CONSUMER DIRECTED ACTION OF NYS

BUILDING SELF-DIRECTED POWER

Eliminate MLTC to better manage care

Managed long-term care (MLTC) was supposed to effectively coordinate care and improve quality for those eligible for both Medicare and Medicaid. Since the transition to mandatory managed long-term care, nursing home services and assessments have been taken away from the plans and plans now receive approximately $4,500 per member per month to essentially manage one benefit. Meanwhile, there is nearly no care coordination, accountability, or transparency. These insurance companies are reaping windfall profits at the expense of New York's Medicaid system. Transitioning to a managed fee-for-service model would achieve the goals the failed experiment of MLTC promised while saving the Medicaid program almost $3 billion a year that currently go to MLTC administration and overhead.

In 2011, the state sought to more effectively and efficiently provide high quality long-term care services to those eligible for both Medicaid and Medicare. The goal was to have one entity coordinate all of the services an individual received, whether they were paid for by Medicaid or Medicare. The plans took over responsibility for assessments from the counties and became responsible for all long-term care services. Since then the MLTCs have continuously had their responsibilities pared back.

It was in 2013 when Visiting Nurse Services, now VNS Health, was discovered to be working with social adult day centers to enroll otherwise healthy older residents through incentives like free takeout, casino trips, and more. Consequently, social adult day was removed as a stand-alone benefit in the insurance program, and the state began paying a new vendor, Maximus, to pre-screen applicants for MLTC. In 2015, individuals in a nursing home for over three months were removed from MLTC. As part of MRT 2, the state made a determination that the companies were manipulating assessment scores, transferring the assessment process to Maximus as well. By that time, these companies received about $4,500/year in capitation fees to take an assessment performed by another company and turn it into an authorization of personal care or consumer directed personal assistance services, then pay for the services authorized without coordinating benefits.

Holding the insurance companies accountable for paying agencies for the services being delivered has proven difficult. When wages were increased in 2022, the Legislature appropriated $725 million to pay for the raise. MLTC rates were adjusted by over $2.50/hr of service; however, agencies overwhelmingly reported receiving increases of less than $1, with one plan actually cutting rates.

While the lack of transparency and accountability meant providers, workers, and consumers suffered, the insurance companies have been doing very well. Between 2020 and 2022, Senior Whole Health made over $370 million in profits, Centers Plan for Healthy Living made over $245 million, Fidelis Care made almost $199 million, Healthplus made $194 million, and VNS Health made just over $187 million. These profits had nothing to do with the delivery of healthcare, they stemmed from moving money from the DOH to providers.

A managed FFS system will create an apparatus for true service coordination and care management provided by "care management entities" that specialize in working with those who use long-term care consumers. It would remove incentives revealed by VNS Health very early in the program's existence, while introducing much needed transparency and accountability. Passing the Home Care Savings and Reinvestment Act ensures that our Medicaid dollars are going where they belong: to the provision of services and care management that keep disabled and older New Yorkers at home and out of institutions.

Consumer Directed Action of New York serves as the "Voice of CDPAP," representing consumers using CDPA and the fiscal intermediaries who administer the program. For more information, call 518-813-9537 or email info@cdpaanys.org.