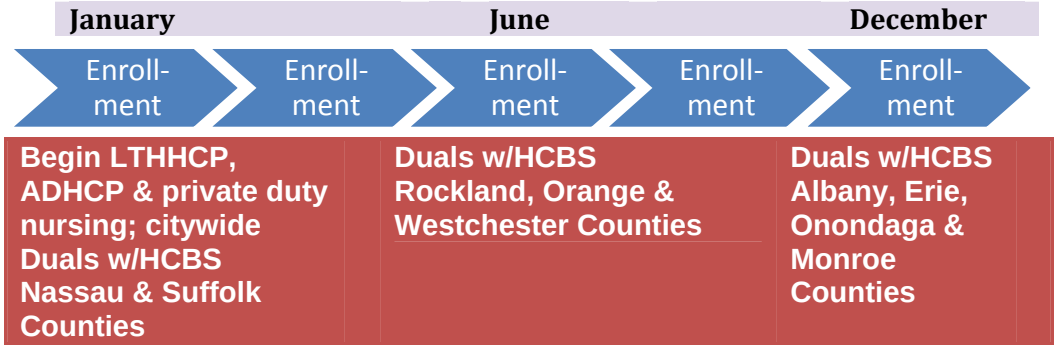
As of this writing, implementation for other populations and other regions of the state is not yet spelled out.

MLTCP Enrollment; 2012 New York City



CDPAP= Consumer Directed Personal Assistance Program; LTHHCP= Long Term Home Health Care Program, ADHCP= Adult Day Health Care Program

MLTCP Enrollment; 2013 Downstate & Upstate



Duals= Individuals who are eligible for both Medicare and for Medicaid; HCBS=Home and Community Based Services

Enrollment for other counties with capacity is anticipated to begin in June, 2014

Implementing Managed Long Term Care

The New York State Department of Health is the entity in charge of pursuing the recommendations, relating to Medicaid, of the MRT. The New York State Department of Health is now, and has, conducted ongoing stakeholder meetings on implementing managed long term care for LTSSs. It has published "Instructions for the Completion of Certification Application for Managed Long Term Care Plans" along with the associated forms.

It has contracted Maximus, a private enrollment company, to design an enrollment process for both existing Medicaid consumers of LTSSs and new enrollees. They will lead the development of all tools directed to the consumer.

New York's Medicaid Director, Jason Helgerson, noted, in a joint hearing of the Senate Finance and Assembly Ways and Means Committees (February 8, 2012), the possibility of having local nonprofits provide facilitated enrollment for Medicaid eligible persons in need of LTSS.

Medicaid consumers needing LTSSs may only enroll in PACE or MAPs programs after they are assessed by the program and determined to meet the unique criteria required to participate in these programs. Other MLTCPs will need to conduct an assessment to determine if the potential enrollee is appropriate for their program.

Where it Will be Implemented

The major focus for implementing Managed Long Term Care is New York City. The entire implementation effort will be conducted in the City during 2012 and will remain ongoing after 2012. During the second year (2013), the population that is eligible for both Medicare and Medicaid (Duals) in downstate and in the larger urban areas upstate will be enrolled.

Possible Opportunities and Challenges

Opportunity

Managed long term care plans must provide the full range of LTSSs described in the Medicaid State Plan (MSP). A plan/model is not limited to providing only those services, however. Managed long term care operates by using a risk model. The managed care provider accepts a set monthly payment for every enrolled member. The plan/model will be able to provide other services that increase the quality of care and/or reduce utilization of more costly services (evidence-based) or have the potential to do so. Since "payment to the CCM will be based on the functional impairment level and acuity of its members"[28] and not upon service payment history, there are strong incentives for managed care entities to incorporate services that will diminish reliance upon more expensive services, such as many of the services provided by the aging services network. This payment methodology presents real opportunities for the aging services network. An example of this would be a plan/model contracting with a provider for adult day services to substitute for supervision of the consumer by a personal care attendant, thereby increasing the quality of the service delivered (increased opportunities for stimulation and social interactions) and creating efficiencies for the plan/model (less expensive).

[28] (New York State Department of Health; Medicaid Redesign Team, 2011)

Challenges for the Aging Services Network

With that noted, there are very real barriers that stand in the way of the aging services network contracting or partnering with CCMs.

One of the most significant challenges is one that may not be immediately apparent yet is a powerful barrier to breach. It directly affects the ability to engage with the plans/models. The redesign of Medicaid supported LTSSs continues the program's reliance on a medical model of delivering services. Medical professionals are socialized to "do no harm," to protect the "patient." Their training and experience leads them to utilize services of allied professions (it could be argued that personal care is a major exception, but it is still "ordered" by medical professionals who seek to protect the patient). Assessment and care planning activities are conducted in this tradition and focus on the deficits of the individual and how to mitigate them as well as protect the consumer. The aging services network's philosophical underpinnings are that of the social work tradition. Its focus is on the dignity of the individual and their right to self-determine what is best for them, what constitutes an acceptable quality of life and what constitutes acceptable risk. Assessment and care planning honor the individual's right to self-determination and focus on the strengths of the individual, which includes the well-being of the individual's informal supports. Bridging these two professional cultures will be challenging. Aging services network's history in attempting to engage with managed care programs is not a very positive one.

Responding to the Challenge

One activity that would be most helpful to the aging services network is for the various associations to survey their members to find examples of where there are relationships that are mutually beneficial for the aging services network entity and a health sector entity. Publishing testimonials about the importance of these relationships from all parties involved could provide aging services network organizations with tools to demonstrate to managed care entities the value of their services. Conducting workshops and other activities to train the associations' membership on how these relationships came about and how they are sustained would be helpful to the aging services network. Equally important would be to make available workshops, best practice models and/or other training activities at association meetings and conferences where the health care sector comes together, especially where the leadership of plans/models is present.

Challenges for the Aging Services Network

Many aging services network entities do not have any experience in determining a unit cost for it services and, therefore, do not have experience in pricing their services. Aging services network organizations will need to develop rates for services and ensure that all their costs are covered, while at the same time, provide a rate that is less expensive than other potential providers in order to be considered by the managed care organization. While some aging services network organizations, including AAAs, have undertaken this process, many have not and will need to embark on this journey if they want to provide services as part of managed long term care. Further, aging services network entities have little to no experience in negotiating contracts, a key skill in this new approach to delivering LTSSs.

Responding to the Challenge

While not widespread, there are aging services network entities that have developed the experience to rationally price their services and have acquired contract negotiation skills (i.e. AAAs providing services to Veterans with disabilities). Associations should identify best practices in the "how's" of service pricing and contract negotiation and disseminate them. Aging services network entities associations should offer training and workshops on these topics. Web-based tools, webinars and workshops are examples of how to build aging services network entities capacity in this area.

Opportunity

More and more health care systems are using a multi-disciplinary approach to case management. This is especially true when they are serving persons with complex needs that span the health, social and environmental domains. For the aging services network entities organizations that have case/care management programs, establishing partnerships with (contracting with) managed care entities to provide the social and environmental components of the multi-disciplinary team would benefit all parties. It would provide a revenue stream for the aging services network entities organization, it would meet the outcomes sought in the newly redesigned Medicaid system (improved quality and increased efficiency) and it allows the managed care entity to add quality without adding staff. Aging services network entities, that have established relationships with health care providers, will be in a strong position to leverage those relationships to engage with plans/models.

Challenge

Only a very small minority of aging services network entities have relationships with health care/managed care providers. There is little history within MLTCPs for using a blend of nursing and social work to form assessment and care management teams. As was noted earlier, the dominant medical organizational culture is a deterrent to such collaborative partnerships.

Response

Similar to other approaches, there is evidence that demonstrates that when the two disciplines (health and social work) collaborate the outcomes for the person in need of LTSSs are better. Finding ways to disseminate that information can be supportive of engaging with plans/models. Aging services network entities' sponsored presentations and workshops at aging services network entities' conferences and at MLTCP conferences can help overcome the reticence to partner in this area.

Opportunity

Currently, there is no specified role for NY Connects (New York's federally recognized ADRC) in the MRT redesign of Medicaid. And, while predicting the future for NY Connects is certainly challenging, there continues to be a real opportunity for it to succeed and for it to play its very important role of providing consumers with conflict free assessment, care planning along with system navigation support. Described earlier were two very important programs under the ACA that would, if the state applies for them, provide significant additional federal revenue for the state. One criterion for participation in these programs is the state must provide for the functions of an ADRC. It makes no implementation sense, and it would be politically difficult, not to utilize NY Connects to fulfill that obligation. Furthermore, the ADRC effort is an initiative of CMS. It is reasonable to assume that CMS will continue to encourage a role for NY Connects. Finally, in a small group meeting, Mr. Helgerson spoke of his

possible interest in finding additional resources to enable NY Connects to meet its obligations as an ADRC. The aging services network associations should explore the possibilities for NY Connects' role in MLTCPs and for adequate financing for NY Connects. An examination of how the ADRC, in Mr. Helgerson's home state of Wisconsin functions, in relation to their Medicaid managed LTSSs, could be very instructive.

Opportunity

Another area where the aging services network can be of important service is in facilitating enrollment of persons into MLTCPs. Within the aging services network there are organizations with far-reaching capacity to reach older adults. AAAs, as well as others in the aging services network, have extensive experience in reaching difficult to reach/serve adults and assisting them in the insurance market place. Without local counseling options it will be difficult for older individuals, and others, to receive the intensive face-to-face support they will require in order for them to make informed decisions concerning their MLTCP choices. The experience and skill set for the aging services network to provide this service is described in the first section discussing the ACA.

From a policy and implementation perspective the most efficient and effective approach to providing MLTCP navigation/facilitation to adults, throughout NYS, is to utilize aging services network organizations. However, it is not clear, at this time, what and if there is a role for facilitators of enrollment.

As was discussed earlier, the state has contracted with Maximus to function as an enrollment broker. How facilitated enrollment would differ from Maximus's work is not yet clear. The timing is right for representatives of the aging services network associations to initiate meetings with the office of the State Medicaid Director on this topic.

Opportunity

Members of MLTCPs who become hospitalized are very costly to the plans. That is especially true for those members who are re-hospitalized in less than 30 days after being discharged from the hospital. Certainly the plans that are at risk for all health and LTSSs costs will be the most interested in avoiding re-hospitalization of members. However, the other plans will be interested as well. Re-hospitalized members will become heavy users of all services, including LTSS. As the state implements its new effort with CMS to integrate care for all duals, the need to manage hospital transitions of members will increase substantially. The evidence that there is a need for intervention (beyond traditional hospital discharge planning) when an individual with complex care needs transitions from the hospital to the community is very compelling.[29] NYSOFA has tested a volunteer model, Community Supports Navigators (CSN), based on Dr. Eric Coleman's Care Transitions Intervention (CTI).

Challenge

While the CSN initiative is limited in scope, outcomes show that such a model is not only possible, but it can be effective in promoting successful transitions and it can do so in a very cost effective manner. It

[29] (Eric A. Coleman, 2006)

would be dramatically less costly for a MLTCP entity to partner with an AAA or other aging services network organization than to develop its own transition initiative using paid medical professionals. Additional research is required to demonstrate the effectiveness of volunteer based hospital transition models.

Response

Similar to efforts to effectuate other opportunities, it would be most helpful to the aging services network for the various associations to survey their members to find examples of hospital transition programs that have been mutually beneficial for the aging services network entity and a health sector entity. Conducting workshops and other activities to train the associations' memberships on how to develop and operate an aging services network hospital transition program is vital to positioning the aging services network to provide this critical service. Publishing testimonials about the importance of these relationships from all parties involved could provide aging services network organizations with a mechanism to demonstrate to managed care entities the value of an aging services network managed, volunteer-based, hospital transition service. It is also important to conduct workshops, best practice models and/or other training activities at association meetings and conferences where the health care sector comes together, especially where the leadership of plans/models is present.

Because of the importance to the MLTCP, it is not a stretch to believe that some MLTCPs would be willing partners in supporting the aging services network in developing a volunteer based hospital transition program. Once an aging services network organization has studied the issue, it should consider such a discussion with the MLTCP. This is particularly the case for any aging services network organization that already has positive relationships in health care.

Opportunity

There is very compelling evidence that supporting and sustaining caregivers results better outcomes for persons needing LTSS. Better consumer outcomes translate in lower service utilization.

Challenge

Integrating support services for caregivers will likely to be a tough sell to MLTCPs. There are several reasons for this. First, as was noted earlier, MLTC is built on a healthcare model. In health care professions there is a limited tradition of caring for the caregiver, though there is a growing awareness in the health arena of the benefits of doing so. This lack of tradition and the lack of awareness of the importance of caregivers in supporting the individual in need of LTSS will hamper aging services network organizations' efforts to partner with MLTCPs to integrate caregiver supports in the member's plan of care. Secondly, many individuals who have transitioned to Medicaid to meet the costs associated with their LTSSs have no caregivers. They have outlived their primary caregiver, they have exhausted their informal supports, their supports have moved away, or they did not have them to begin with. The reality is that persons receiving Medicaid supported LTSSs are less likely to have involved caregivers than is the case in the general population receiving non-Medicaid LTSSs. It would be instructive to survey MLTCP entities to learn both how they plan to sustain caregivers, if at all, and how many of their members have active caregivers.

Response

There is a substantial body of research demonstrating the value of supporting caregivers, in terms of positive outcomes for the consumer and positive outcomes for the payer. This evidence should be compiled by the aging services network associations and disseminated to the aging services network and to the MLTPs. Workshops and other presentations to both the aging services network and to conferences attended by the MLTPs would serve to educate both groups. In each case a portion of workshops and presentations should be devoted to the business case for supporting caregivers and the role that aging services network organizations can play in that work.

Opportunity

CMS has been urging, but not currently requiring, the adoption of the "comprehensive" model of participant direction. It is reasonable to believe that the CDPAP program will evolve and become a comprehensive model. When, and if, that happens, the aging services network can be a partner/contractor with managed care entities. The aging services network has gained valuable experience in operating participant directed care programs. The New York State Office for the Aging (NYSOFA) has, for the last few years, received a federal grant to develop participant directed care in aging services. NYSOFA has conducted a very successful demonstration program to assist Area Agencies on Aging (AAAs) in integrating participant directed care into their programs. Now, all AAAs may provide participant directed care in their state funded Expanded In-home Services for the Elderly Program (EISEP) and in their Community Services for the Elderly (CSE) programs. NYSOFA is using CMS's comprehensive model for participant directed care. Further, a number of AAAs now contract with the Veteran's Administration to provide home and community based services to veterans in need of LTSS. Each AAA providing services to veterans must offer a comprehensive participant directed care option. The AAAs, with their experience with the comprehensive model, are well situated to provide a participant directed care program for a managed care entity.

Challenge

Currently, the only participant directed care permitted in New York's Medicaid program is the Consumer Directed Personal Assistant Program (CDPAP). "Participant direction has two basic features, each with a number of variations. The more limited form of participant direction—which CMS refers to as "employer authority"—enables individuals to hire, dismiss, and supervise individual workers. The comprehensive model—which CMS refers to as "budget authority"—provides participants with a flexible budget to purchase a range of goods and services to meet their needs."[30] CDPAP is a very, very limited program with approximately 9,000 enrollees. It is limited, as well, in what the participant can direct. As the name implies, it only covers the employment, by the enrollee, of a personal assistant. This is very different from what is generally thought of in a robust participant directed care program; what CMS sees as a comprehensive model (or budget authority model). The role in CDPAP, if any, for the aging services network is, at best, limited.

[30] (The Clearinghouse for Home and Community Based Services, 2012)

Response

Aging services network associations should continue to educate their members as to the why and the how of operating participant directed care programs. Best practice models in New York State and out of state exist and should be disseminated to the aging services network. Aging services network associations could reach out to the Independent Living Centers' association and find common ground to advocate, with the Office of the Medicaid Director, legislators and other decision makers to promote the CMS comprehensive model.

Opportunity

MLTCPs will need to provide some level of transportation to their members. Many aging services network organizations, from AAAs to adult day services to senior centers as well as a host of other non-profit community organizations, have provided various types of transportation (general, assisted, escorted, etc.) for many years. Aging services network entities are equipped to meet all non-emergency, MLTCP members' transportation needs. In most cases, aging services network organizations will be able to provide transportation services on behalf of the MLTCP plan for less than it would cost the plan to organize and operate directly. Aging services network entities offer MLTCPs the important benefit of a "one-stop" call. Rather than trying to arrange a taxi for one, an assisted transport for another or an escorted transport for another, by partnering with an aging services network transportation provider, all MLTCP members' transportation needs can be met by the aging service network. Finally, because of the lessons learned over a long experience that aging service network entities have in service to older adults and others with impairment, the MLTCP members served will have a very high satisfaction rate.

Response

Aging services network entities should reach out to the MLTCPs in their area and discuss the benefits of partnering with them to provide transportation services to their members.

Opportunities for Adult Day Services, Home Delivered Meals and Disease Prevention and Health Promotion Services (DPHPs)

The potential for adult day services to contribute to the two principal outcomes of improved quality and enhanced efficiency is enormous. Adult day services provide a stimulating, monitored environment in which many people flourish. Adult day services foster social relationships, consumers' hands and minds are busy, changes in participants' well-being are observed and acted upon and informal care givers are sustained. Each of these outcomes contributes to both the quality of life and the health of the individual. Actively engaged older adults in need of LTSSs will use fewer health care resources than those who are not socially engaged. It is also more cost effective than providing one-on-one supervision/monitoring and it is less expensive than medical model day services. Medical model day services should be reserved for those individuals who need daily medical interventions and/or who are medically unstable, regardless of any other determinate. Further, since a meal is provided in adult day services programs, the need for ensuring that the individual has a balanced, nutritious meal is taken care of. Partnerships with aging services network entities providing adult day services would enhance the aging services network's revenue stream and assist the managed care entity to manage costs while

improving quality/care. The aging services network, through contracts with LTHHCPs, has an extensive experience and history of providing adult day services to consumers who are supported with Medicaid.

For higher functioning persons in need of LTSSs, participation in a senior center equates to similar positive outcomes for the individual as was noted for adult day services. Like adult day services, senior center participants benefit from a stimulating, monitored environment. They are socially engaged, they are busy and when changes occur they are noted and acted upon. And, participants are provided with a nutritious meal. The research literature abounds with evidence that socially engaged older adults are both happier and healthier than those that are not. And, as such, they require fewer expensive health interventions. Partnerships between senior centers would enhance the center's revenue stream and assist the managed care entity to manage costs while improving quality/care.

Home delivered meals programs provide several things essential to the well-being of adults. The most obvious is the affordable, nutritious meal that is delivered to the person. In addition to the meal, nutrition education and counseling are available. Poor nutrition is a predictor of poor health. Beyond addressing the individual's nutrition needs, persons delivering meals check on the participant and report any significant changes for the host agency to act on. Finally, the delivery person seeks to interact with the participant, not only to observe changes, but also to provide socialization, albeit limited. A managed care entity must assess for, and address, any need for nutrition intervention. Contracting with a home delivered meals program is a far better solution for a managed care entity than providing for in-home meal preparation.

Disease Prevention and Health Promotion services (DPHPs) provided by and/or funded by the Area Agency on Aging (Older Americans Act Title IIID) are possible areas for partnerships between the aging services network and managed care entities. While the populations being served by MLTCPs, by definition, already have impairment(s), there are financial incentives for the managed care entities to promote the health of their enrollees. That is especially true for the models that are fully capitated (PACE and MAP). In addition to the MRT redesign, New York State is pursuing an initiative with CMS that would share any savings accruing to Medicare with the state (for the first time ever). This initiative will follow the managed care approach and will strongly incent the state to continue to move persons who are dually eligible for Medicare and Medicaid into fully capitated models.

The evidence behind each of the DPHP programs currently recognized under Title IIID can be found at: http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Title_IIID/index.aspx

The following are programs that are proven (evidence-based) to either be preventive and/or promote the health of the individual:

- Active Living Every Day
- A Matter of Balance
- Chronic Disease Self-Management Program
- Enhance Fitness
- Healthy Eating for Successful Living Among Older Adults

- Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)
- Healthy Moves for Aging Well
- Medication Management Improvement System
- Prevention and Management of Alcohol Problems in Older Adults
- Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
- Stepping On
- Strong for Life
- Tai Chi: Moving for Better Balance
- Active Choices
- Enhanced Wellness
- Fit and Strong!
- Walk with Ease
- Diabetes Self-Management Program
- Positive Self-Management Program for HIV
- Arthritis Self-Management (Self-Help) Program
- Chronic Pain Self-Management Program
- Online Chronic Disease Self-Management Program
- Better Choice, Better Health—Diabetes
- Healthier Living with Arthritis (Internet Arthritis Self-Management Program)
- Tomando Control de su Salud (Spanish Chronic Disease Self-Management Program)
- Programa de Manejo Personal de la Artritis (Spanish Arthritis Self-Management Program
- Programa de Manejo Personal de la Diabetes (Spanish Diabetes Self-Management Program).[31]

Challenge

As with other aging services network services, MLTCPs are not familiar with, or accustomed to utilizing, these services delivered by aging services network entities. Because of the MLTCPs medical tradition, they are less inclined to use social model services.

Response

Aging services network associations must provide the evidence on the worth of these services and on what value they bring to the MLTCPs bottom line. Similar strategies that were discussed for addressing other challenges, apply here as well (e.g. researching the evidence, conveying the evidence to the memberships and to the MLTCPs, making the business case for utilizing aging services network services and supports).

[31] (U.S. Department of Health and Human Services; the Administration on Aging, 2012)

Summary of *Challenges* Confronting the Aging Services Network

Challenge	Response/Strategy
Engaging MLTCs/CCMs	Survey, testimonials, training activities, best practices
Marketing Services	Testimonials, best practices, evidence-based outcomes
Pricing Services	Disseminate Best Practice Experiences (ex. aging services network entities providing services under the Veteran's Administration HCBS program)
Currently, No NY Connects Role	Aging services network associations promote the state's participation in BIPP and CFC; Consult with NYSDoH's Office of the Medicaid Director on the possibility of one or more funding resources for NY Connects
Currently, A Very Restrictive Participant Directed Program • **CDPAP is the only option**	Develop a relationship with the ILCs to promote a "comprehensive" model of Participant Directed Care in MLTCPs; gather and provide evidence of the positive outcomes (dollars and consumer outcomes) to relevant decision makers

Summary of *Opportunities* for the Aging Services Network

Opportunity	Strategy
Facilitate Enrollment	Aging services network associations initiate discussions with NYSDoH over possible roles and responsibilities for facilitating enrollment
Multi-disciplinary Assessments	Provide evidence of the effectiveness of multi-disciplinary assessment; aging services network entities with experience in non-medical assessment and care planning functions engage with MLTCPs
Conflict Free Information, Assessment, Care Planning and LTSS System Navigation	Aging services network associations initiate discussions with NYSDoH, Office of the Medicaid Director, over possible roles and responsibilities for NY Connects
Hospital to Community Transitions	Aging services network associations educate members on CTI and existing CTI based programs sponsored by NYSOFA; aging services networks create volunteer based transition programs (independently or in concert with MLTCPs)
Caregiver Supports	Aging services network associations, along with associations of MLTCPs, survey plans re caregiver planning; through the MLTCP associations, educate plans on the reasons to formally support caregivers
Adult Day Services as a quality enhancement and as an efficiency • **Substitute for in-home supervision** • **Substitute for meal preparation** • **Substitute Adult Day Health**	At conferences of MLTCPs, aging services network associations present on who benefits and how it can substitute for more costly service arrangements; aging services network organizations offering adult day services discuss partnering with MLTCPs
Senior Center Services as a quality enhancement and an efficiency • **Substitute for supervision** • **Substitute for meal preparation**	Encourage managed care organizations to test paying for participation as a "benefit" and measure outcomes for those who do participate and those who do not
Home Delivered Meals as health promotion and as an efficiency • **Increases nutrition/health status** • **Substitute for meal preparation**	At conferences of MLTCPs, aging services network associations present on who benefits and how it can substitute for more costly service arrangements; aging services network organizations offering Home Delivered Meals discuss partnering with MLTCPs

Transportation (paid or volunteer)	**Aging services network organizations reach out to MLTCPs and discuss partnering to provide the plan's members with all their non-emergency transportation needs and the benefits associated with using the aging services network organization with its long experience**
Disease Prevention and Health Promotion including Chronic Disease Management	Prepare descriptive materials to market DPHP services to managed care entities. Such materials should discuss the evidence of the efficacy of any proposed DPHP program.
Participant Directed Care	See Challenges above

Affordable Housing Work Group (AHW)

The Direction/Approach for Affordable Housing in NYS and Medicaid's Role

In redesigning Medicaid, the state understands that housing is a key building block for maintaining an individual's independence. "….the Medicaid Redesign Team identified increasing the availability of affordable and supportive housing for high-need Medicaid beneficiaries who are homeless, precariously housed or living in institutional settings as a significant opportunity for reducing Medicaid cost growth." The AHW's charge is centered on ensuring that persons in need of LTSSs have access to supportive housing that maximizes their independence. "The work group will evaluate New York's current programs of supportive housing in reference to the reasonable availability and adequacy of those programs for the purpose of assuring that individuals unable to live independently are neither inappropriately institutionalized nor denied the availability of necessary care and services." The AHW is examining existing resources that could be made available to increase the availability of supportive housing and it is looking at "opportunities for the investment of additional resources for supportive housing that will result in savings to the Medicaid program and improvements in the quality of services to targeted individuals."[32]

Recently, Mark Kissinger, Long Term Care Division Director at the NYS Department of Health, stated that his agency is undertaking a full re-examination of regulations governing Assisted Living in New York State. An opportunity exists for the aging services network associations to work with NYSDoH on improving the regulations on behalf of older adults as well as helping to lay out possible roles for aging services network organizations. The reverse is true as well. With any re-opening of a regulatory process there is always the chance that the role(s) currently filled by aging services network organizations could be diminished. It is very important for the aging services network associations to be actively engaged on this issue.

As was noted earlier, New York State plans to submit an new 1115 waiver to include, among other things, the costs (all or in part) of housing, especially supportive housing, in the State's Medicaid program for those persons eligible for Medicaid and who require LTSS. Associations, and others, wishing to express their views on housing with supports should initiate conversations with the NYSDoH's Office of the Medicaid Director.

In the table that follows, the seven recommendations made by the AHW and adopted by the MRT are described.

[32] (New York State Department of Health, Medicaid Redesign Team; Affordable Housing Work Group, 2011)

The following is a list of the recommendations made by the AHW and adopted by the MRT (MRT Final Report Rec. #196):

Recommendation	Timing	Implementation Approach	Where	Opportunities and/or Challenges
A1 - Work with New York City to develop a NY/NY IV agreement and with other interested counties to make a similar commitment that will provide integrated funds for capital, operating expenses/rent and services in new supportive housing units targeting high-cost, high need users of Medicaid, especially those transitioning out of restrictive institutional settings. State housing and health and human services agencies should participate in the process.	TBD & Pending	A new NY/NY agreement will be developed. Additional federal investment will be sought based on projected savings that will accrue to the Medicaid program.	New York City and other interested counties	For aging services network organizations that currently provide, or are seeking to provide supportive housing, additional funds may become available for expansion and/or development. Since such housing will be targeted to high need Medicaid recipients, the level of support present in the housing will be significant.
A2 - Establish a formal mechanism to set aside a portion of Medicaid and non-Medicaid savings related to any reduction of inpatient hospital or nursing home capacity to a fund dedicated to housing development.	TBD & Pending	"A portion of any closure savings should be mandated to be invested in housing related programs. These savings should be reinvested in the development of new and rehabilitated housing, both scattered site and congregate, as well as the supports necessary to ensure that vulnerable populations receive the services they need to maximize expected outcomes."	Not stated in report	For aging services network entities that currently provide or are seeking to provide supportive housing, additional funds may become available for expansion and/or development. Since such housing will be targeted to high need Medicaid recipients the level of support present in the housing will be significant.
A3 - A portion of the $75 million in the SFY 2012-13 MRT funding allocation plan should be transferred to OMH, OTDA and HCR for distribution through HHAP, OMH programs, Housing Trust Fund and tax-exempt bond programs. OPWDD programs should also be considered for investment.	SFY 2012-2013	Provide funding for single site and scatter site housing units. May also use some of the funds for supports for target populations (high-cost Medicaid consumers).	Not stated in report	This is part of the Governor's enacted budget. These monies will become available shortly. In addition to aging services network organizations that are interested in developing housing, for the aging services network organizations serving the targeted populations, there may be

				opportunities for service funding as well. Relevant associations should open discussions with the state agency (ies) with jurisdiction over housing and/or services of interest.
A4 - OMH capital and operating funding should be unfrozen for supportive housing for SFY2012-13 and SFY2013-14.	SFY2012-2013 and SFY2013-2014	Increase the supply of stable and secure housing available to homeless and deinstitutionalized persons receiving critical mental health services.	Not stated in report	Limited opportunity for the aging services network organizations.
A5 - Set-asides and incentives for supportive housing construction in HCR Qualified Allocation Plan should be evaluated and considered for an increase when awarding federal Low-income Housing Tax Credits.	SFY2012-2013	Increase the share of HCR tax credits that go to supportive housing. The AHW suggests using these funds as an incentive to increase the set-aside units to 50% (from 30%). However, the suggestions made by the AHW will "….require tradeoffs against other housing related goals. The tradeoffs need to be carefully considered before any changes can be made."	Not stated in report	For those aging services network organizations interested in the development of very low income housing and/or special needs populations, this may represent an opportunity to partner with a developer to construct such housing. It will be imperative for these organizations to initiate an ongoing dialogue with HCR.
A6 - Include in MRT 1115 Medicaid waiver funding for ongoing housing services and supports and operating costs.	SFY2012-2013	The NYSDoH Office of the Medicaid Director is currently developing an application to CMS for a new 1115 Waiver. Contained within this new waiver is a proposal to fund services that enable the person to "….transition to housing, pay the rent and access the support services they need to manage their condition."	Not stated in report	If successful in obtaining CMS approval (and this provision of the proposed waiver is certainly consistent with CMS's policy direction), this would greatly expand funding for many of the services provided by the aging services network. This should be watched closely by the aging services network associations. They should provide comment on the Waiver request to ensure that aging services network organizations can provide services to the target populations. The aging

				services network associations should keep their memberships informed and provide any necessary training to aging services network organizations. It is quite likely, though not stated, that interested aging services network organizations will need to provide any such funded services in partnership with a MLTCP.
A7 - Explore the creation of a pilot program of "social impact investment bonds" that would pay for development, operations and services in supportive housing.	TBD	"Social impact investment bonds are relatively new mechanisms that allow qualified nonprofits to assume the risk typically undertaken by government to address a specific societal need such as homelessness… The contract could allow for payments exceeding the cost of the intervention if greater savings were achieved."	Not stated in report	A very exciting proposal that transfers innovation from the experience in the United Kingdom. There is insufficient detail to describe what the opportunities and challenges are for the aging services network. On the surface, it suggests that there could be enormous opportunity for aging services network organizations, particularly those that are already engaged in providing supportive housing. The aging services network associations should follow developments in the design and implementation of this pilot program.

Program Streamlining and State/Local Responsibilities Workgroup

The final recommendations of this MRT committee's work included one recommendation specific to long term services and supports. Contained within that recommendation was the following language: "Disabled and elderly New Yorkers in need of long term care services should have the same access to enrollment and eligibility assistance as other applicants for Medicaid. New York's plan for meeting consumer assistance needs must include a focus on this vulnerable population, whether it is through the use of Navigators, Consumer Assistance Programs, Facilitated Enrollers or some other funded initiative."[33]

Opportunity

If and when this recommendation is operationalized, it will be necessary to provide localized face-to-face support for those in need of Medicaid long term services and supports. NY Connects, along with the broader aging services network, is positioned to provide navigation/facilitation support to this population.

Please see the table in the report's Appendices for "Key Components of Navigator, Consumer Assistance and Facilitated Enrollment Program."

[33] (NYSDoH, 2011)

Conclusion

The implementation of the Affordable Care Act and the redesign of New York's Medicaid program have far ranging implications for health care and long term services and supports. Older adults will be affected in ways, and by degrees, far in excess of their representation within our state community. The delivery systems for health care and for long term services and supports are now, and forever, changed. The full impact of these changes is yet to unfold and be understood. However, we do know that the landscape for the aging services network will soon be very different from what it is today. We know that many of the goals and objectives of these two change initiatives can be met, in part, through the engagement of the aging services network. The question is: will that come to pass? There are good reasons for that to occur and there are considerable barriers that stand in the way.

What is clear is that for the aging service network to flourish it will not only have to adapt, it will have to aggressively pursue roles and responsibilities for which it is well suited. These will not simply be granted. Only through thoughtful planning and execution can the aging service network overcome the barriers confronting it to play key roles on behalf of older adults and others with disability.

This document has sought to inform the reader of known opportunities and of the known challenges. Some of the potential roles outlined in this paper will be easier to achieve than others. Some will be very challenging to achieve.

Examples of roles that are more attainable (but, not at all assured) are:

- Facilitation activities
- Outreach too hard to reach populations
- Advocacy
- Contracting for various services such as home delivered meals, adult day services and transportation

Examples of roles that face greater challenges to the aging service network:

- Partnering to conduct multi-disciplinary assessments
- Conflict free assessments and care planning
- Integrating caregiver supports into MLTPs
- Hospital to community transitions
- Participant directed care

Hard work and a laser focus will be necessary if the aging services network is to be viable and if it is to grow in its capacity to serve.

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Appendix

Taxonomy

AAAs – Area Agencies on Aging. In New York State, every county is served by an AAA. The 5 counties of NYC are served by one AAA and the counties of Warren and Hamilton are served by one AAA. All other counties have their own AAA. The AAA determines the needs of older persons in its Planning and Service Area and works to address those needs through the provision and/or funding of local services and through advocacy.

ACA – The Patient Protection and Affordable Care Act (enacted March 23, 2010). Currently, the Supreme Court is considering the constitutionality of the individual mandate requiring the purchase of health insurance, will the remainder of the act stay intact if the individual mandate is found to be unconstitutional and whether or not the federal government can enforce the expansion of Medicaid called for in the ACA.

Aging Services Network – A generic term used to include all manner and types of non-medical provider entities established to address the needs of older adults (though such organizations may serve younger populations as well).

ADRC – Aging and Disability Resource Center. The ADRC programs are a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS); they are designed to streamline access to long-term care. The ADRC program is an opportunity to effectively integrate the full range of long-term supports and services into a coordinated system. By simplifying access to long-term care systems, ADRCs and other point of entry systems are serving as the cornerstone for long-term care reform in many states.

CBOs – Community Based Organizations. Generally, not-for-profit organizations that serve a particular catchment area.

Community-Based Health Teams and Health Teams – See Independence at Home Demonstration.

CCM – Coordinated Care Management. A type of managed long term care program. See MLTCPs.

CDPAP – Consumer Directed Personal Assistant Program. A Medicaid program for persons with a disability. Enrollees can hire, fire, supervise, train and authorize payment for their own personal assistant to provide for their personal care needs.

CHHA – Certified Home Health Agency. An entity certified by the NYSDoH to provide intermittent skilled care to medically needy individuals in their home for a short duration (generally). These entities are recognized providers by both Medicare and Medicaid.

CMS – The Centers for Medicare and Medicaid Services. The federal agency overseeing both the Medicare program and the Medicaid program.

CSN – Consumer Supports Navigator. A demonstration initiative begun by the New York State Office for the Aging to improve hospital to home transitions. It commenced with two counties participating; Albany and Tompkins. The initiative uses high level volunteers (often from the Retired Medical Corp) to "coach" individuals and their families as they prepare for and are discharged from the hospital. The model is based on Eric A. Coleman's Care Transitions Intervention (CTI).

CCTP – Community-based Care Transitions. A grant program, authorized by the ACA and administered by CMS, to improve community collaboration for at-risk individuals being discharged from the hospital to reduce readmission rates of the participating hospitals. New York State currently has four such programs in development.

DPHP – Disease Prevention and Health Promotion. Monies made available to Area Agencies on Aging through Title IIID of the Older Americans Act to provide, or contract for, evidence-based services that prevent disease and/or promote health of older adults.

Duals - Dual Eligibles. Persons who are eligible for, and receive, benefits under both Medicaid and Medicare.

HBE - Health Benefit Exchange. An Exchange is a key provision of national health reform that creates a new marketplace for each state to offer health benefits to individuals and small businesses. Under national health reform, states must have an Exchange in place by January 1, 2014. Exchanges can be developed and implemented by the state or by the federal Department of Health and Human Services. Work is going forward on NYS's HBE, however, the NYS Senate is not in favor of the HBE. Governor Cuomo has indicated that he may establish the HBE by Executive Order, thereby overcoming the need for action by the Senate.

Independence at Home Demonstration. The Independence at Home demonstration program is to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012).

LTHHCP – The Long Term Home Health Care Program (sometimes called the Lombardi Program or the Nursing Home Without Walls program). This program was established by New York State legislation (Championed by Senator Tarky Lombardi) for the purpose of providing home care services to individuals who are medically eligible for nursing home placement as an alternative to institutionalization. Individuals receive case management and may receive other services based on assessment and individual's required services and plan of care. Services offered may include nursing, therapies, and personal care services. In addition, the waiver allows Medicaid to pay for some services not provided through "regular" Medicaid such as respiratory therapy, medical social services, nutritional counseling, home maintenance and improvements, moving assistance, respite care, home delivered meals and personal emergency response system. NYS operates this program under a waiver from CMS.

MA - Medicaid

MAP – Medicaid Advantage Plus. A type of MLTCP

MCO – Managed Care Organization. A type of MLTCP

Medicaid Health Home - The ACA, the health reform law, provided states with a new Medicaid option to provide "health home" services for enrollees with chronic conditions. Further, to encourage states to take up the new option, ACA authorized a temporary 90% federal match rate (FMAP) for health home services specified in the law. The health home option, established by 2703 of ACA, became available to states on January 1, 2011. Health homes are designed to be person-centered systems of care that facilitate access to, and coordination of, the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional

medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.

Medical Homes - The Patient-Centered Medical Home (PCMH) is a model of primary care delivery. In PCMH practices, patients receive well-coordinated services and enhanced access to a clinical team. Clinicians practicing in PCMHs use decision support tools, measure their performance, engage patients in their own care and conduct quality improvement activities to address patients' needs. The PCMH Model has the potential to improve clinical quality, improve patient experience and reduce health system costs. PCMH is currently a demonstration funded by the Commonwealth Fund and others.

MLTCPs – Managed long term care plans/providers/programs. MLTCPs (managed long term care plans/providers/programs) is used, in this paper, as an encompassing acronym that includes all of the various types of managed long term care plans, allowed in the redesigned NYS's Medicaid system of long term services and supports, in a general category. MMLTC or MMLTCP are acronyms that apply to one specific type of managed long term care plan/provider. There are five different types of MLTCPs, MMLTC/MMLTCP is but one of those.

MMLTC or MMLTCPs – Medicaid Managed Long Term Care Program. A type of MLTCPs.

NY Connects. The comprehensive long term care system begins with NY Connects, a local program that provides easy access to information and assistance for people who are exploring long term care options or who are already receiving a long term care service but would like more information. NY Connects staff is available to help free of charge. NY Connects is New York State's federally designated ADRC.

PACE – Program for All Inclusive Care for the Elderly. A type of MLTCPs.

PERS – Personal Emergency Response System. PERSs are in-home electronic monitoring systems that alert others if the person being monitored has encountered a problem that requires outside help (e.g. a fall) or the person has been inactive for a specified duration.

Qualified Plan. In order to participate/offered in the HBE, an insurance plan must be qualified by the HBE. Plans must meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information. The HBE will require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

SUMMARY OF LTSS MANAGED CARE PLANS IN MEDICARE AND MEDICAID

Type of insurance covered	**MEDICARE AND MEDICAID**		**MEDICAID ONLY**	
Type of plan	**Medicaid Advantage PLUS**	**PACE**	**Medicaid Managed Care (“**Mainstream”)	**Managed Long Term Care – MLTC - Partial Capitation**
Who may/may not/ or must join	**Dual eligibles may join – not mandatory.** **Optional for “dual eligibles” –** people with Medicaid and Medicare **who DO NEED Medicaid community-based long- term care services (home care).** **When MLTC becomes mandatory,** may select one of these plans instead of an MLTC partial capitation plan		**Most people with Medicaid-only must join.** ***Dual eligibles are excluded-may not join.*** **For people with Medicaid only –** Eff. 10/11 - Exemption limited to 6 months if have chronic medical issues with specialist not participating in any managed care plans. 4/12 – mandatory for homeless, ESRD, Lombardi (put in Taxonomy??) 10/12 – mandatory for nursing home residents (but not for dual eligibles) 4/13 – mandatory for MBI-WPD, all other waivers, ICF-DD/MR residents, foster children	**Dual Eligibles in NYC who need community-based long-term care will be required to join beginning July 1, 2012, if CMS approves waiver. Other counties will follow in 2012-13.** Option to join either a Medicaid Advantage Plus or PACE plan, but if do not choose, will be assigned to one of these MLTC plans. **People with Medicaid only (no Medicare) may join this instead of mainstream Medicaid managed care IF THEY ARE nursing-home eligible and need home care services.**

Type of insurance covered	MEDICARE AND MEDICAID		MEDICAID ONLY	
Type of plan	**Medicaid Advantage PLUS**	**PACE**	**Medicaid Managed Care (“**Mainstream”)	**Managed Long Term Care – MLTC - Partial Capitation**
Medicare Services – **What does plan cover?**	**YES includes all Medicare Services** Including physicians, hospital inpatient, outpatient, Emergency, CHHA, medical equipment, short-term rehab, lab and radiology *MUST USE PROVIDERS that are in the Plan’s Network*		**NONE** **(people with Medicare EXCLUDED from enrollment)**	**NONE** Obtain Medicare services through “original” Medicare or Medicare Advantage plan
MEDICAID primary care services – **Does plan cover them?**	**YES** Includes all Medicaid primary, outpatient and inpatient hospital, emergency care, lab and radiology, and short-term CHHA, prescription drugs (to small extent covered for dual eligibles). Must use in-network providers.		**YES** Includes all Medicaid primary, outpatient and inpatient hospital, emergency care, lab and radiology, and short-term CHHA, prescription drugs Must use in-network providers.	**SOME -- Physicians & Hospital– NOT covered by MLTC plan.** Use original Medicare or Medicare Advantage plan and “regular” Medicaid for doctors, hospital, lab tests, etc. (line spacing) **Some Medicaid primary care services covered by plan – must use in- network providers for:** o Audiology/ hearing aids; o Optometry/eyeglasses o Podiatry o Dental o Medical equipment, medical supplies, prostheses, orthotics o Transportation to doctors’ offices (not emergency)

Type of insurance covered	MEDICARE AND MEDICAID		MEDICAID ONLY	
Type of plan	**Medicaid Advantage PLUS**	**PACE**	**Medicaid Managed Care (“**Mainstream”)	**Managed Long Term Care – MLTC - Partial Capitation**
MEDICAID long-term care services – **Does plan cover them?**	**YES – includes all long term care -** personal care, nursing home, adult day care, PERS, long-term certified home health care (CHHA), private duty nursing**,** Nursing Home, home modifications, consumer-directed personal assistance program (CDPAP)		**SOME –** **Since 8/2011 – includes personal care.** **Includes short-term CHHA** In future, may include nursing home, adult day care, PERS, long-term CHHA, private duty nursing	**YES – includes all long term care -** personal care, nursing home, adult day care, PERS, long-term certified home health care (CHHA), private duty nursing**,** Nursing Home, home modifications, consumer-directed personal assistance program (CDPAP)
Plans in NYC (Some do not cover all boroughs)*	1. Amerigroup 2. Elderplan MedicarePlus MLTC 3. Fidelis MA Plus 4. GuildNet Gold 5. EmblemHealth MAPlus MLTC 6. VNSChoice-MLTCPlus 7. WellCare Advocate Complete	1. CCM Pace 2.ArchCare	1. Affinity 2. Amerigroup 3. HealthFirst PHSP 4. EmblemHealth (formerly HIP/GHI) 5. Health Plus PHSP 6. Metro-Plus 7. Neighborhood Health Partners 8. Fidelis - Catholic 9. United Healthcare Community Plan 10. Wellcare of NY	1. AmeriGroup Community Connections 2. CCM Select 3. HomeFirst/ElderPlan 4. ElderServe 5. GuildNet 6. HHH Choices 7. Independence Care System 8. Senior Health Partners 9. VNS Choice 10. WellCare Advocate

Type of insurance covered	MEDICARE AND MEDICAID		MEDICAID ONLY	
Type of plan	**Medicaid Advantage PLUS**	**PACE**	**Medicaid Managed Care (“**Mainstream”)	**Managed Long Term Care – MLTC - Partial Capitation**
No. enrolled NYS 12/2011	**1,671**	**4,036**	**3,036,100**	**39,487**

Modified by Optimum Partners Consulting, Neal E. Lane, February 29, 2012. Modified by removing columns relating to Medicare Advantage and Medicaid Advantage.

Prepared by Selfhelp Community Services, Inc. Evelyn Frank Legal Resources Program, Jan. 25, 2012, revised 2/23/2012 ©

Enrollment data from http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly

More about managed long term care at http://wnylc.com/health/news/29/ and http://wnylc.com/health/entry/114/

For list of all plans by borough, with contact information, see http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm

MRT Work Groups

1. Affordable Housing Work Group
2. Basic Benefit Review Work Group
3. Behavioral Health Reform Work Group
4. Health Disparities Work Group
5. Health Systems Redesign: Brooklyn Work Group
6. Managed Long Term Care Implementation and Waiver Redesign Work Group
7. Medical Malpractice Reform Work Group
8. Payment Reform and Quality Measurement Work Group
9. Program Streamlining and State/Local Responsibilities Work Group
10. Workforce Flexibility and Change of Scope of Practice Work Group

NYS Managed Long Term Care Plans, by Type and Coverage Areas

Name	Plan Type	Payment Accepted	Age Requirement	Service Area by County	Mailing Address/Phone
AMERIGROUP Community Connections	Partial	Medicaid	18 and older	New York City (All boroughs)	*21 Penn Plaza* *360 West 31 Street* *New York, NY 10001* *(800) 950-7679*
AMERIGROUP Medicaid Advantage Plus	MAP	Medicaid Medicare	18 and older	New York City (All boroughs)	*21 Penn Plaza* *360 West 31 Street* *New York, NY 10001* *(800) 950-7679*
ArchCare Senior Life (Catholic Managed Long Term Care, Inc.)	PACE	Medicaid Medicare Private Pay	55 and older	Bronx and New York (Manhattan)	*1432 Fifth Avenue* *New York, NY 10026* *(866)263-9083*
Catholic Health-LIFE (Catholic Health Systems)	PACE	Medicaid Medicare Private Pay	55 and older	Erie	*55 Melroy Avenue* *Lackawanna, NY 14218* *(716) 819-5433*
Comprehensive Care Management PACE (Beth Abraham Family of Health Services)	PACE	Medicaid Medicare Private Pay	55 and older	New York City (All boroughs), Nassau, Suffolk, Westchester	*1250 Waters Place* *6th floor* *Bronx, NY 10467* *(877)226-8500*
Comprehensive Care Management Select	Partial	Medicaid	18 and older	Bronx, Kings, New York, Queens, Westchester	*1250 Waters Place* *6th floor* *Bronx, NY 10467* *(877)226-8500*
Eddy Senior Care (Northeast Health System)	PACE	Medicaid Medicare Private Pay	55 and older	Schenectady (Not entire county) Albany (Not entire county)	*504 State St* *Schenectady, NY 12305* *(518) 382-3209*

Elant Choice	Partial	Medicaid Private Pay	18 and older	Orange, Rockland	*46 Harriman Dr* *Goshen, NY 10942* *(877) 255-4678*
Elderplan, Inc. MAP	MAP	Medicaid Medicare	18 and older	New York City (All boroughs)	*6323 Seventh Ave* *Brooklyn, NY 11220* *(877) 891-6447 (MAP)* *(877)771-1119 (Partial)*
HomeFirst (Elderplan, Inc.)	Partial	Medicaid	18 and older	New York City (All boroughs)	*6323 Seventh Ave* *Brooklyn, NY 11220* *(877) 891-6447 (MAP)* *(877)771-1119 (Partial)*
ElderServe Health, Inc.	Partial	Medicaid	18 and older	New York City (All boroughs), Nassau, Suffolk, Westchester	*5901 Palisade Ave* *Riverdale, NY 10471* *(800) 370-3600*
Fidelis Care at Home (NY Catholic Health Plan, Inc.)	Partial	Medicaid	18 and older	Orange, Rockland	*400 Rella Blvd Suite 116* *Suffern, NY 10901* *(800)688-7422*
Fidelis Medicaid Advantage Plus	MAP	Medicaid Medicare	18 and older	New York City (All boroughs), Albany, Montgomery, Rensselaer, Schenectady	*95-25 Queens Blvd* *Rego Park, NY 11374* *(888)343-3547*
GuildNet (Jewish Guild for the Blind)	Partial	Medicaid	18 and older	Bronx, Kings, New York, Queens Nassau, Suffolk	*15 West 65th Street* *4th Floor* *New York, NY 10023* *(800) 932-4703* *(212) 769-7855*
GuildNet Gold	MAP	Medicaid Medicare	18 and older	Bronx, Kings, New York, Queens Nassau, Suffolk	*15 West 65th Street* *4th Floor* *New York, NY 10023* *(800) 932-4703* *(212) 769-7855*

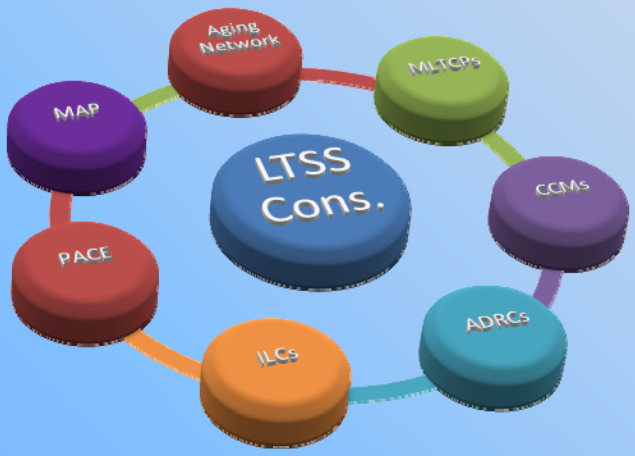
HHH Choices Health Plan, LLC (Hebrew Hospital Home)	Partial	Medicaid	18 and older	Bronx	*2100 Bartow Ave Suite 310* *Bronx, N Y 10475* *(888) 830-5620* *(718) 678-1600*
HIP Medicaid Advantage Plus MLTC (Health Insurance Plan of New York)	MAP	Medicaid Medicare	18 and older	New York City (All boroughs)	*55 Waters St* *New York, NY 10041* *(888) 447-9161*
Independence Care System (Cooperative Home Care Associates)	Partial	Medicaid	18 and older	Bronx, New York, Kings	*257 Park Ave South* *2nd floor* *New York, NY 10010* *(877) 427-2525* *(212) 584-2500*
Independent Living for Seniors	PACE	Medicaid Medicare Private Pay	55 and older	Monroe (Not entire county)	2066 Hudson Ave Rochester, NY 14617 (585)922-2831
PACE CNY (Loretto/Independent Living Services)	PACE	Medicaid Medicare Private Pay	55 and older	Onondaga	Sally Coyne Center for Independence 100 Malta Ln Syracuse, NY 13212 (800)208-5284 (315)452-5800
Senior Health Partners (Healthfirst Company)	Partial	Medicaid Private Pay	55 and older	Bronx, Kings, New York, Queens	345 East 102nd St Suite 200 New York, NY 10029 (800) 633-9717
Senior Network Health, LLC (Mohawk Valley Network, Inc.)	Partial	Medicaid Private Pay	18 and older	Oneida Herkimer	*2521 Sunset Ave* *Utica, NY 13502* *(888) 355-4764* *(315) 624-4545*
Senior Whole Health	MAP	Medicaid Medicare	65 and older	Albany, Columbia Dutchess, Greene, Montgomery, Orange, Rensselaer, Saratoga, Schenectady, Ulster, Warren, Washington	*200 S. Pearl St.* *Albany, NY 12202* *(866) 211-1777*

Total Aging in Place (Weinberg Campus, Inc.)	Partial	Medicaid Private Pay	55 and older	Erie (Not entire county)	*461 John James Audubon Parkway* *Amherst, NY 14228* *(866) 882-8185* *(716) 250-3100*
Total Senior Care, Inc.	PACE	Medicaid Medicare Private Pay	55 and older	Cattaraugus Alleghany (Only in certain townships)	*52 North Union St* *Olean, NY 14760* *(716) 379-8474* *(866) 939-8613*
VNS Choice (Visiting Nurse Service of New York)	Partial	Medicaid	65 and older	New York City (All boroughs)	*1250 Broadway, 11th Floor* *New York, NY 10001* *(888) 867-6555* *(212) 609-5600*
VNS Choice Plus	MAP	Medicaid Medicare	18 and older	New York City (All boroughs)	*1250 Broadway, 11th Floor* *New York, NY 10001* *(888) 867-6555* *(212) 609-5600*
Wellcare Advocate (Wellcare Health Plans, Inc.)	Partial	Medicaid	18 and older	Bronx, Kings, New York, Queens	*110 Fifth Ave. 3rd floor* *New York* *NY 10011* *(866) 661-1232* *(212) 463-6100*
Wellcare Advocate Complete	MAP	Medicaid Medicare	18 and older	Bronx, Kings, New York, Queens	*110 Fifth Ave. 3rd floor* *New York* *NY 10011* *(866) 661-1232* *(212) 463-6100*

Key Components of Navigator, Consumer Assistance, and Facilitated Enrollment Programs

	Navigators	CAPs	Facilitated Enrollment (FEs)
ACA Section	§1311(i)	§1002	N/A
Timing	Start date: 2014	Start date: October 2010	Secured through 1115 Waiver (1997) and authorized by NY State statute (1998)
Funding & Administration	□ Exchange generates funding for Navigators & awards grants. □ Qualifying states may also claim a share of Medicaid/SCHIP administrative match.	□ States receive HHS funding for state-based programs. □ ACA authorization $30 million ($2.2 million NYS) in FY2011. □ HHS Exchange Establishment grants available through FY 2014.	□ For community-based FEs (which submitted 112,000 applications in 2010), New York annually distributes ~$17 million to 41 contracted Lead Agencies. □ Plan-based FEs (which submitted 330,000 applications in 2010) are funded through the administrative portion of a plan's premium cost. □ SDOH Office of Health Insurance Programs ensures that FEs' policies and procedures meet the needs of applicants and are in accordance with State and Federal laws and regulations. □ FEs are required to participate in SDOH training, but are not licensed or certified.
Functions	Navigators must "at least" perform the following duties: □ Maintain expertise in eligibility, enrollment, and program specifications and conduct public education; □ Provide information and services in a fair, accurate and impartial manner; □ Facilitate enrollment in QHPs;	CAPs must perform the following duties: □ Assist consumers with appeals and grievances; □ Collect, track, and quantify problems and inquiries from consumers with group health plans and other coverage; □ Educate consumers on their rights and responsibilities with respect to health insurance coverage;	FEs must perform the following duties: □ Screen individuals for Medicaid, FHP, and CHPlus eligibility; □ Educate individuals about health plan options; □ Assist individuals in selecting a health plan; □ Complete the appropriate application; □ Collect the required documentation;

	• Refer enrollees with questions, grievances or complaints about health plans or coverage to CAPs or other appropriate state agency; • Provide information in a culturally and linguistically appropriate way, ensuring access for consumers with disabilities.	• Assist consumers with enrollment by providing information, referral and assistance; • Resolve consumer problems with obtaining tax credits.	• Certify original documentation of citizenship; • Transmit the completed application to the appropriate entity; • Troubleshoot any post-application issues; and • Assist consumers in renewing their coverage.
Entities	Broad list of business and community groups eligible. Grant recipients must include entities from at least two categories: • Community and consumer-focused nonprofit groups; • Trade, industry, and professional associations; • Commercial fishing, ranching and farming groups; • Chambers of commerce; • Unions; • Resource partners for SBA; • Licensed agents and brokers; and • Other public or private entities (e.g. Indian tribes, state or local human service agencies).	State has choice of: • Independent office of health insurance consumer assistance; or • State Ombudsprogram.	The following entities can serve as FEs: • Community-based organizations and consumer focused nonprofit groups (including health and human service providers, immigrant organizations, and local government agencies); or • Health plans.



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New York State Coalition for the Aging
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www.coalitionforaging.org

New York State Association of Area Agencies on Aging
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www.agingny.org

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