A Review of the Managed Long-Term Care Issues in the FY 25 Executive Budget

By Paul Francis with Adrienne Anderson and Sally Dreslin

Introduction

Governor Kathy Hochul introduced her Executive Budget for State fiscal year 2024-25 (FY 25) on January 16, 2024, and introduced the related 30-Day Amendments on February 15, 2024. Rather than reviewing the entire FY 25 Executive Budget, Sally, Adrienne, and I decided to focus in depth on just a few of the major issues in the Health budget. In this Policy Brief, we review in depth a proposal that is not actually included in the FY 25 Executive Budget but is likely to be part of the budget negotiations, to eliminate partial capitation managed long-term care (MLTC) plans and revert to a fee-for-service system for individuals who do not choose to enroll in a fully capitated MLTC plan. This proposal is being advanced by stakeholders and certain legislators as an alternative to the long-term care savings initiatives included in the FY 25 Executive Budget.

Spending on personal care through partial capitation MLTC plans is the largest single category of Medicaid spending and is among the fastest growing. In this policy brief, we start by examining the sources of the explosive growth of personal care spending in New York over the last dozen years and the contribution of the Consumer Directed Personal Assistance Program (CDPAP) to that growth. The evolution of the policy of mandatory enrollment in managed long-term care is inextricably linked to the growth of personal care spending and expansion of enrollment in MLTC plans.

The FY 25 Executive Budget includes a number of proposals designed to reduce the growth in spending in CDPAP as well as other, smaller initiatives related to long-term care. With the exception of a few comments about the Executive Budget proposal to enable the State to procure MLTC plans, we are not reviewing these other long-term care proposals because they are "payer agnostic" and would be applicable irrespective of any changes in the role of Medicaid managed long-term care.

Spending through partial capitation MLTC plans is almost entirely devoted to personal care, and, to a much smaller extent, home care. Although the terms are sometimes used interchangeably, "home care" in New York essentially refers to nursing services provided in the home, while "personal care" refers to non-medical assistance services such as housekeeping, meal preparation, bathing, toileting, and grooming provided by personal care aides.

We note at the outset that the distinctions among State share spending, non-federal spending, and gross spending (including federal share) in Medicaid can easily lead to confusion. The federal share for MLTC plans and fee-for-service is generally 50%, but the federal share is closer to 60% for mainstream managed care. In this paper, when we are discussing the revenue of and spending by MLTC plans, we will generally be referring to gross spending, while Budget expenditure amounts will refer to State share

spending. We will do our best to be clear when the amounts cited represent the gross amount and when they represent the State share of Medicaid spending.

The Growth of Long-Term Care Spending In New York and the Evolution of MLTC

In FY 2025, State-share DOH Medicaid spending adjusted for COVID-19 enhanced federal funding is projected to total $30.4 billion, an increase of approximately $3 billion (10.9 percent) from the revised FY 2024 levels, assuming that $1.2 billion in savings proposals in the Executive Budget are adopted. The FY 25 Executive Budget financial plan points out that State-share Medicaid spending, including administrative costs, is projected to be 39 percent higher in FY 2025 than the levels recorded three years prior in FY 2022.[1]

The Executive Budget does not break out the categories of Medicaid spending, but the following breakdown for FY 23 State-share spending is adapted from the "Medicaid Global Cap Spending Report: April 2022 through March 2023 Quarterly Report:"[2]

April 2022 to March 2023 Medicaid Global Cap Target vs. Actual Spending ($ in millions)		
Category of Spending	**Global Cap Target (in millions)**	**Actual (in millions)**
Medicaid Managed Care	$21,698	$21,104
Mainstream Managed Care	$14,692	$13,490
Long-Term Managed Care	$7,006	$7,614
Total Fee-for-Service	$7,823	$7,787
Inpatient	$2,628	$2,702
Other non-LTC Spending	$835	$801
Nursing Homes	$3,337	$3,205
Personal Care	$706	$738
Home Health	$132	$155
Other LTC	$185	$185
Other Medicaid Expense	$8,080	$8,672
Local Cap Contribution	($6,566)	($6,566)
COVID-19 eFMAP	($4,441)	($4,441)
Audit Collections	($433)	($402)
Total	**$26,161**	**$26,153**
Total Adjusted to Exclude COVID-19 eFMAP	**$30,602**	**$30,594**
Overall LTC Spending (MLTC, Nursing Home, Personal Care, Other LTC):		**$11,897**
As a percent of total Medicaid spending:		**39%**
MLTC and Personal Care Spending Only:		**$8,352**
MLTC and Personal Care Spending Only, as % of Adjusted Total Medicaid Spending:		**27%**
MLTC and Personal Care Only, as % of Overall LTC Spending:		**70%**

[1] FY 2025 NYS Executive Budget Financial Plan, p. 11. Available: https://www.budget.ny.gov/pubs/archive/fy25/ex/fp/fy25fp-ex.pdf

[2] https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2022-2023/docs/4th_qtr_rpt.pdf

Although spending on nursing home care represented a majority of long-term care spending not so long ago, Table 1 makes clear that long-term care spending in the Medicaid budget is now dominated by personal care, which is mostly paid for through partial capitation MLTC plans. "Partial capitation" refers to MLTC plans that receive a capitated payment from the State to cover only long-term services and supports (LTSS) for their members, as opposed to the smaller number of "full capitation MLTC plans" that cover LTSS *and* medical expenses. As of January 2024, there were approximately 335,000 members enrolled in all MLTC plans and approximately 282,000 members currently enrolled in "partial capitation" MLTC plans.[3] For purposes of simplicity, in the remainder of the paper when we use the term "MLTC plans" we are referring to partial capitation plans unless the context otherwise requires use of the term "full capitation MLTC plans."

Ideally, an analysis of personal care and MLTC plans would examine the full continuum of care for individuals with complex chronic conditions that render them unable to live independently without support. The cost and effectiveness of the delivery of personal care have ramifications for the whole continuum of care, including home and community-based services, home-based nursing care, hospital care, and long-term nursing home care. Our hope is that the Master Plan for Aging and the Commission on the Future of Healthcare will have the capacity to undertake that comprehensive analysis. However, critical decisions may be made in the upcoming Budget about the future role of MLTC plans. We think it's important to provide an objective, fact-based analysis of these issues now while they are being considered by policymakers.

Growth in personal care spending since 2011 and the expansion of CDPAP

Although long-term care represented only about 10% of total healthcare expenditures in New York,[4] the State share of long-term care spending in Medicaid in New York in FY 2023 accounted for approximately 39% of total State share Medicaid spending in that year adjusted for COVID-19 e-FMAP payments.[5] Two categories of personal care spending, partial capitation MLTC plans and personal care in fee-for-service (FFS), accounted for $8.4 billion (State share) or 70% of total long-term care expenditures in Medicaid and are growing faster than the average rate of Medicaid growth. Although partial capitation MLTC plans cover other spending categories, such as short-term nursing home care, home health care, and adult day care, personal care, but personal care services (PCS) provided through Licensed Home Care Service Agencies (LHCSAs) and CDPAP account for close to 90% of the medical expenses of MLTC plans.

Home care and personal care are available through Medicaid fee-for-service (FFS), and mainstream managed care plans (MMC) plans. MMC encounter data is harder to come by, but home care and personal care delivered through fee-for-service spending accounted for approximately $893 million in FY23.[6] Still, the vast majority of personal care is reimbursed through partial capitation MLTC plans.

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[3] https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/
[4] https://www.kff.org/other/state-indicator/health-care-expenditures-by-state-of-residence-in-millions/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[5] https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2022-2023/docs/4th_qtr_rpt.pdf
[6] https://www.health.ny.gov/health_care/medicaid/regulations/global_cap/monthly/sfy_2022-2023/docs/4th_qtr_rpt.pdf

Long-term care spending in New York is much higher than in other states for a variety of reasons. In addition to the comprehensive nature of benefits and historically expansive eligibility rules, New York has liberal "spend-down" and "spousal refusal" rules in New York. A cottage industry of legal advisors who facilitate financial planning with the purpose of securing Medicaid eligibility for long-term care services, in the eyes of many, made long-term care a de facto middle-class entitlement program funded by Medicaid. The State has long wrestled with how to reconcile its desire to provide assistance to this vulnerable population while containing the costs that arise from the policy.

MRT I and "Care Management for All"

A good place to start in explaining the tremendous growth of personal care and MLTC plan spending over the last decade is to understand the thinking behind policies in this area that were developed by the first Medicare Redesign Team (MRT I). Immediately upon taking office in 2011, Gov. Andrew Cuomo created MRT I, which was co-chaired by Dennis Rivera, the popular former leader of 1199SEIU, and Michael Dowling, the CEO of what is now called Northwell Health and formerly a top aide to Gov. Mario Cuomo. At the staff level, MRT I was guided by the talented new Medicaid director, Jason Helgerson, and the highly experienced Deputy Secretary for Health, Jim Introne, who had also served as the Deputy Secretary for Health under Gov. Mario Cuomo and had decades of involvement with long-term care.

MRT I was perhaps the most strategic and ambitious healthcare initiative in New York State to date. Among MRT I's core strategies was the adoption of "Care Management for All," which required mandatory enrollment in managed care for almost all populations. Although programmatic arguments in favor of managed care were the primary driver for the policy's architects, cost containment was also viewed by many as an important objective. The policy of mandatory enrollment in managed long-term care plans represented a shift from fee-for-service reimbursement and administration by the Counties, of much of the State's long-term care program.

One could say that Care Management for All won the long-term care strategy "war" in New York, but then lost the "peace" that followed. The implementation of Care Management for All has been hobbled by regulatory restrictions and stakeholder revenue-maximization behavior that has undermined the ability of MLTCs to effectively manage care. Jim Introne was the principal architect of the Care Management for All policy and for many years he has lamented its implementation. Jim has written:

> "Over a decade after its adoption, the goal of making Care Management for All available to all of the State's vulnerable populations remains unrealized. The great majority of the State's elderly, nursing home eligible population remains enrolled in partially capitated managed care plans that are only responsible for Care Management for a subset of the services available to meet their needs and, even here, the State allows considerable variation in their models of care."[7]

Jim's vision for Care Management for All was that it would be similar to the Program of All-Inclusive Care for the Elderly (PACE). PACE plans are "integrated" programs in two respects: first, the plan and the provider are incorporated in a single entity with a shared bottom line so that there is alignment between the interests of the payer and the provider; and second, the plan covers both LTSS and medical services, so the payer benefits from the reduction of medical expense that might result from more effective, efficient provision of long-term services and supports.

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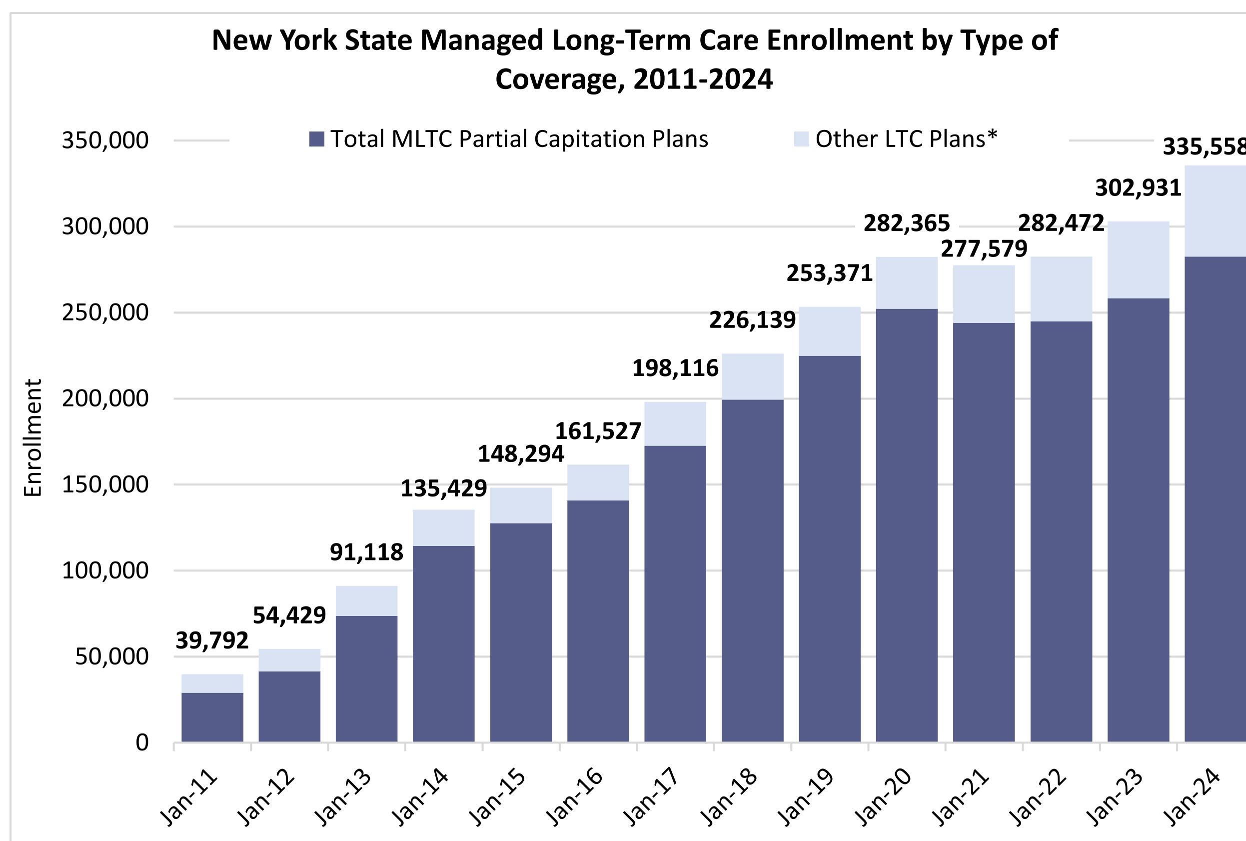
[7] Jim Introne, "Care Management for People with Complex Chronic Conditions", April 2021.

Approximately 85-90%[8] of enrollees in MLTC plans are "dual eligible", meaning they qualify for both Medicaid and Medicare. Increasing enrollment of dual eligibles in fully integrated managed care plans has been one of the State's strategic priorities for long-term care. The belief is that integrated programs offer the best way to enable the provider to customize benefits across the continuum of care for individual members while capturing savings in medical expenses resulting from providing high-quality long-term care services to the member.

By contrast, in a "partially capitated" plan that only covers long-term care benefits, the payer does not receive any financial benefit from the reduction of medical expenses that might result from a more effective provision of long-term care services. Enrollment in PACE and the other primary fully integrated program, the new Medicaid Advantage Plus (MAP) plan has increased significantly in recent years, but with total enrollment of approximately 53,000 members as of January 2024, is still only 19% the size of partial capitation MLTC plans as of January 2024.[9]



**The State defines Other LTC plans to include PACE, Medicaid Advantage Plus, and the Fully Integrated Duals Advantage (FIDA) Demo.*

[8] New York State Department of Health Final Report on Managed Care Organization Services. January 22, 2024. See p.6. available at: https://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf

[9] Analysis based on January Reports from 2011-2024, available at: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

Implementation actions hampering the effectiveness of Care Management for All

The implementation of Care Management for All came to be influenced by partial capitation MLTC plans once the MRT I was disbanded. Although the original intention was that partial capitation MLTC plans would be transitional and ultimately require a direct affiliation or contractual relationship with a Medicare plan, such as a fully integrated PACE or MAP, that requirement was dropped. New partial capitation plans were authorized and allowed to immediately benefit from mandatory enrollment in managed care, with the number of plans increasing from 16 in 2011 to 25 today.[10] This meant that the policy goal in Care Management for All of *the alignment of financial interests* was never achieved.

The following describes how other elements of the policy vision for Care Management for All became diluted in implementation:

Accountability for outcomes. The vision of Care Management for All was that the managed care plan would control all aspects of its members' plan of care. They would be held accountable both for ensuring there was a sufficient network of providers to supply the services set forth in the plan of care and for ensuring the quality of that care. In practice, however, DOH has had limited ability to hold plans accountable for member outcomes.

Authority and autonomy over all aspects of care management. In another significant deviation from the philosophy that MLTC should be responsible for all care management as part of having accountability for member outcomes, the State vested the primary authority for care coordination with "Health Homes," in large part because Health Homes were temporarily eligible for 90% federal financial participation (FFP) – 10% State-share, while the plans retained responsibility for care management in the form of developing person-centered plans of care. Separating care management and care coordination in this way limited the ability of partial capitation MLTC plans to manage care holistically. Moreover, Health Homes are treated as licensed Medicaid providers and, as such, do not have a direct contractual relationship with the State, which hinders the State's ability to manage them.

Authority and autonomy over development of the plan of care. The vision of Care Management for All was that MLTC plans would have significant flexibility to customize plans of care for all of their members, which implied that they would have the authority to award some members less generous plans of care in terms of hours, while having additional resources available for others. However, Administrative Law Judges (ALJs) in Fair Hearing challenges brought by members began to override the MLTC plans' determinations of the appropriate plan of care. Although the plans strenuously disagreed, legal staff at DOH believed that it did not have the authority under federal law to require ALJs to give deference to the clinical judgment of a plan's assessment team, which greatly weakened the hand of MLTC plans in Fair Hearings.

The unanticipated growth of CDPAP. The unanticipated and explosive growth of CDPAP, including the role of fiscal intermediaries (FIs), led to further challenges in realizing the original vision of Care Management for All. As described further below, CDPAP regulations were liberalized on several occasions since 2014, which fueled growth in the program. FIs also spearheaded marketing of the CDPAP, which

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[10] In the FY 24 Budget, the State gave authorization to DOH to require partial capitation MLTC plans to offer a fully integrated product by January 1, 2024. This is expected to reduce the number of partial capitation MLTC plans by April 1, 2024.

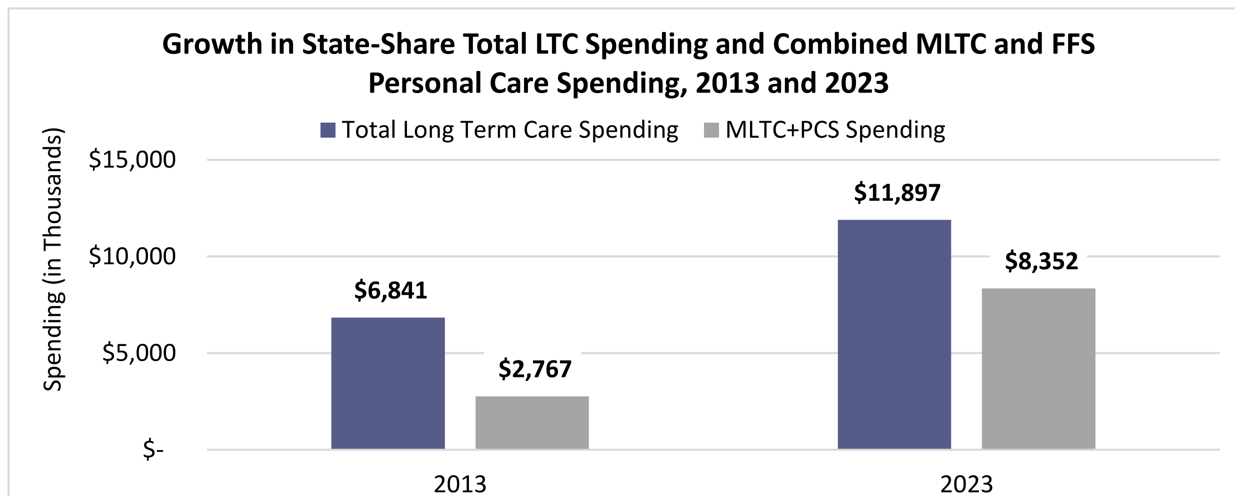
stimulated the demand, and certain FIs are believed to have collaborated with MLTC plans in other ways that increased utilization.

Nursing home carveout. Finally, as the State struggled to find short-term savings to control Medicaid spending in the face of cascading growth of long-term care spending, in April 2020 the State implemented the "carve out" of nursing home services from MLTC plans after the first 90 days of a member's residence in a nursing home and returned reimbursement to the fee-for-service system. Although this measure produced short-term savings, it also had the effect of making MLTC plans seem more like payment intermediaries and less like entities responsible for managing all aspects of long-term care to improve outcomes.

The inexorable growth in long-term care spending from 2011-2020 and the growth of CDPAP

Spending on personal care through partial capitation MLTC plans has grown dramatically since 2011. Multiple factors contributed to this growth, and it is difficult to determine with accuracy which particular factors were most responsible. The aging of the population certainly played some role in this growth. Between 2011 and 2020, the number of New Yorkers aged 75 or above grew from approximately 1.3 million to approximately 1.5 million.[11] But policy changes were probably a more important contributor to growth than the demographic trend.

Some of these policy changes involved the way the Care Management for All policy was implemented. But many people believe the combination of the profit-maximizing behavior of several large for-profit plans and the liberalization of policies related to CDPAP services accounted for much of the growth in personal care spending.



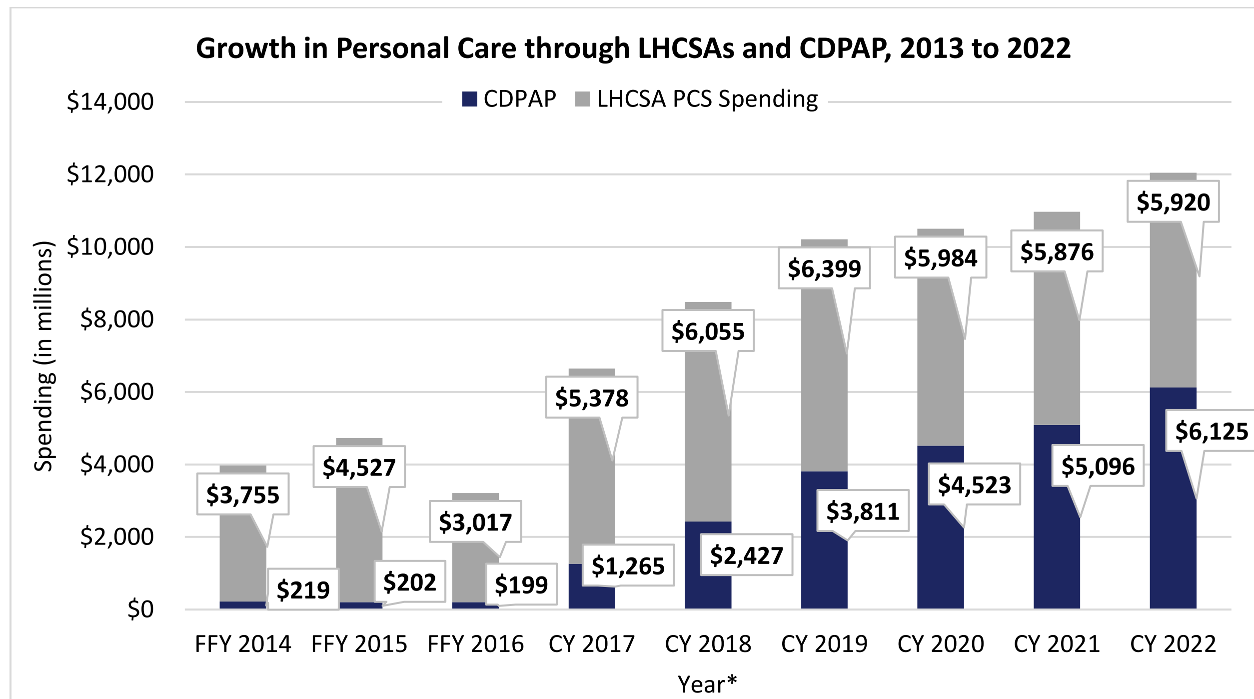
CDPAP was first established in 1995,[12] but grew significantly after a series of policy decisions that expanded the eligibility of people who could receive personal care services and expanded the universe of people who could provide caregiver services under the program. CDPAP enables the recipient of

[11] 2011 and 2020 data retrieved from: https://www.health.ny.gov/statistics/vital_statistics/vs_reports_tables_list.htm
[12] https://www.health.ny.gov/health_care/medicaid/publications/adm/11adm6.htm#:~:text=In%201995%20the%20legislature%20passed,choice%20in%20obtaining%20such%20services

services to hire his or her own personal care aides and have them reimbursed through a "fiscal intermediary" or FI, with which the MLTC plan has contracted, typically at the same rates as the plan contracts with LHSCAs. The FY 25 Executive Budget includes a number of proposals designed to slow the growth and reduce the expense of CDPAP.

An important contributor to the growth of CDPAP spending was the extension of "wage parity" to CDPAP workers in 2017.[13] The original intention of wage parity was purportedly to create parity between personal care and home health aides, but it was also intended to enable LHSCAs to secure healthcare benefits for their workers, most of whom were represented by 1199SEIU. However, because there is no mechanism to provide healthcare benefits and few opportunities to provide other benefits to workers in CDPAP, the belief is that the wage parity amount typically is paid to CDPAP workers in cash.
Wage parity only applies in the downstate region, but the downstate region accounts for the vast majority of personal care spending. Wage parity in New York City historically has required that the worker be paid an additional $4.09 per hour above the minimum wage in cash or benefits, while the amount in suburban counties downstate is slightly lower. These amounts were reduced by $1.55 in the FY 24 Budget, which was offset by an increase in the minimum wage for home and personal care workers.

The extension of wage parity to CDPAP workers may have been a tipping point that led to a sharp acceleration of growth in CDPAP and the program's increasing share of total MLTC spending, as reflected in the table below. The State does not currently make public data about CDPAP, so the information in this table is derived from multiple information sources.



**2014-2016 data reflect federal fiscal years. Source for FFY 2014-16:* https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/NYfy17.pdf

[13] This was implemented through an amendment to PHL § 3614-c in 2017.

The unanticipated growth in personal care spending, in particular, was the primary cause of Medicaid spending exceeding the Medicaid Global Cap by approximately $1.7 billion in FY 20. The State Budget is based on cash receipts rather than accrual accounting, so the short-term fix for this crisis was to shift one month's worth of Medicaid managed care payments from FY 20 to the first month of FY 21. Although that "solved" the FY 20 Budget problem on a one-time basis, it also highlighted the urgent need for structural reforms that would reduce the rate of growth in Medicaid spending, especially spending on long-term care. Intensive efforts during 2019 by the Executive Chamber, DOB, and DOH in that regard evolved into a second Medicaid Redesign Team (MRT II) being appointed by Gov. Andrew Cuomo at the beginning of 2020.

Efforts to control long-term care spending growth through the 2020 Medicaid Redesign Team II (MRT II) recommendations

MRT I reflected the ambition of a new governor and a new senior Health team to develop a comprehensive strategic and stakeholder-driven approach to reform health policy in New York in a way that would both improve care and control costs through a new Medicaid Global Cap. In contrast, MRT II was a less ambitious and more targeted effort that was transparently focused on bending the curve in Medicaid spending, especially on long-term care. The out-of-control growth in personal care enrollment and spending was clearly unsustainable, so identifying explicit savings measures became an imperative.

The Summary of the long-term care recommendations of MRT II began as follows:

> "Spending on long-term care–more specifically, personal care and consumer directed personal care services (CDPAS)–is growing at an unsustainable rate and is the single largest cause of the State's Medicaid structural deficit. Therefore, reforming the way in which Medicaid reimburses for personal care is the area with the largest number of proposals being advanced to the MRT II. …
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> "Initiatives in prior years that were intended to control MLTC spending within the growth rates established by the Medicaid "Global Cap" have failed to adequately address the problem. Accordingly, a comprehensive series of reforms and actions to redesign the delivery of Medicaid services are being advanced, many of which were unanimously endorsed by the Long-Term Care Advisory Group formed by the Department of Health as part of the larger MRT II process."

The most significant MRT II long-term care reforms included:

- Modifying eligibility criteria for personal care and CDPAP by increasing the minimum needs requirements related to activities of daily living (ADLs);
- Reducing the incentives of MLTC plans to stimulate enrollment through consumer marketing and other administrative reforms that sought to limit "forum shopping";
- Removing the incentive of MLTC plans to make liberal eligibility assessments by establishing a Statewide Independent Assessor, which was required to conduct assessments with a uniform assessment tool;

- Consolidating the number of FIs and LHSCAs to generate greater efficiency through economies of scale, which was expected to reduce administration costs; and
- Instituting an eligibility lookback period of 30 months for community-based long-term care services, including personal care services (this remains pending but is likely to be rejected by CMS).

Nearly all of the MRT II long-term care recommendations (which are available online) were adopted in the enacted FY 21 Budget. However, implementation of many of the most significant reforms was put on hold for more than two years because of the maintenance of effort (MOE) requirement related to the COVID-19 federal public health emergency period and subsequently, the MOE requirements under the American Rescue Plan Act (ARPA) which included enhanced Medicaid funding. The MOE prohibited states from reducing Medicaid eligibility or benefits from those in effect on January 1, 2020, which some of the MRT II reforms would have done.[14]

Post-MRT II efforts to control long-term care costs

The growth in spending on long-term care and personal care through partial capitation MLTC plans slowed during 2020 and 2021 (FY 21 and FY 22) because of a variety of factors associated with the COVID-19 pandemic. Nevertheless, the State recognized that the underlying problems driving enrollment growth in partial capitation MLTC plans remained, and engaged in efforts to control costs that were not restricted by the MOE. Because most of the growth in MLTC enrollment was occurring in CDPAP, addressing deficiencies in that program was a particular focus.

Some states use a single FI to serve as the payment intermediary for all of the consumer directed personal assistants in the state, while New York had approximately 536 FIs in 2020.[15] A procurement designed to consolidate the number of FIs was initiated in December 2019 and awards were made to 68 FIs in 2022.[16,17] However, the result of the procurement now faces more than 200 legal challenges from incumbent FIs that were not selected. The State believes it will be unable to implement the procurement and has sought to repeal the procurement in the FY 25 Executive Budget. Because contracting with FIs was the vehicle the State intended to use to limit consumer marketing, that effort also failed, and marketing of CDPAP continues unabated to this day. Given the experience with FI consolidation, the State declined to further pursue consolidation of LHCSAs.

The next major initiative that was developed to reduce costs by restructuring the MLTC market was a proposal in the FY 24 Executive Budget to procure all Medicaid managed care plans, as opposed to the current system, which licenses any MLTC plan that meets minimum requirements. Procurement, which is the practice in at least 26 other states,[18] would enable the State to select plans based on criteria

[14] https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/
[15] https://www.health.ny.gov/health_care/medicaid/redesign/mrt10003/2018-01-12_fiapplication.htm
[16] https://www.health.ny.gov/funding/rfo/20039/docs/awardees_names_and_counties.pdf
[17] While some FIs active before the procurement were not awarded contracts, some could remain "Collaborating partners" to selected "lead FIs" following the procurement. See: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/21-01.htm
[18] https://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf

including efficiency and quality. The procurement proposal was summarily rejected by the legislature in Budget negotiations.

Current policy options to address the growth in long-term care costs

The recent growth in Medicaid spending has again created a sense of urgency to control spending. In total, various long-term care savings initiatives in the FY 25 Executive Budget are "scored" as saving approximately a total of $560 million in FY 25 and approximately $1.059 billion million when fully implemented. These include politically difficult proposals, such as the elimination of wage parity in CDPAP (saving the State approximately $200 million in FY 25 and approximately $401 million when fully implemented), the competitive procurement of MLTC plans (generating no savings in 2025 but $300 million in savings when fully implemented in FY 27),[19] and $100 million annually through miscellaneous initiatives to manage utilization in CDPAP.[20] As noted above, the legislature rejected similar proposals in last year's Executive Budget, including the elimination of wage parity in CDPAP and the procurement of all managed care plans.

The FY 25 Executive Budget proposal for a procurement of managed care plans is more limited than the FY 24 Executive Budget proposal, in that the procurement would only apply to partial capitation MLTC plans. Although a procurement of partial capitation MLTC plans would likely improve the managed long-term care system by increasing the State's control over plans, it faces many challenges. First, based on history, the legislature may well reject the proposal or burden it with so many protections for incumbent plans that it defeats the purpose. Second, the experience of the FI procurement is a cautionary tale about how difficult it is to implement significant policy changes using procurement as the vehicle. Third, the low hanging fruit of consolidation may already have been picked. DOH received the authority in the FY 24 Budget to require all partial capitation MLTC plans to operate a fully integrated plan by January 1, 2024, which is leading to industry consolidation.

It is the combination of all of the elements described above – unsustainable growth in personal care spending, a structure of partial capitation MLTC plans that makes it difficult for them to realize the original vision of managed care, and the political unattractiveness of alternative savings options that has given energy to the proposal to eliminate partial capitation MLTC plans.

The Home Care Savings & Reinvestment Act and the Proposal to Eliminate Partial Capitation MLTC Plans

Faced with these alternatives, the Senate and Assembly majority are now seriously exploring an idea that has been around for some time but which never gained enough traction to even be included in the One-House budgets (i.e., the elimination of partial capitation MLTC plans and a return to fee-for-service except for individuals who enrolled in fully capitated plans such as MAP and the PACE program). The proposal is embodied in a legislative bill called the *Home Care Savings & Reinvestment Act* (the "Act"),

[19] FY 2025 NYS Executive Budget Financial Plan, p. 112. Available: https://www.budget.ny.gov/pubs/archive/fy25/ex/fp/fy25fp-ex.pdf

[20] In addition, the FY 25 Executive Budget calls for reductions in operating subsidies for financially distressed nursing homes and reduction in the capital rate add-on for nursing homes (total savings of $104 million in FY25 and $416M through FY28), the discontinuation of quality pool payments for MLTC ($56 million in FY25 and $224 million through FY28).

which is co-sponsored by the Chairs of the Senate and Assembly Health Committees and advocated for by 1199SEIU. The bill's advocates argue that it would generate significant savings when fully implemented and that it should be considered as an alternative to the savings initiatives proposed in the FY 25 Executive Budget.

The proposal to eliminate the partial capitation MLTC plans may well be a significant issue in the Health budget this year. Even if it is not enacted, the idea is not going away and will likely be revisited in future years if other initiatives to control the growth of personal care spending are not sufficient. What we endeavor to do in the remainder of this paper is to explain in some detail, the major provisions of the proposal, the programmatic reasoning behind the proposal, and to offer an objective and transparent scoring of the fiscal impact that can be compared to other analyses of the proposal as policymakers decide whether to move forward with it.

Certain specific provisions of the Home Care Savings & Reinvestment Act

The Legislative Intent of the Act clearly sets forth the purpose of the bill. It states:

> "The original intent of the MLTC program was that the managed long term care plans would develop into fully capitated plans over time. This has not happened. Therefore, it is the intent of the legislature to repeal the partially capitated managed long term care program and instead, provide appropriate home and community-based long term care benefits under a fee-for-service arrangement. Fully capitated programs such as the PACE program shall continue to be an option."

It is significant that the Act would preserve integrated managed long-term care programs that cover both Medicaid and Medicare services, such as PACE and Medicaid Advantage Plus (MAP) plans. Although the vision of Care Management for All was not realized in the implementation of partial capitation MLTC plans, integrated plans have come much closer to achieving the policy objectives of improving care for vulnerable populations and controlling costs.

Care coordination and care management are separate functions, although the terms are often conflated. At the risk of oversimplification, care management involves the determination of eligibility and the development of a person-centered plan of care that includes the number of hours of personal care and other benefits. Care coordination involves the ongoing coordination of services provided in accordance with the person-centered plan of care.

True care management requires payment flexibility, which enables the care manager to offer more services to some individuals and fewer services to others to achieve the optimal result both programmatically and in terms of the total cost of care. In theory and in practice, investments in long-term services and supports (which may include investments addressing the social determinants of health) may both benefit an individual's well-being and reduce the total cost of care. However, unlike integrated plans that cover both Medicare and Medicaid and/or integrate the provider and the payer, partial capitation MLTC plans receive no benefit from medical savings (which typically accrue to Medicare). As a result, MLTC plans have little incentive to engage in care management and primarily focus on care coordination.

The Act requires that the State retain Care Coordination Entities (CCEs) to perform the care coordination functions of the partial capitation MLTC plans. The Act provides that while CCEs *may* be Health Homes, DOH is permitted to establish CCEs under an alternative organization structure. One of the main

drawbacks of Health Homes is that, as Medicaid service providers, they do not have a contract with the State, which reduces the State's ability to manage them. By contrast, OPWDD has established a program of Care Coordination Organizations that do have contracts with the State, to provide conflict-free care coordination services within OPWDD's fee-for-service system.

The Act is silent about how care management (i.e., the determination of eligibility and the development of a person-centered plan of care) would be administered. The State has already removed MLTC plans from the eligibility determination process through the creation of the Statewide Assessor following MRT II. The vision of MRT II was that the role of the Statewide Assessor would be augmented by the creation of a uniform "tasking tool" for the development of plans of care. However, this was never adopted because of strenuous opposition from MLTC plans. The underlying objective of creating a Statewide Assessor was to reduce the variation between MLTC plans in the development of plans of care for individuals with similar circumstances and levels of acuity. Conferring more authority in the Statewide Assessor to develop plans of care may be a State initiative irrespective of the future of partial capitation MLTC plans. For purposes of thinking about the Act, it is possible that care coordination and care management (development of the plan of care) may be vested in the CCEs or absorbed into the State administration of the FFS program.

What do partial capitation MLTC plans actually do?

Before commenting on the proposal to eliminate partial capitation MLTC plans, we should begin with an understanding of what these plans actually do. Partial capitation MLTC plans perform a range of functions. It is helpful to identify those functions to determine what might be lost in a reversion to a fee-for-service system. The primary functions that MLTC plans perform include the following:

- **Development of a plan of care**: once eligibility for MLTC services has been established through the Statewide Assessor, the MLTC plan conducts a second assessment and, using what is known as a "tasking tool," develops a person-centered plan of care. The plan of care establishes the number of personal care hours per week and other services (e.g., adult day social care) required by the individual. If the number of hours awarded is less than the individual (or their family) believes is appropriate, the individual may challenge the determination in a Fair Hearing process and/or "forum shop" by applying to a different MLTC plan where they think they might be assigned a more generous number of hours. The primary fiscal argument MLTC plans make in defending the existing program is that they develop plans of care that more efficiently manage utilization than would be the case under fee-for-service. Advocates of the proposal argue, however, that a combination of forum shopping, revenue-maximization by MLTC plans, and limitations on the ability of MLTC plans to prevail in Fair Hearings suggests that the current system may actually contribute to increased utilization.

- **Administration of payments to providers and reporting**: MLTC plans contract with LHSCAs and FIs (on behalf of CDPAP workers), which provide the actual personal care services to the MLTC plans' members. Because such a large percentage of the payments to LHSCAs and FIs are devoted to minimum wage and wage parity payments, the range of rates achieved through negotiation is small but not immaterial.

How well do MLTC plans perform?

In evaluating the proposal, it is also important to understand how well MLTC plans are performing these functions. New York currently has 25 partial capitation MLTC plans, which is more than in any other state. MLTC plans and their supporters argue that elimination of MLTC plans and a reversion to fee-for-service would negatively impact their members' quality of care. The MLTC Coalition[21] has published a *White Paper and Fiscal Impact Analysis,* which cites the large percentage of enrollees that receive various public health benefits such as flu shots or vaccines and the fact that 86% of MLTC enrollees rate their plan as "good or excellent." The MLTC Coalition white paper also defends the efficiency of partial capitation MLTC plans.

A more nuanced and less favorable discussion of the effectiveness of partial capitation MLTC plans is included in the Final Report on Managed Care Organization Services (the "Final Report"),[22] which was prepared by the Boston Consulting Group on behalf of DOH to evaluate managed care plan procurement options. The Final Report was issued on January 22, 2024. In assessing MLTC plans, it states:

> "The presence of so many plans in the MLTC market and the existence of low-enrollment plans contributes to several challenges. Namely, plans with low enrollment have 14% higher per-member administrative costs than those with high enrollment. Low-enrollment plans are also less profitable, are less likely to offer aligned Medicare products, are more likely to be rated one star (lowest) by the state, have 25% higher complaint rates on average, and are losing enrollment from members choosing to change plans.
>
> Meanwhile, the large number of plans in the market increases provider contracting and billing burden while stretching state resources for contracting and oversight. The MLTC market faces other challenges beyond market composition. Key challenges include quality issues and gaps in quality measurement, limited alignment with Medicare, and shortages of medical at home workers and limitations of the existing network adequacy standards."

The Final Report concluded:

> "Overall, the MLTC market is fragmented, with too many market players and small plans. There is significant room for improvement in offering integrated Medicare and Medicaid plans to members; improving plan quality (especially Upstate); enhancing measurement of access and quality data; and simplifying administrative infrastructure for providers, plans, and the state. Since many of these challenges are tied to the number of plans offered overall and the number of low-enrollment plans in the market, giving the state a mechanism to select the optimal number of plans through a procurement is a potential key lever toward improvement."[23]

Evaluating the programmatic impact of a shift from partial capitation MLTC plans to fee-for-service is something of an article of faith. However, an important consideration when thinking about the potential

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[21] The coalition is composed of MLTC plans and certain stakeholders, including the New York Conference of Blue Cross and Blue Shield Plans, the New York Health Plan Association, the Home Care Association of New York State, LeadingAge New York, and the New York State Coalition of Managed Long Term Care Plans.

[22] New York State Department of Health. Final Report on Managed Care Organization Services. See p. 36. Available: https://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf

[23] Ibid. at p. 47.

impact on members of the elimination of partial capitation MLTC plans is that 12 of the current 25 partial capitation MLTC plans, including all but one of the ten largest MLTC plans in terms of enrollment, also offer a fully integrated MAP plan. If enrollees do perceive the benefits of managed care and want to remain with their existing managed care insurer, most could transfer to a fully integrated MAP plan operated by their existing insurer and all enrollees can transfer to a fully capitated MLTC plan if they want to remain in managed care.

Different positions regarding the elimination of partial capitation MLTC plans

There are now at least four policy viewpoints regarding the elimination of MLTC plans:

- The 25 partial capitation MLTC plans are opposed to the FY 25 Executive Budget proposal to allow the State to procure MLTC plans and are vehemently opposed to the legislature's proposal to eliminate partial capitation MLTC plans and return to fee-for-service reimbursement except for fully capitated plans such as PACE and MAP. The MLTC Coalition's white paper argues, in effect, that the plans have been a success, suggesting that elimination of partial capitation MLTC would increase annual costs by between $3.0 billion-$4.5 billion.

- The administration, as reflected in the FY 25 Executive Budget proposals, implicitly believes that many of the problems with partial capitation MLTC plans would be solved through procurement of MLTC plans, which would enable the State to improve the program by only working through plans that met the State's quality and efficiency metrics. The arguments in favor of procurement of managed care plans in general, including partial capitation MLTC, are set forth in DOH's "Final Report on Managed Care Organization Services."[24]

- The advocates (led by 1199SEIU) for elimination of partial capitation MLTC plans implicitly are suggesting that because the programmatic and fiscal failures of these plans – irrespective of whether they were inherent in the original design or resulted from the failures in implementation – are so comprehensive that the State should start over from scratch with the fee-for-service system at its core. The *Home Care Savings & Reinvestment Act* reflects the position of advocates for eliminating capitation MLTC plans.

- Jim Introne, who was the principal architect of the Care Management for All policy in 2011, believes that the current system is fundamentally broken, but believes the solution is to fix the system by reversing decisions made during implementation that undermined so many of the core principles of the policy of mandatory enrollment in managed long-term care. There is no one more knowledgeable of long-term care in New York than Jim, so we've asked him to describe how he would go about that and will post his thoughts in the next few weeks.

We are not making a recommendation with respect to the proposal at this time because the State may have additional information that changes our conclusion. However, our analysis is more consistent with that of the advocates than any of the other positions articulated above.

[24] It should be noted that while elimination of MLTC plans and procurement of MLTC plans are mutually exclusive, the other programmatic savings proposals in the FY 25 Executive Budget (such as those involving CDPAP) are payer agnostic and thus could be adopted with or without changes that directly impact MLTC plans.

Evaluating the fiscal impact of the elimination of partial capitation MLTC plans

“Scoring” the fiscal equation for evaluating the fiscal impact of this proposal is straightforward. The question is whether savings in administrative and care management expenses that are realized in a fee-for-service system are offset by other factors, including loss of tax revenue and federal financial

participation, less effective negotiation of reimbursement rates, and, especially, changes in utilization in a fee-for-service system. The Table below shows the data used in our scoring analysis, which is based on cost report data. Estimated 2023 revenue and expenses are trended forward at a growth rate of 10%, which is somewhat below the current rate of growth.

Existing Program with Baseline Trend Growth			
Year	**2023 (annualized)**	**2024**	**2025**
Member Months	3,124,472	3,436,919	3,780,611
Total Premium Revenue	$15,170,239,197	$16,687,263,117	$18,355,989,429
Total Revenue	$15,283,407,999	$16,811,748,799	$18,492,923,679
Premium Revenue Growth %	12%	10%	10%
Personal Care Service (PCS/LHCSA) Expenses	$5,331,211,295	$5,864,332,424	$6,450,765,667
CDPAP Expenses	$6,559,838,987	$7,215,822,885	$7,937,405,174
Total PCS + CDPAP Expenses	$11,891,050,281	$13,080,155,309	$14,388,170,840
Total PCS + CDPAP Expenses as % of Gross Medical Expenses	88%	88%	88%
Non-PCS + CDPAP Expense	$1,596,270,480	$1,755,897,528	$1,931,487,281
Sum of Gross Medical Expenses before Care Management Expense	$13,487,320,761	$14,836,052,837	$16,319,658,121
Sum of Care Management Expenses	$607,383,397	$668,121,737	$734,933,910
Administration Expenses	$1,113,907,656	$1,225,298,421	$1,347,828,264
Sum of Total Medical and Admin. Expenses	$15,139,311,829	$16,653,243,012	$18,318,567,313
Sum of Net Income	$172,369,472	$189,606,420	$208,567,062

Description of the factors and assumptions on which the scoring is based

The table below and the ensuing description identify the factors and assumptions we have applied to the data to score the fiscal impact of the proposal to eliminate MLTC plans and return to fee-for-service. The basis for each of these assumptions is discussed following the table. We also discuss the reasoning behind our assumptions and how those differ from assumptions used by the two other groups that have analyzed the fiscal impact of the proposal – 1199SEIU in support of the Act, and the MLTC Coalition in opposition to the Act.

Net Savings/(Costs) from Elimination of Partial Capitation MLTC Plans			
Year	**2023 (annualized)**	**2024**	**2025**
Savings from not Paying Administration and Care Management Expenses of Partial Capitation MLTC Plans, minus:	$1,721,291,053	$1,893,420,158	$2,082,762,174
Loss of Federal Premium Tax Revenue	$132,739,593	$146,013,552	$160,614,908
Loss of FFP Related to Wage Parity (Neutral)	$0	$0	$0
Increased Reimbursement Cost to Providers	$41,618,676	$45,780,544	$50,358,598
New State Care Coordination Expense for FFS Program	$340,722,044	$374,794,249	$412,273,674
New State Admin. Expense for FFS Program	$400,494,315	$440,543,746	$484,598,121
Loss of DOH Population Management across Managed Care Product Lines	$0	$0	$0
Loss of Budget Savings	$0	$0	$0
Increase or Decrease in Utilization	$0	$0	$0
Total Gross Savings after Offsets	**$805,716,425**	**$886,288,067**	**$974,916,874**
Total State Share Savings after Offsets	**$402,858,212**	**$443,144,034**	**$487,458,437**

- **Savings from not paying administration and care management expenses of partial capitation MLTC plans**. The amount of administration and care management expenses not paid to MLTC plans as a result of the assumed elimination of partial capitation MLTC plans, on an estimated pro forma basis for 2023 of approximately $1.7 billion, which is forecasted to grow to approximately $2.1 billion in 2025. Net savings to the State from not making these premium payments are offset by lost revenue to the State and new expenses incurred by the State in operating a fee-for-service system.

- **Loss of tax revenue**. If partial capitation MLTC plans were discontinued, the State would lose an amount that equates to 50% of the 1.75% premium tax on for-profit MLTC plans that is essentially paid by the federal government. We estimate that based on an assumption of total 2025 premiums of $18.5 billion, lost tax revenue would be approximately $161 million. This amount would be reduced slightly since the premium tax only applies to for-profit MLTC plans.

- **Loss of federal financial participation**. The MLTC Coalition white paper raises a valid concern with respect to the potential loss of FFP in the event that partial capitation MLTC plans are eliminated and the system returns to fee-for-service. For technical and historical reasons, FFP for wage parity is

not available in the fee-for-service program but is available in managed care.[25] The MLTC Coalition white paper estimates that this would cost the State approximately $854 million in FY 24.

The loss of this amount of federal funding would almost certainly be a showstopper. However, our assumption is that the State could structure around this challenge in a variety of ways. This issue was last addressed by CMS in 2015, and the answer may be different in 2024. Another way to structure around the loss of FFP could be to increase base pay for personal care workers while reducing or eliminating wage parity payments – something the State did in part in the FY 24 Budget. Although our scoring assumes that the State would be able to overcome this obstacle, the potential loss of FFP is a major issue that would need to be addressed in any legislation that sought to eliminate the partial capitation MLTC plans.

An intriguing element that is relevant to the issue of wage parity is whether large efficiencies in the wage parity program could be achieved if CMS approves the administration's FY 25 Executive Budget proposal to increase eligibility in the Essential Plan (EP) to 350% of the federal poverty level (FPL). This would enable a large percentage of personal care workers to be eligible for EP (especially those in the CDPAP). Especially if the FY 25 Executive Budget proposal to eliminate wage parity in CDPAP is not adopted, restructuring the wage parity program in a way that contemplates more workers receiving health coverage through could generate substantial savings for the State.

We are not counting on any additional savings from such an EP initiative, but neither do we assume that the State would lose any amount of FFP payments as a result of the elimination of partial capitation MLTC plans, because we think the State would be able to structure around it.

- **Changes in reimbursement levels to LHSCAs and FIs/CDPAS workers**. Although not raised in the MLTC Coalition white paper, we assume that reverting to fee-for-service would result in slightly higher hourly payments to LHSCAs and FIs with a centrally determined fee-for-service rate than the rates negotiated by MLTC plans. Based on historical experience, the average contracted rate negotiated by MLTC plans has been approximately $0.30-$0.40 per hour below the amounts assumed by DOH for actuarial purposes, which would equate to approximately $50 million annually.

- **New care management/care coordination costs**. As discussed above, care management and care coordination activities are distinct activities from each other and from the cost of administration. While it might be an oversimplification, for purposes of the scoring model, we treat care management as the process of the development of a plan of care for a member and care coordination as the activity of coordinating services included in the plan of care. There is a wide variation in the estimate of the cost of care management/care coordination among the 1199SEIU model, the MLTC Coalition model, and our scoring model. We discussed these differences in more detail in a Step Two Policy Project Commentary called "Analyzing Complex Public Policy Issues."

  Based on our assumptions regarding the cost of development of a plan of care and the cost of ongoing care coordination is a pro forma 2023 cost of approximately $345 million compared to

[25] Although few people may be aware of this fact, the State does not pay wage parity to workers who are providing services funded through the fee-for-service system.

estimated MLTC plan expenditures for care management/care coordination in 2023 of approximately $607 million. However, both the MLTC Coalition white paper and the 1199SEIU analysis appear to be looking at the new cost to the State of administration and care management/care coordination under a fee-for-service system. Although we score these items separately, in comparing analyses, it may make sense to look at the combined administration + care management/care coordination expense.

- **New State administrative costs of conducting the fee-for-service system**. The MLTC Coalition white paper analyzes the Act on the basis that the alternative fee-for-service program would be managed through the Counties in much the same way fee-for-service was managed in 2011. However, we think it is far more likely that the State would manage fee-for-service administration on a statewide basis, as it has done with eligibility under the Statewide Assessor.

  We base our estimate of new administrative costs for operating a fee-for-service system on the current administration cost (or the administration loss ratio (ALR)) of MLTC plans. The DOH *Final Report on Managed Care Service Organizations* notes that while the *average* ALR of MLTC plans is 5.7% of total premiums, large MLTC plans have an ALR of 3.3% because of their economies of scale. We think it is a fair assumption that the State, with even more economies of scale, could administer the fee-for-service program for 80% of the administrative expense ratio of large MLTC plans, which results in a projected ALR of 2.64% of total premiums and generates approximately $441 million of administrative expense in 2024.

  The combined new cost of administration + care management/care coordination in our model for 2024 is $815 million, compared to an estimated administration + care management/care coordination estimate of $1.146 billion in the MLTC Coalition white paper.[26] The 1199SEIU analysis reports the 10-year present value of costs and savings, so it is more difficult to draw a direct comparison. Our understanding is that this analysis may be revised subject to feedback they have received, but our reading of their most recent analysis is that total combined administration + care management/care coordination costs in 2024 would be approximately $678 million.

  By comparison, assuming a 10% growth factor from 2023 levels, the combined administration and care management/care coordination costs in 2024 would be approximately $1.9 billion. In short, all of the savings in our scoring model and in the 1199SEIU analysis come from the assumption of lower administration + care management/care coordination costs compared to what is paid to the partial capitation MLTC plans, partially offset by other factors.

- **Loss of DOH population management across managed care product lines**. The MLTC Coalition white paper notes that the State is able to receive FFP that would not be available in fee-for-service for the MLTC plans provision of "home delivered meals, social daycare, and social and environmental supports" The white paper estimates that it would cost approximately $60 million – $120 million (which presumably represents the federal share of these payments) above what it does today to offer these services through fee for service. Unfortunately, there is no publicly available data

[26] Available at: https://nysblues.org/wp-content/uploads/2024/02/rivera-paulin-bill.pdf

indicating how much the plans currently spend on such items, and this information was not included in the white paper. Given that providing these types of "health-related social needs" is now a core priority of CMS and the centerpiece of the current 1115 waiver, we think the State will find a way to structure around this problem and not lose FFP by providing these services through a different vehicle.

- **Loss of savings from recent Budget actions**. The MLTC Coalition white paper argues that the State would lose approximately $55 million in Budget savings from recent initiatives to increase the Medical Loss Ratio (MLR) from 86% to 89% and $52 million from premium withholds related to the achievement of performance milestones. However, we believe that any reduction in administrative expenses related to the increased MLR is reflected in actual results for 2023. Moreover, premium withholds for performance milestones are generally set at a level that most plans can meet, so this essentially just shifts spending from one year to the next.

  The MLTC Coalition white paper also argues that the State would lose $79 million in FFP related to the QIVAP program, which benefits LHCSAs with high expenses attributable to their medical benefit plan. We are not scoring this as an offset, because there may be other ways to achieve the objective of continuing to provide this supplemental compensation to certain LHCSAs.

- **Changes in enrollment and hourly utilization**. By far the largest lever and most difficult-to-score factor in a fiscal analysis of the proposal to eliminate MLTC plans and return to fee-for-service is the impact on enrollment and hourly utilization (often referred to together as simply "utilization"). Every 1% increase or decrease in utilization would increase or decrease gross spending by approximately $135 million in 2023 dollars and larger amounts in future years. If there were a statistically valid control group that could be used to compare utilization in fee-for-service versus through the MLTC plans, we could find an objective statistical benchmark for scoring this. However, no such control group exists. So analysts are forced to rely on their theories about whether utilization would increase or decrease in a new fee-for-service structure.

  The MLTC Coalition white paper concludes that utilization would increase by between $700 million and $2.24 billion annually. This assumption is primarily based on a 2015 estimate from the State's actuary, which estimated that moving from fee-for-service to managed care would result in a reduction of approximately 33% in costs on a per member per month (PMPM) basis. The MLTC Coalition white paper uses this statistic to make their estimates of increased utilization seem reasonable. In our view, however, the estimates of between 5% and 16% increased utilization are simply hypothetical estimates. The white paper acknowledges the subjectivity involved when it states: "While the magnitude of these savings could be debated, some level of increased service authorization must be anticipated in moving back to FFS, especially considering the counties' current lack of cost exposure and inclusion of these savings in current MLTC rates."

  Although the MLTC Coalition white paper assumes that administration would return to the Counties, we believe it is more likely that the fee-for-service program would be managed centrally by the State (directly or through vendors) as it has done with the Statewide Assessor.

Both our scoring and the 1199SEIU analysis assume there would be no change in utilization resulting from a return to fee-for-service. The 1199SEIU analysis does not discuss its rationale for holding utilization constant. The basis of our conclusion is not an empirical analysis, but rather the observation that MLTC plans today have no incentive for cost containment and few tools to work with, even if they wanted to control utilization.

Our belief is that utilization is more likely to *decrease* than increase from baseline growth rates if MLTC plans are eliminated. This view is based on the belief that incentives for cost containment would be better aligned under the fee-for-service system than they are today and a conviction that with modern technology and business processes, determinations of eligibility and plans of care can be made by a State-contracted entity at least as effectively as through MLTC plans.

However, because we acknowledge that there is considerable uncertainty about the direction of changes in utilization if MLTC plans are eliminated, for purposes of scoring, we assume *zero* changes – positively or negatively – in cost due to changes in utilization.

- **Running the equation – our scoring of the fiscal impact of the FFS proposal**. Our full scoring model is included as an Appendix. These estimates could be converted to a State fiscal year estimate assuming an 18-24-month implementation period from the effective date of the legislation of April 1, 2024.

Conclusion

Making fundamental changes in a $15 billion-plus program should not be undertaken lightly. Our analysis would likely, if accurate, lead to a conclusion in favor of the proposal to eliminate MLTC plans and return to fee-for-service. However, we are not making a recommendation at this time that the legislature and the executive enact this proposal because we recognize that this is a complex issue, the scoring of which would benefit from more granular data and analysis.

We also recognize the challenge of securing a sufficient consensus for this proposal to be enacted in connection with the FY 25 Budget. The inability of the State to consolidate the number of FIs even after authorizing legislation had been enacted and a procurement had been completed, as well as the legislature's rejection of the proposal to conduct a procurement of managed care plans last year, shows how difficult it is to enact or implement policies that put even small operations out of business. So the challenge of getting all parties to agree to the likely elimination of the major product line of more than a dozen partial capitation MLTC plans is daunting.

That said, the proposal to eliminate partial capitation MLTC plans is a serious idea and it is not going away even if it is not enacted in the FY 25 Budget. The level of growth in personal care spending over the last decade is unsustainable. Bending that curve will likely require both the type of programmatic changes that have been proposed in the Executive Budget and finding major efficiencies in the administration of the program. As was the case with the Pharmacy Carveout, circumstances change. The ability of the State to manage a fee-for-service program in this area is much greater with the technology and business processes available in 2024 than it was in 2011. As is the case with the best private sector companies, the State needs to be able to pivot when new opportunities arise.

The public would be well served if a comprehensive and transparent analysis of the proposal to eliminate the partial capitation MLTC plans emerged from this Budget. The Final Report regarding procurement of managed care plans also serves as an example of how a comprehensive study that emerged from an unsuccessful Executive Budget proposal can provide insights that inform future decisions.

It is important to note that even if the legislature and the executive agree to include the proposal to eliminate the partial capitation MLTC plans in the Enacted Budget, it would essentially be creating an option to move in this direction, not a fait accompli. The *Home Care Savings & Reinvestment Act* itself states that "this transition shall not be implemented until the commissioner of health is satisfied that all necessary and appropriate transition planning has occurred, and federal approvals have been obtained." Whenever a budget proposal has an effective date later than the end of the annual Budget in which it is being enacted, the succeeding Budget gives opponents a second bite at the apple to undo the reform and also gives the executive the opportunity to recalibrate if factors shift.

There may be useful analogies in the experience with the Pharmacy Carveout, which the State enacted in the FY 22 Budget but did not become effective until the beginning of FY 24. As would be the case with this proposal, the Pharmacy Carveout did not provide any budget savings in the first budget year. Notwithstanding that, the State focused on the long-term benefits of structural change and found a way to close its near-term Budget gap. The opponents of the Pharmacy Carveout sought to undo the reform in the FY 23 and the FY 24 Budgets. However, during that time the State became more confident as it moved through the process for implementation that it would be able to effectively administer the alternative program. The Pharmacy Carveout also demonstrated that once the reform is enacted in statute and implementation is ready to go live, it becomes difficult to stop. Given how difficult it is to gain legislative consensus for fundamental changes in Medicaid programs, the Pharmacy Carveout template of deferred implementation of a program that is authorized in statute may become the best way in which the State is able to implement controversial changes in Medicaid programs.

This Policy Brief is based on the best information publicly available. We believe our facts and analysis are correct, while our conclusions are our own and are certainly subject to disagreement. One of the Step Two Policy Project's reasons for being is our belief that the decisions on important and controversial issues, such as the proposal to eliminate partial capitation MLTC plans, benefit from the democratization of analysis by objective third parties as part of a transparent public policy debate. We hope this Policy Brief contributes to that process.

Appendix: Step Two Policy Project Scoring Model (Gross Dollars)

Existing Program Data with Baseline Trend Growth			
Year	**2023 (annualized)**	**2024**	**2025**
Member Months	3,124,472	3,436,919	3,780,611
Total Premium Revenue	$15,170,239,197	$16,687,263,117	$18,355,989,429
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Sum of Net Income	$172,369,472	$189,606,420	$208,567,062

Net Savings/(Costs) from Elimination of Partial Capitation MLTC Plans			
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Savings from not Paying Administration and Care Management Expenses of Partial Capitation MLTC Plans, minus:	$1,721,291,053	$1,893,420,158	$2,082,762,174
Loss of Federal Premium Tax Revenue	$132,739,593	$146,013,552	$160,614,908
Loss of FFP Related to Wage Parity (Neutral)	$0	$0	$0
Increased Reimbursement Cost to Providers	$41,618,676	$45,780,544	$50,358,598
New State Care Coordination Expense for FFS Program	$340,722,044	$374,794,249	$412,273,674
New State Admin. Expense for FFS Program	$400,494,315	$440,543,746	$484,598,121
Loss of DOH Population Management across Managed Care Product Lines	$0	$0	$0
Loss of Budget Savings	$0	$0	$0
Increase or Decrease in Utilization	$0	$0	$0
Total Gross Savings after Offsets	**$805,716,425**	**$886,288,067**	**$974,916,874**
Total State Share Savings after Offsets	**$402,858,212**	**$443,144,034**	**$487,458,437**

Assumptions and Calculations			
Premium Tax Revenue			
Total	**$265,479,186**	**$292,027,105**	**$321,229,815**
Federal	$132,739,593	$146,013,552	$160,614,908
State	$132,739,593	$146,013,552	$160,614,908
As a % of Premium Revenue	1.75%	1.75%	1.75%
Loss of Federal Premium Tax Revenue	**$132,739,593**	**$146,013,552**	**$160,614,908**
State Reimbursement Cost to Providers			
Base PCS+CDPAP Expense	$11,891,050,281	$13,080,155,309	$14,388,170,840
Increased Hourly Cost	0.35%	0.35%	0.35%
Increased State Reimbursement Cost to Providers	**$41,618,676**	**$45,780,544**	**$50,358,598**
New State Admin Expense for FFS Program			
Total Premium Revenue	$15,170,239,197	$16,687,263,117	$18,355,989,429
80% of Large MLTC Plan Admin Expense Ratio of 3.3%	2.64%	2.64%	2.64%
New State Admin Expense for FFS Program	**$400,494,315**	**$440,543,746**	**$484,598,121**
State Care Management Expense for FFS Program			
Total Member Months	3,124,472	3,436,919	3,780,611
Members per Month	260,373	286,410	315,051
Patient to Care Manager Ratio	64	64	64
No. of Required Care Managers	4,068	4,475	4,923
Annual Care Manager Salary	$70,000	$70,000	$70,000
Total Cost of Care Managers	$284,782,604	$313,260,865	$344,586,951
Care Manager to Supervisor Ratio	8	8	8
No. of Required Supervisors	509	559	615
Supervisor Salary	$110,000	$110,000	$110,000
Total Cost of Supervisors	$55,939,440	$61,533,384	$67,686,723
Total Cost of Care Managers and Supervisors	**$340,722,044**	**$374,794,249**	**$412,273,674**