New York State is rolling out an ambitious set of Medicaid reforms that are moving care for complex and costly Medicaid beneficiaries—long-term care services and supports, behavioral health care, and services for the developmentally disabled—from fee-for-service (FFS) into managed care. The first of these large-scale policies was requiring frail elderly and physically disabled Medicaid beneficiaries who rely on home- and community-based long-term care services (HCBS) to join a managed care plan.

This data brief documents the shift of Medicaid HCBS from FFS in 2010 to a predominantly managed care model in 2013. It presents regional differences in services and spending, and evaluates the growth in Medicaid managed long-term care and the corresponding decline in FFS HCBS, particularly in personal care use, reflecting an explicit State policy goal.
The home- and community-based long-term care services in this report account for much of New York’s Medicaid spending, and they have generally been paid on an FFS basis directly by the State. The Medicaid policy reforms being implemented that carve these long-term care services for elderly and disabled beneficiaries into managed care include:

- applying mandatory enrollment in managed long-term care plans (MLTC) to beneficiaries dually eligible for both Medicaid and Medicare (duals) who need at least 120 days of qualifying long-term care services;
- applying mandatory enrollment in mainstream Medicaid managed care plans to Medicaid-only beneficiaries who require personal care services and Medicaid-only beneficiaries enrolled in the 1915(c) waiver Long-Term Home Health Care Program (LTHHC); and
- expanding the mainstream Medicaid managed care benefit package to include personal care, home delivered meals, and medical social services.

**Methodology**

This analysis uses aggregated person-level data from the State’s Medicaid Data Warehouse accessed using Salient Interactive Miner. Below are the descriptions and definitions of the long-term care service payment methods, beneficiaries, and regions that underpin this analysis.

**Payment Methods for Long-Term Care Services**

For this analysis, home- and community-based long-term care services paid for on a fee-for-service basis have been grouped into three categories: personal care, Long-Term Home Health Care Program, and other FFS home care services. MLTC includes the three types of managed long-term care plans: MLTC Partial Capitation, Program of All-Inclusive Care for the Elderly, and Medicaid Advantage Plus. In the charts, these are grouped together in a single category. Additional detail on these plans is included in the inset box on the following page.
Services included in this analysis were delivered between December 2010, before the mandatory MLTC enrollment policy was proposed, and October 2013, the most recent date for which complete Medicaid claims data were available after accounting for a five-month claim lag in FFS claims.

### Home- and Community- Based LTC Services Analyzed in This Report, by Payment Type

**Fee-for-Service**

1. **Personal care**, including housekeeping and home attendant services.

2. Services provided through the Long-Term Home Health Care Program (LTHHCP), which include nursing, personal care, home health aide services, physical, occupational, and speech therapies, medical equipment and supplies, medical social services, audiology, respiratory therapy, nutritional counseling, and additional waiver services such as home improvement or adaptation, home-delivered and congregate meals, social day care, non-medical transportation, and respite care.

3. **All other home care services** paid on a fee-for-service or episodic payment basis² that do not fall into the personal care or LTHHCP categories, including certified home health agency (CHHA) services, home health aide services, nursing, respite care, occupational and physical therapy provided in the home, respiratory care, and speech pathology, as well as services under the Nursing Home Transition and Diversion Waiver.³

**MLTC Plans**

In this analysis, three types of managed care plans are grouped together as “MLTC”: MLTC Partial Capitation, PACE, and MAP.

**MLTC Partial Capitation** plans receive a monthly premium from Medicaid to cover long-term care services and supports, including home health services, personal care, adult day care, and nursing home care. Partial Capitation plans do not cover primary and acute care.

**Program of All-Inclusive Care for the Elderly (PACE)** plans offer the full range of Medicare and Medicaid acute and long-term care services to duals age 55 or over who are eligible for a nursing-home level of care.

**Medicaid Advantage Plus (MAP)** plans offer the full range of Medicare and Medicaid acute and long-term care services to duals eligible for a nursing home level of care.

### Beneficiaries

This analysis examined Medicaid beneficiaries who were elderly or disabled and received HCBS at any point in the study period, characterizing the services they received at the level of a calendar month. Within a single month, being enrolled in a managed long-term care plan and receiving HCBS on a fee-for-service basis were considered mutually exclusive.⁴ Being enrolled in the LTHHCP was also mutually exclusive with receiving FFS personal care and other home care. However, beneficiaries could receive both personal care and “other home care” services on an FFS basis in the same month. If a beneficiary received both FFS personal care and FFS other home care services in the same month, they were counted in the personal care cohort for that month.

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³ Due to data limitations, we were not able to exclude short-term home health care users, whose short-term service use is generally covered by Medicare if they are dually eligible.

⁴ Beneficiaries enrolled in MLTC who also had short-term FFS HCBS use were included only in the MLTC group.
Regions
This analysis examined Medicaid beneficiaries and spending across three distinct geographic regions aggregated by county: New York City (Bronx, Kings, New York, Queens, and Richmond Counties); Nassau, Suffolk, and Westchester Counties (NSW); and “Rest of State” (ROS). These regions are consistent with the geographic implementation of mandatory MLTC enrollment for duals during the study period. Mandatory MLTC enrollment began in the fall of 2012 in New York City, and in January 2013 in Nassau, Suffolk, and Westchester Counties. (An accompanying brief, Mandatory Managed Long-Term Care in New York’s Medicaid Program: Key Eligibility and Enrollment Issues, provides more detail on the rollout of mandatory MLTC, including an implementation timeline on page 5.)

Changes in Long-Term Care Utilization and Spending in New York State
As intended by these changes in Medicaid policy, most elderly or disabled Medicaid beneficiaries requiring 120 days or more of HCBS now receive their care through a managed long-term care plan.

- In December 2010, nearly four out of five Medicaid HCBS users statewide (79 percent) received their services on a fee-for-service basis, and 21 percent were enrolled in an MLTC plan.
- By October 2013, the shares of MLTC enrollees and FFS users had nearly inverted: 71 percent of HCBS beneficiaries were enrolled in an MLTC plan.
- MLTC enrollment more than tripled over this period, rising from 32,904 to 115,025 enrollees.

In the FFS categories, there was a dramatic decrease in users of FFS personal care.

- The number of FFS personal care users statewide fell by 70 percent (40,587) from 57,807 Medicaid beneficiaries in December 2010 to 17,220 in October 2013. FFS personal care users accounted for 38 percent of HCBS long-term care users statewide in December 2010, shrinking to 11 percent in October 2013.
Figure 1
HCBS Long-Term Care Users in New York, December 2010 to October 2013


Figure 2
HCBS Long-Term Care Spending in New York, December 2010 to October 2013

• Statewide enrollment in the LTHHCP saw little change for most of the study period, averaging 15,225 enrollees per month between December 2010 and June 2013, before enrollment in the LTHHCP was closed as a result of folding this population into mandatory MLTC.

• The number of Medicaid enrollees statewide receiving other home care services on a FFS basis fell by 46 percent (21,887), dropping from 47,101 users in December 2010 to 25,214 users in October 2013.

Figure 2 illustrates the shift of statewide Medicaid dollars spent on HCBS services from FFS payments to managed care premiums. As with enrollment, spending on MLTC premiums is now greater than spending on FFS HCBS services.

• In December 2010, MLTC premiums accounted for about quarter of statewide spending (26 percent) and FFS payments represented 74 percent of total HCBS spending.

• By October 2013, expenditures on MLTC premiums accounted for 81 percent and FFS payments had shrunk to 19 percent. These MLTC premium payments had more than tripled (increasing by 254 percent) from $134 million in December 2010 to $475 million per month in October 2013—on an annualized basis, a rise from $1.6 billion to $5.7 billion.

In less than three years, implementation of mandatory managed care has fueled the growth of Medicaid’s MLTC sector to nearly $6 billion annually of the State’s $16.4 billion Medicaid program. It is important to note that this shift from fee-for-service to managed care entails a change in how—and whom—the State pays to cover these services and supports. This analysis does not examine changes in the ways or amounts providers are paid to deliver services or the volume of services they provide.

Rates of Service Use by Region

Regional variation in the distribution of institutional versus community-based long-term care services in New York State is well established. In New York City, there is greater utilization of HCBS and less use of nursing facilities, while this pattern is reversed outside of the city. In December 2012, nursing home payments for Medicaid beneficiaries accounted for 40 percent of total Medicaid long-term care spending for elderly and physically disabled beneficiaries in New York City, compared to 71 percent in Nassau, Suffolk, and Westchester and 79 percent in the rest of the state. The majority of Medicaid beneficiaries who use HCBS reside in New York City; in October 2013, three out of four Medicaid beneficiaries using HCBS were in New York City (see Figure 2). As with users, the majority of statewide HCBS spending is in New York City; in October 2013, more than eight out of ten Medicaid HCBS dollars ($490 million of $578 million) were spent on services delivered in New York City.

Figure 3
HCBS Users by Region, October 2013


7 United Hospital Fund analysis of Salient data. Includes payment cycles through 1906. Access date March 13, 2014.
Examining HCBS service users by region (Figure 4) reflects the phased geographic implementation of the conversion from fee-for-service HCBS to managed care across New York State, which began first in New York City. As of October 2013, most Medicaid HCBS beneficiaries in New York City had moved from FFS to managed care, while this conversion was still in progress in Nassau, Suffolk, and Westchester, and had just begun in the rest of the state.

- Between December 2010 and October 2013, the share of beneficiaries in New York City receiving FFS home- and community-based services dramatically declined from 74 percent to 15 percent, while the share of beneficiaries enrolled in MLTC substantially increased from 26 percent to 85 percent.
- In Nassau, Suffolk, and Westchester, by October 2013, more than half of Medicaid beneficiaries using HCBS (54 percent) were enrolled in a MLTC plan, up from 9 percent in December 2010—a sixfold increase.
- In the rest of the state, the share of HCBS beneficiaries enrolled in MLTC almost doubled by October 2013, but the majority (85 percent) of beneficiaries still receive FFS HCBS.

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**Figure 4**

**HCBS Users by Region, December 2010 and October 2013**

<table>
<thead>
<tr>
<th>Region</th>
<th>Dec 2010</th>
<th>Oct 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>74%</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>24%</td>
<td>22%</td>
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<tr>
<td></td>
<td>9%</td>
<td>8%</td>
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<tr>
<td>Other Home Care</td>
<td>28%</td>
<td>85%</td>
</tr>
<tr>
<td>Personal Care</td>
<td>36%</td>
<td>54%</td>
</tr>
<tr>
<td>MLTC</td>
<td>26%</td>
<td>41%</td>
</tr>
<tr>
<td>LTHHCP</td>
<td>4%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Note: Columns may not sum to 100% because of rounding.
**Growth in Managed Long-Term Care Enrollment**

Growth in MLTC enrollment through October 2013 has been driven by increased enrollment in New York City, which accounts for the majority of Medicaid beneficiaries using HCBS services and which was the first part of the state subject to mandatory enrollment in MLTC. Across the study period, New York City accounted for at least 90 percent of MLTC enrollees statewide per month.

Before the mandatory MLTC enrollment policy was officially announced, almost all MLTC enrollment growth occurred in New York City. From December 2010 through July 2012, before notification of the mandatory MLTC enrollment policy for duals, MLTC enrollment grew by 21,648 to reach 54,552 beneficiaries; 96 percent of this enrollment growth (20,800 beneficiaries) occurred in New York City.
The State began mailing education notices about mandatory MLTC enrollment in July 2012. Between July 2012 and October 2013, statewide MLTC enrollment more than doubled, growing by 60,473 to 115,025 enrollees. From July 2012 to January 2013, during which time mandatory MLTC enrollment began to be implemented in New York City, enrollment grew by a total of 23,722 enrollees statewide to 78,274 beneficiaries. Of this growth, 95 percent (22,634 beneficiaries) occurred in New York City. Between January 2013, when mandatory enrollment expanded to Nassau, Suffolk, and Westchester, and October 2013, MLTC enrollment grew by 36,751. Of this growth, 83 percent occurred in New York City (30,581 beneficiaries) and 14 percent was attributable to enrollments in Nassau, Suffolk, and Westchester (5,240 beneficiaries).

**FFS Personal Care Users Decline**

Over the study period, the number of FFS personal care users in New York fell by 70 percent (40,587) from 57,807 to 17,220 Medicaid beneficiaries statewide. As shown in Figure 6, the number of Medicaid beneficiaries using FFS personal care was trending downward before the mandatory managed care enrollment policies targeting FFS personal care users were implemented. The number of personal care users fell by 2,828 (6 percent of the total decline) from 57,807 users in December 2010 to 54,979 in July 2011.

The staggered decline in personal care users in Figure 6 matches the implementation of Medicaid policies that moved personal care users into managed care plans. In August 2011, personal care for non-duals statewide was moved into mainstream managed care. Between July and August 2011, in the single month leading up to the personal care carve-in, the number of Medicaid beneficiaries using FFS personal care fell by 4,340 (11 percent of the total decline) to 50,639 users. From August 2011 to September 2012, before the mandatory MLTC enrollment policy for duals began, the number of FFS personal care users declined by 4,654 (11 percent of the total decline) to 45,985 users.
When mandatory MLTC began in September 2012, the decline in FFS PC users was less steep than the decline that occurred in July 2011 before non-duals were mandated into mainstream Medicaid managed care for two reasons: first, because beneficiaries had a 60-day enrollment period during which they could still receive FFS personal care; and second, because implementation was rolled by region rather than for everyone in the state at once. From September 2012 to January 2013, during which time the mandatory policy applied only to personal care users in New York City, the number of FFS personal care users declined by 13,451 (33 percent of the total decline) to 32,534.

After the mandatory enrolment policy applied to most FFS users and expanded to Nassau, Suffolk, and Westchester, between January 2013 and October 2013, the number of personal care users fell by the greatest margin, dropping by 15,314 (38 percent of the total decline) to 17,220.
As a result of enrollment in managed care plans, primarily in MLTC but also in mainstream Medicaid managed care for non-duals, the distribution of FFS personal care users statewide has shifted from New York City to elsewhere in the state. New York City personal care users made up a majority of statewide users from December 2010 until February 2013, when the city’s share fell to 46 percent of statewide users. By February 2013, most existing personal care users in New York City would have been required to enroll in MLTC, as this was the first population subject to mandatory enrollment (they were given 60 days to enroll after receiving an initial notice between September and December 2012). In February 2013, FFS personal care users in Nassau, Suffolk, and Westchester accounted for 20 percent of the statewide total (up from 11 percent in December 2010); and users in the rest of the state accounted for 34 percent (up from 19 percent in December 2010).

Regions outside New York City accounted for increased shares of personal care use even though the absolute number of beneficiaries using FFS
personal care there declined, thanks to the larger decline in the number of personal care users in New York City. This is a major shift: for decades, FFS personal care utilization and spending was heavily concentrated in New York City. As mandatory MLTC enrollment is rolled out beyond the initial eight downstate counties, the number of FFS personal care users there is expected to drop further. However, there will continue be some FFS users statewide because beneficiaries using less than 120 days or using certain types of personal care services (Level I services) are excluded from mandatory enrollment.

**Conclusion**

The State’s recent Medicaid policy changes aimed at enrolling most elderly and disabled Medicaid beneficiaries who use home- and community-based long-term care services in managed care have, in less than three years, largely transformed this component of the Medicaid program from a fee-for-service system to a managed care model. As of October 2013, a majority of both beneficiaries and spending for HCBS are now in managed care—an achievement that a few years ago would have seemed unreachable.

The State’s vision is that a managed care model will support the shared goal of improving quality and efficiency in the delivery of home- and community-based services by instituting care management across the full spectrum of long-term care services. Rolling out such a model also serves as an interim step in the State’s goal of full integration in financing and service delivery for duals, including long-term care, primary and acute care, and behavioral health services covered by both Medicaid and Medicare. As the State pursues the implementation of the Fully Integrated Duals Advantage (FIDA) demonstration starting in October 2014, it will build heavily on its experience rolling out mandatory MLTC.