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ISSUE BRIEF

LONG-TERM CARE IN NEW YORK: INNOVATION IN CARE FOR ELDERLY AND DISABLED PEOPLE

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New York's need for long-term care is particularly significant. In 1996, elderly New Yorkers comprised 13 percent of the state's population,[1] a figure expected to grow to about 16 percent by 2020.[2] The state also ranks first in the percentage of elderly who are on Medicaid—22 percent in 1996—creating high pressure on this public component of the long-term care financing system.[3] A profile of the state's Medicaid home care service users suggests that the overall needs of the long-term care population are substantial: the majority of recipients have severe physical limitations and multiple chronic health conditions, and more than half are cognitively impaired.[4] In addition, Medicare does not cover long-term care to any significant extent, and few older New Yorkers—less than 3 percent of those over age 65—have private long-term care insurance.[5]

Thus, New York faces the formidable challenge of creating and sustaining systems that provide a wide range of long-term care services to its elderly and disabled population. Furthermore, the state is chiefly responsible for overseeing the delivery and quality of long-term care services within its borders. Its long-term care provider community comprises more than 3,000 nursing facilities, residential care facilities, adult daycare centers, and home health care agencies. Included in this group is the Visiting Nurse Service of New York, the largest not-for-profit provider of home health care in the country.

New York has been committed historically to a strong health care system for its residents—a commitment that extends to long-term care as well. Overall, the state operates a good but expensive program: it spent $11.8 billion on Medicaid long-term care in 1998, accounting for nearly 45 percent of all Medicaid spending in the state;[6] additional spending in New York on home health agency services, nursing facility care and hospice by Medicare totaled $1.4 billion in 1996.[7] In 1996, low-income elderly and disabled people—who are most likely to use New York's long-term care services—numbered about 539,000 and 585,000 people, respectively, of the state's 3.3 million Medicaid recipients.[8]

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Medicaid Expenditures for Long-Term Care Services, 1998

Type of Service	New York (in thousands)	New York Per Capita	United States (in thousands)	United States Per Capita
Long-term care	$11,789,615	$649	$59,064,651	$219
Institutional				
Nursing home	$5,792,332	$319	$34,290,799	$127
Other institutional	$2,047,529	$113	$9,852,914	$36
Home- and community-based care				
Home health	$839,011	$46	$2,218,436	$6
HCBS waiver	$1,455,658	$80	$9,092,318	$34
Personal care	$1,655,086	$91	$3,469,146	$13
Total Medicaid	$26,993,244	$1,485	$167,669,435	$620

Note: Represents claims of expenditures eligible for federal matching funds based on state fee-for-service payments during 1998.
Source: Brian Burwell, The MEDSTAT Group, analysis of data for the AARP Public Policy Institute, April 1999.

Compared with many other states, New York's Medicaid program has generous eligibility criteria, extensive coverage of personal care services, and high nursing home payment rates. Despite the state's position as a leader in offering home- and community-based care programs (HCBS), some experts view rapid growth of nursing home expenses in recent years as a sign that New York is losing ground in its progress toward a system that balances institutional and noninstitutional care.[9]

New York's fiscal pressures conflict with its commitment to maintaining an adequate long-term care system for residents. It is now employing all three categories of activities that states use to control long-term care spending: reducing Medicaid reimbursement, services, or eligibility; bringing in more outside resources, including Medicare and private insurance; and reforming the delivery system to make it more efficient. The state is one of 13 being monitored and analyzed as part of Fund-supported work at the Urban Institute.

INSTITUTIONAL LONG-TERM CARE

At first glance, New York appears to have a sizable institutional infrastructure for providing long-term care services. It had more than 600 nursing homes caring for more than 130,000 patients in 1996.[10] On a per capita basis, however, the supply of nursing home beds—116 per 1,000 elderly people age 75 and older—is relatively low compared with the national average of 131 beds.[11]

The state has among the highest nursing home expenditures in the nation. In 1998, residents faced costs as high as $88,000 annually in the New York City metropolitan area and $66,000 annually in upstate counties.[12] These high costs, as well as a payment rate that includes a relatively comprehensive set of services, are also reflected in the Medicaid program: New York ranks second-highest in monthly Medicaid nursing home costs per patient ($5,515 in 1996).[13] Further contributing to nursing home costs under Medicaid is patients' high level of impairment—due in part to limits on nursing home bed supply—and high proportion of Medicaid enrollees: more than 80 percent of the state's nursing facility patients are program beneficiaries.[14]

Half of New York Medicaid long-term care spending in 1998 was for nursing home care; together with other institutional services, such care represents about two-thirds of state long-term care Medicaid spending.[15] High nursing home spending, however, does provide an impetus to offer home- and community-based alternatives at the same or a lower cost. Innovative programs that deliver high-quality, cost-effective care are desirable particularly for individuals who are able to remain at home with appropriate care. Even if home- and community-based services were not less expensive than nursing home care when all costs—including room and board—were considered, alternatives to nursing home care may be encouraged on the basis that they contribute to a higher quality of life.

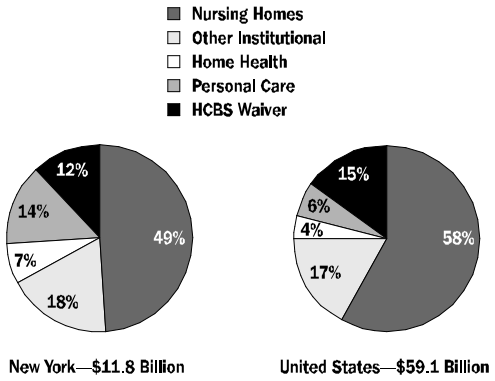
Pressure to reduce Medicaid spending and to institute regulatory reform raises concerns for quality of care in nursing homes. In New York, the Department of Health monitors the quality of care in Medicare- and Medicaid-certified nursing homes on behalf of the Health Care Financing Administration. The state was one of five in a recently completed Fund-supported examination of federal- and state-level activities to enforce nursing home quality standards established by the Omnibus Budget Reconciliation Act of 1987.

NONINSTITUTIONAL LONG-TERM CARE

New York is an outlier in spending for home health care, personal care, and home- and community-based services, toward which most states dedicate a relatively small percentage of Medicaid funds. Not surprisingly, in 1996, New York had the highest percentage of Medicaid home health care, personal care, and home- and community-based service beneficiaries in the nation and the second-highest percentage of long-term care expenditures going toward such programs.[16] Despite generous benefits, the system of

delivering home care services in New York is typical of that in other states: very fragmented with multiple programs, providers, and reimbursement sources.

Medicaid Expenditures for Long-Term Care, 1998



Source: Brian Burwell, The MEDSTAT Group, analysis of data for the AARP Public Policy Institute, April 1999.

Home Health Care

About 180 certified home health agencies provide Medicare and Medicaid home health services to more than 200,000 beneficiaries in New York.[17] Medicaid covers all mandatory home health services plus the optional services: (a) physical, occupational, and speech therapy, and audiology, (b) private-duty nursing, and (c) hospice care. Medicaid home health expenditures were $839 million in 1998, accounting for 7 percent of Medicaid long-term care spending in New York and more than one-third of national Medicaid expenditures on home health.[18] In 1996, Medicare covered only $895 million of home health care and hospice care costs for New York beneficiaries.[19] New York is actively seeking to maximize these payments for home health care services.

Personal Care

Personal care services provide assistance for beneficiaries in activities of daily living (ADLs), such as dressing, bathing, and eating, rather than home medical care. In New York, these services are delivered by 525 licensed home care services agencies serving 85,000 beneficiaries with functional or cognitive disabilities.[20] Medicaid's personal care program has been very generous historically, and, until recently, virtually without limits: for example, some recipients of personal care services have generated costs as high as $100,000 or have received 24-hour attendant care.[21] Personal care is a particularly significant component of home care in New York. The $1.7 billion program accounted for 14 percent of Medicaid long-term care spending in 1998, and 80 percent of expenditures were incurred in New York City alone.[22] New York also spends nearly half the national Medicaid budget for personal care.

Home- and Community-Based Service Waivers

Home- and community-based service waivers can be used to cover specific groups of people or specific geographic areas and offer a wide range of nonmedical, social, and support services as benefits. Such programs may also have higher income eligibility standards. New York's program is known as the Long-Term Home Health Care Program. It involves 113 providers—including hospitals, nursing homes, and certified home health agencies—serving 20,000 beneficiaries.[23] In 1998, Medicaid home- and community-based services waivers of $1.5 billion accounted for 12 percent of Medicaid long-term care spending in the state.[24]

The Long-Term Home Health Care Program provides a comprehensive, case-managed equivalent of nursing home care at home for chronically ill people of all ages. Services include physical and other therapies, home health aides, personal care, medical social services, nutrition services, medical supplies and equipment, and, under the Medicaid waiver, nonmedical services. Most providers are subject to a per-patient limit on total costs of 75 percent of the average Medicaid cost for comparable nursing home care in the same region. Historically, program care costs have averaged 50 percent of the average cost of nursing home care.[25] This program is considered one of the state's most successful innovations in long-term care, having survived several rounds of budget cuts and retained the strong support of the state legislature.

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New York's Expanded Services

New York, along with 39 other states as of 1997, has created programs to meet the needs of older people who are able to avoid nursing home placement and remain in their own homes. These state-only funded programs of home- and community-based care are relatively small. In New York, they include the Expanded In-Home Services for Elderly Program, which spent $28 million in fiscal year 1997, or $75 per disabled elderly person; and the Supplemental Nutrition Assistant Program, which spent $14 million for home-delivered meals.[26]

The multi-service, expanded in-home services program was established in 1986 to address the need for a comprehensive community-based chronic care delivery system for functionally impaired elderly people who are at least 60 years old, have one or two limitations in ADLs, and are not eligible for Medicaid, Medicare, or adult protective services. Local offices for the aging contract with social service agencies to provide case management and community-based nonmedical home care or personal care services such as adult daycare, emergency response, and home repair. The cost to recipients is based on a sliding scale: people living below 150 percent of poverty pay nothing, and those living above 250 percent of poverty pay the full cost of services. New York subsidizes counties through local offices for the aging for 75 percent of costs. This program is reported to have a long wait list.

Challenges to Maintaining Existing Noninstitutional Programs

New York's commitment to allowing people to remain at home rather than in institutions is being challenged by the growing prevalence of high-cost home care cases. Not only have such costs provided impetus for recent years' budget proposals affecting home care programs, but assessments of future expected costs are now required for long-term Medicaid beneficiaries receiving care in the home. Patients whose average monthly costs are expected to exceed 90 percent of residential health care facility service costs in the area are referred to other long-term care services.[27]

As part of work supported by the Fund, the Visiting Nurse Service of New York is examining the state's efforts to control Medicaid and state-only spending on noninstitutional long-term care services. The project focuses on understanding the impact on frail elders' access to needed services and identifying options for improving access. Other case study sites include California, Florida, Georgia, and Wisconsin.

MANAGED LONG-TERM CARE

Elderly and disabled patients, who represent the highest costs to states, are the most likely to benefit from some type of care management. New York is among a number of states that envision managed long-term care and the eventual integration of all acute and long-term care services as a potential way to lower spending growth rates, improve care quality and appropriateness, limit the number of participating providers, and shift financial risk from the state. Most state efforts are only in the planning stages and are limited in scope.[28]

New York is one of the first states to aggressively pursue managed long-term care and to do so on a statewide basis. This strategy was formalized in the Long-Term Care Financing Act of 1997, which established a legislative and regulatory framework for integrating long-term care service delivery and financing through the development of managed long-term care plans. Subsumed under this single authority were all existing such plans; in addition, the legislation authorized the creation of 24 managed long-term care pilot programs that will serve 25,000 chronically ill and elderly Medicaid beneficiaries.[29] Health maintenance organizations, nursing facilities, home care agencies, hospitals, and nonprofit organizations with a history of coordinating elder services will be allowed to participate in the demonstration. Existing sites include one social health maintenance organization, four PACE organizations, two continuing

care networks, and five plans in the Medicaid Long-Term Care Capitation Program (described below).

The initial seed money and the final push for this recent New York initiative came from work supported by the Fund and other foundations in the early 1980s, and sustained by additional, more recent support. A common characteristic of managed long-term care programs is their use of capitated payment rates for Medicaid and/or Medicare services. Under capitation, plans receive a fixed dollar amount from each payer to provide certain types of services to a patient. Such an approach can increase flexibility to deliver care in creative ways within dollar limits, and savings may result from delivery of cost-effective services or administrative efficiencies.

Program for All-Inclusive Care of the Elderly

The Chronic Care Management (CCM) program in the Bronx, New York, was initially developed in the early 1980s by Beth Abraham Hospital with support from the Robert Wood Johnson Foundation. Building on that effort, in 1984 the Fund supported a randomized trial of the program's feasibility and cost-effectiveness. Comparison of data on CCM enrollees and nonenrolled elderly New Yorkers during a 32-month period demonstrated greatly reduced use of acute care services by CCM enrollees and substantially lowered costs: patients spent 32 percent fewer days in the hospital and 75 percent fewer days in skilled nursing homes, generating a savings of 9.4 percent—or $3,550—per person per year.

In 1987, the evaluation proved critical in securing state approval for one of the first federally managed health and long-term care service programs for people with both Medicaid and Medicare coverage. CCM and 10 similar provider organizations around the nation operated as PACE demonstrations for more than a decade. The Balanced Budget Act of 1997 established permanent provider status for PACE under Medicare and also established PACE as an optional Medicaid state service.

CCM, now known as Comprehensive Care Management, and other PACE provider organizations feature a comprehensive delivery system and integrated Medicaid and Medicare financing. PACE services include all Medicare and Medicaid services plus an additional 16 services. Delivery systems emphasize use of adult daycare supplemented by in-home and referral services. Enrollees receive assessment, care planning, and services from an interdisciplinary medical and social work team typically consisting of a physician, nurse, social worker, and physical therapist. Providers are fully capitated for primary, acute care, and long-term care services.

Nationwide, 26 PACE sites operating in 16 states provided services to almost 5,000 individuals in 1996.[30] New York State is currently home to four sites, including two of the original PACE demonstrations. CCM continues to be a leader nationally and in the community it serves, and it is the only PACE program serving the disabled population under age 55. CCM enrollment today numbers about 750, including 450 people who receive services in their homes or in Beth Abraham-supported housing developments and 300 who receive services at the adult daycare facility.[31]

In addition to supporting the development of PACE, the results of the Fund-supported evaluation led New York State to support a similar program—Continuing Care Networks—which began at Rochester General Hospital via a planning grant from the Robert Wood Johnson Foundation.

Medicaid Long-Term Care Capitation Program

The effects of the evaluation of CCM continue beyond the scope of PACE projects. New York State's two original PACE sites are considered forerunners to the current New York State Medicaid Long-Term Care Capitation Program.[32] In 1994, through a grant to Health Research, Inc., the Fund encouraged the New York Department of Health to implement a demonstration of capitated managed care for people requiring

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long-term care services who are eligible for both Medicaid and Medicare. The project has developed a voluntary program for chronically ill or disabled individuals over age 21 who are otherwise considered "nursing home appropriate."[33]

The five initial plans in the Medicaid Long-Term Care Capitation Program were selected through a competitive bidding process. Four of these plans were operational as of April 1999 and a fifth is scheduled to begin enrollment this summer. Sponsors are the Visiting Nurse Service (VNS) of New York, Community Health Care Services at Hebrew Hospital Home, Senior Network Health at Mohawk Valley Network, Broadlawn Health Partners at Long Island Home, and Partners in Community Care at Good Samaritan Hospital. VNS Choice, which has been in operation the longest (since January 1998), already has 1,000 members and is larger than any of the other managed long-term care programs in New York State including the PACE sites; the other operating plans have collectively enrolled only 70 individuals. A total enrollment of more than 3,000 is projected at the end of three years.[34]

A key program feature is that enrollees and plans negotiate the contents of a care plan. Although covered services are provided either directly by the plans or through subcontractors, all plans rely on nurses to perform care management. The long-term care portion of Medicaid services is initially capitated so that the plan assumes financial risk for agreed-upon services; the state's intent is to capitate all Medicaid and Medicare services within three years of plan operation. In the interim, plans must arrange or coordinate noncapitated services with long-term care services.

The goals of the Medicaid Long-Term Care Capitation Program are to provide greater service flexibility; increase patient satisfaction; improve health status and delay functional decline; test capitation as a way to constrain growth in costs; and develop provider expertise with partial capitation as a first step toward full integration of Medicare and Medicaid. To assess program progress in achieving these goals, the Fund is supporting an independent evaluation by the Urban Institute. Clearly, plans require a significant amount of time to understand and develop the infrastructure needed to support this comprehensive program for which they are assuming financial risk.

The long-term care industry's enthusiastic response to the Request for Proposals by Health Research, Inc., for the Fund-supported New York State Medicaid Long-Term Care Capitation Program—141 letters of intent and 17 proposals—led to numerous requests to more quickly open the program to additional providers. This, along with the governor's 1996 Task Force on Long-Term Care, helped stimulate the state's latest managed long-term care initiative legislated in 1997. This initiative is effectively expanding the Medicaid Long-Term Care Capitation Program to 24 additional sites. Having documented cost savings and better medical management through the CCM evaluation nearly a decade earlier, the Fund's second project in this area provided further impetus for the state to consider managed long-term care.

OTHER LONG-TERM CARE INNOVATIONS

As described above, New York has taken several important steps to improve its long-term care delivery system. In addition, the Office of Continuing Care was established within the Department of Health in November 1997. This integration facilitated better coordination of activities and introduced efficiencies by placing within one organization all programs that support and serve frail elderly and physically disabled populations.[35]

Nevertheless, with public funds as the primary source of long-term care financing, New York has strong incentives to control expenditure growth. Long-range approaches recommended by the governor's Task Force on Long-Term Care include promoting private insurance and developing cost-effective residential alternatives to nursing homes.[36]

Since March 1993, New York has operated a public-private partnership program

for the purchase of private long-term care insurance. Under this program, individuals who purchase a state-approved insurance policy with three years' worth of coverage for nursing home care, six years for home care, or a combination of the two can keep an unlimited amount of assets and still qualify for Medicaid. The number of active policies grew from 12,000 in early 1997 to 21,000 in late 1998, and the average annual premium cost for all policyholders was $2,064.[37] The state has given the program permanent statutory authority and hopes to boost future sales through improved marketing.

New York has not yet fully developed affordable options through nonmedical residential facilities. These are facilities where, by definition, residents cannot live completely independently but are not as disabled as the nursing home population. A major barrier to the expansion of residential care alternatives in the state is the small number of such facilities. Adult homes and assisted living facilities that receive Medicaid funds are regulated by a certificate-of-need process that is under a temporary moratorium. Thus, by 1998, as many as 35,000 residential care beds (35 beds per 1,000 people age 75 and older) were licensed in New York, compared with 117,000 nursing facility beds (116 beds per 1,000 people age 75 and older).[38] In addition, New York has a complicated system of regulating these providers and is in the process of developing new regulations to consolidate the multiple licensing categories that already exist.[39]

CONCLUSION

The goal of improving the delivery and cost-effectiveness of care to New Yorkers with long-term care needs who are able to stay in their own homes will require many years of activities to produce visible effects. Furthermore, as in the case of the PACE program in the Bronx, an extensive partnership—consisting of foundations that helped get the programs started, a dedicated private nonprofit health care organization with a commitment to developing and delivering the programs, and public financing to sustain them—was necessary to improve long-term care services for frail elders. Finally, capitated funds from Medicaid and Medicare have been essential to the ongoing viability of these innovative private sector approaches to long-term care delivery.

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